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Psychodynamic Psychiatrists' Experiences of Being Stalked

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Abstract: Despite the estimated 15% likelihood that a psychiatrist will become the victim of stalking, there is little formal recognition of its prevalence or its impact on well-being. Through narrative accounts, ten psychiatrists with psychodynamic orientations speak of their experiences including how each managed the anxieties consequent to stalking. These include a variety of adaptive psychic operations as well as concrete actions to curtail stalking.

Keywords: stalking, dangerousness, erotomania, delusional disorder, psychiatrist

Though the prevalence of stalking in the general population is estimated at 4.5% (Basile, Swahn, Chen, & Saltzman, 2006), the risk to physicians is substantially greater. In their review of the literature on the stalking of physicians from 1950 to 2015, Nelsen, Johnson, Ostermeyer, Sikes, and Coverdale (2015) located 12 studies showing a prevalence rate of physician stalking ranging from 2% to 25%. The variability in the studies was determined to be a consequence of study design, low response rate to surveys, and the differences in the formal definition of stalking. Other workers have found the risk to healthcare professionals to range between 5% and 10% annually (Mullen, Pathé, & Purcell, 2009; Purcell, Powell, & Mullen, 2005).

Abrams and Robinson (2011) report a prevalence for physicians of 14.9% with psychiatrists, surgeons, and OB/GYNs showing the greatest risk. When strict research criteria were applied, a qualitative thematic analysis of 2,585 psychiatrists in the United Kingdom revealed that 11% of respondents were stalked (Maclean, Reis, Whyte, Christophers, Petch, & Penny, 2013). Significantly, they report, when the re-

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search definition of stalking was removed from the analysis, the proportion of psychiatrists who perceived themselves as victims of stalking almost doubled to 21%. The study offered respondents the opportunity to make statements about their experiences as stalking victims. Several brief statements are reported. More extensive narrative reports of clinicians' experiences were not included, nor were the experiences of psychodynamic psychiatrists separately analyzed. Psychodynamic psychiatrists are those with a psychoanalytic orientation augmented by contemporary neuroscience.

Since it is term encoded in legal statutes, stalking is avoided by the standard psychiatric nomenclature. Instead, phrases serve such as, "efforts to make contact with" (DSM-5; American Psychiatric Association, 2013, p. 91). Another definition regards stalking as referring to behavior or unwanted communications that cause fear or distress and that continue over more than two weeks (Mullen, Pathe, & Purcell, 2009). The U.S. Office for Victims of Crime states, "virtually any unwanted contact between two people that directly or indirectly communicates a threat or places a victim in fear can be considered stalking" (2002, n.p.). The latter definition is notably broad in that it includes harassment, a form of behavior often distinguished from stalking (Pathé & Mullen, 1997). While broad in that regard, this definition omits stalking conducted by government, non-government, or corporate entities. It also fails to consider the matter of "unwanted attention," a term often incorporated in definitions of stalking and that gains importance when individuals are investigated deeply through Internet searches (Claydon, 2017). Finally, this definition like other definitions, fails to consider circumstances that may result in fear that one will be stalked and in which neither the requisite terms "contact" nor "communication" would seem sufficient to prompt the experience of being stalked. Understandably, the definitions of stalking emphasize what the stalker does, not what the targeted reasonable person feels or believes.

The current project seeks to present the voices of psychodynamic psychiatrists who have been stalked or who feared they might be stalked. It aims to add narrative substance to the scaffolding of surveys of psychiatrists targeted by stalkers and, additionally, considers the experiences of those psychiatrists with exclusively psychodynamic interests.

THE PROJECT

In 2016–17, 20 psychodynamic psychiatrists were asked about their possible experiences involving dangerous patients. The author was acquainted with each clinician solicited, but in no instance did the

author know if the psychiatrist had felt endangered by any patient. The author interviewed only senior psychiatrists, that is, those in clinical practice for at least 25 years. The psychiatrists were mostly members of the American Academy of Psychoanalysis and Dynamic Psychiatry. The Academy is a national organization of 550 psychiatrists with a meaningful interest in psychodynamics among whom about half completed psychoanalytic training. The essential question posed was, "Have you ever been in danger from a patient?" No definitions of danger or stalking were supplied. That is, each respondent effectively self-defined the terms. Other core questions were, "When did this occur in your professional career?" and, "Did you feel your subsequent symptoms of distress met the criteria for a mental disorder?" Ten men and ten women were interviewed with the aim of learning how respondents might describe experiences of danger.

RESULTS

Of the 20 psychiatrists, four volunteered that they were stalked. A fifth had believed she might have become the target of stalking or outright assault. Added to these five were three male psychiatrists known to have been subject to stalking. Of these three, one declined to be interviewed, stating that he wished to put the matter behind him. After presentation of an earlier version of this article at the Academy meetings in May, 2017, two additional senior psychodynamic psychiatrists stepped forward and joined the project. Discussion with another senior colleague about the project revealed a sense he had of having been stalked on the Internet. Hence, there are ten narratives included below. Of the ten, two respondents each indicated they had been subject to stalking on two entirely separate occasions. For the purposes of this project only one of these reports per respondent was selected for inclusion. Of the ten respondents, all reported concern or distress—often considerable—but only one believed her symptom picture met the criteria of a "form of PTSD."

NARRATIVES

Each narrative below has been reviewed and approved for presentation and publication by its respective contributor. This entailed both verification by the contributor of essential clinical material as well as adequacy of disguise, in some instances minor and in others major.

Written permission was obtained for inclusion in professional presentations and publications. It was agreed that once approved by the respondent, no modification would be made. The titles and brief introductory paragraphs are the author's own.

1. Accepting a Gift

The following vignette is from a senior psychodynamic psychiatrist who, as a resident, accepted a gift from a patient who then continued to phone and harass the psychiatrist for many years.

During my first year of residency, I began classes at a nearby psychoanalytic institute. One of the questions that was raised at the institute concerned the psychodynamics of accepting gifts from patients. The question was especially meaningful for me because at just that time, a patient on the locked floor where I was working offered me a book of limericks. The book was amusing as I leafed through it and—relying on the argument that the ordinarily human response was psychodynamically legitimate—I accepted the gift. It was the “human” thing to do. The patient carried the diagnosis of schizophrenia that, now, looking back, would be seen as incorrect. Very likely the patient had an unspecified bipolar disorder. What I hadn't appreciated was that receiving the gift created a claim on me. The patient now had a right to my attention. Once discharged, he began calling me. I'd receive angry, threatening calls once or twice weekly, then monthly, then yearly. After returning the first couple of calls, and following a supervisor's suggestion, I ceased responding. Now, 40 years later, calls still come, but now separated by a few years. The calls were threatening at first, but the caller never specified what would happen if I did not return the calls. The most recent call was about a month ago. It was almost friendly. With feelings of regret that I knew should not dictate my behavior, I didn't return the call.

2. The Office too Close to Home

Well-established in private practice, this male psychiatrist failed to appreciate the erotic transference of his female patient, a transference that failed to respond to interpretation or confrontation. The delusional disorder, erotomanic type, proved an ongoing stress for the psychiatrist over many years.

In about my 22nd year as a psychiatrist—I was in private practice by then—a woman came into treatment for depression following the loss of

a love relationship. She had a respected high-ranking administrative job. She loved a co-worker and imagined the co-worker was in love with her. The depressive symptoms began when the co-worker repeatedly and insistently rebuffed my patient.

At the age of 9, my patient's parents separated. Mother was schizophrenic. The girl was sent to a children's home, which we would regard as an orphanage. After a few years, she returned to live with her alcoholic father. She had felt desperately lonely. Realistically, she was abandoned and unloved by her parents. A much older sister expressed no interest in the girl. She attended college and married.

Not long after treatment began, she revealed fantasies about me—that I loved her and she loved me. So, I thought, oh well, erotic transference so we'd work that through. Then I made a mistake. I happened to have two offices, one was in a professional building and the other was in a second-floor apartment annexed to my residence where I lived with my wife and sons and a loudly squawking cockatoo. She quickly interpreted my suggesting that she see me at this second office as my letting her into my personal life: I clearly loved her. She dismissed my statement that the hours of our sessions made this more convenient. My having her come to this office served as proof of my love for her. Despite my interpreting to her that her early abandonment was the root of this, she insisted that this was a personal relationship. I became very anxious when she said, no, this is not a professional relationship: we love each other. I got increasingly concerned.

She began calling at all hours. She made a suicidal gesture, but didn't go through with it because she believed I'd realize my error and would make the relationship personal. My insistence on the therapeutic boundary only made her enraged.

Not quite sure how to proceed, I went with my patient to an analytic colleague. To my chagrin, my colleague sidestepped the matter, saying that whether it was personal or professional, either way, my patient would be disappointed. My patient agreed to stay in treatment, but then accused me of not helping her. She'd storm out of some sessions—or wouldn't leave when her session was over.

It got to be intolerable. My next effort to manage this clinical problem was to start weekly personal supervision from an outstanding clinician. It was interesting but not helpful. Soon, my patient would come to my office when there were no scheduled hours. She'd accost me in the lobby of the office building and in the parking lot. She made suicidal threats. I tried referring her, but she refused. More than feeling physically threatened, I felt threatened by the very real chance that she'd commit suicide. I succeeded in having her see a third consultant, also of outstanding reputation. My patient flew out of the consultant's office in a rage. I called the police because I was sure she'd kill herself. That night, she showed up at my office. She had taken an overdose. I arranged to have her hospitalized. The staff said she should see someone other than me. I agreed. I refused to see her. That was final. But it was not final, not for her.

Over the next several years, she'd call, show up at my office building and loiter in the lobby. She had befriended the guards at the office build-

ing. At times, I'd become aware that she'd drive past my apartment building, back and forth, on the weekends. This went on for years and is still going on. It is 30 years later, the security guard—they have turned over a few times, but each learns the story from his predecessor—would call up to tell me she is waiting in the lobby. She always leaves before I'd come down. Thank goodness.

I still wonder if I could have handled it differently. I feel some guilt here. I didn't realize the depth of her pathology. I've kept her file all these years. She is imprinted indelibly in my mind. I feel guilty and foolish for taking her to the office adjacent to my residence with the cockatoo seeming to trumpet through the walls that, as she saw it, this is an intimate place that proved she was special to me. I treated the erotic transference too lightly, not recognizing that it was beyond interpretation. I failed to realize in time that my patient had an erotomanic delusional disorder. She continues to haunt me. I keep all her records.

3. The Talisman on the Closet Door

The vindictive challenge to this psychiatrist who failed to fulfill the patient's erotic delusional disorder is at the heart of this vignette. The challenge took the form of complaints to the state medical board.

This all began in my tenth year as a psychiatrist. I was in private practice. I have now been in psychiatry for 36 years.

I forget how she was referred to me. She came because of anxiety, but overlaying a borderline personality structure. Later, I'd regard her as having a delusional disorder. She worked at a peripheral medical job, married, had two children. Eventually, bizarre stuff began. She began calling at all hours. She would show up at my office and yell at me. When I moved my office, she appeared unannounced with a plate of cookies. When I was home sick, she called my home and screamed at me, "Why aren't you in your office to see me?!"

At one point, she started group therapy with another therapist and persuaded the others in the group that I was mistreating her. I called the therapist and said she could either see me, or the other therapist, but not both of us.

She complained, "All you ever give me is doctor's love." In one dream, she reported, she came to my house, got into my clothes and felt she was slipping into my skin. At times, she'd come into my office, screaming and yelling. I'd say, "I will just step out of my office and let you cool down." That sometimes worked. Finally, I got her to see another psychiatrist to serve a consulting function. She insisted that I also come to the other psychiatrist's office with her. I agreed. She worked with both that psychiatrist and with me.

Finally, after two years, I discontinued seeing her since she was now in the capable hands of the psychiatrist to whom I had referred her. Eventually, she filed a 20-page complaint to the state medical board that I refused to love her. I got the best lawyer I could find and consulted an excellent psychiatrist and got a letter from another consultant. I prepared a lengthy history of my work with the patient. The medical board dismissed the case. Six months later she filed the same complaint, which was again dismissed.

At one point, a few years later, I received an unstamped letter in my mailbox stating that she had colon cancer. I sent her a simple note saying I was sorry and hoped all would work out. Later, I learned from the psychiatrist with whom she was still in treatment that she thought I was her actual mother, not a signifier or replacement, but her actual mother. I was frightened. She had befriended an analysand of mine and it seemed as if she would continue to be a presence in my professional world. I didn't know what was going to happen. I pictured being in the office alone and I was afraid. I still feel a combination of guilt and anger: I should have done better. I got the complaint dismissed—but it cost a lot, money, time, and terrible emotion.

Until you contacted me, I hadn't realized how traumatized I was. Long ago, I had placed all my notes and letters in a canvas bag and hung them on the doorknob of a closet in my office. All these years later, I have been scared to touch that bag. I am afraid of how I would feel if I read those notes again, yet I am terrified of discarding them or even putting them in storage. Perhaps my error was not in cleanly discontinuing with her. It was a gradual transfer. I was not able to feel compassion for her pain. I was mostly scared. The bag on the doorknob is a talisman that somehow I feel protects me, and it is still there.

4. Terror, Care, and a Satisfactory Conclusion

Hunted by a paranoid schizophrenic man, this terrified first-year female resident found safety in the care and security provided by a concerned administration.

In my internship, I was at a VA hospital in Los Angeles. I was in the surgical team that operated on a woman who had metastatic cancer of the gall bladder. Her brother was an elderly man who was on a locked psychiatric unit of the same hospital. Unfortunately, the patient died on the table. The brother said I killed her. He was a Catholic and since I was a Jew, he concluded that I was responsible for killing her. After I completed my internship I came to the New York Psychiatric Institute for my residency in psychiatry. Soon, I began receiving letters and postcards from this man. He had escaped from the psychiatric unit and was coming to New York. He wrote that he and I would marry and be in heaven together, after he killed me. The letters and cards each had a skull and crossbones. The postcards

were stamped with postmarks showing one after the other that he was advancing eastward.

I showed these to the chair of the department. He recognized the threat, notified the VA hospital from which the patient eloped, alerted the security staff, and had posters of the man placed everywhere. I was very nervous. But I felt protected. Everyone was very concerned. The man did show up, finally. He was arrested and brought back to the VA in Los Angeles. Though I was very worried, I also had a very secure feeling that I was being protected by the administration. From the first letter to the time he was apprehended was about five months. I felt cared about, and that feeling carried forward through my residency. I think that experience may have enhanced my sense of satisfaction as a young psychiatrist. I never felt I had done anything to bring this on. Also, it may not have mattered that I went into psychiatry. He probably would have stalked me no matter what specialty I chose. All that happened 56 years ago.

5. A Hospitalization that Earned the Psychiatrist Vengeful Threats

A patient experienced an entirely appropriate hospitalization as destructive and sought to retaliate against the psychiatrist who had advised the hospitalization.

I was in my sixth year as a psychiatrist, completing a period of employment at a clinic. I am now in my 36th year as a psychiatrist. The patient who stalked me had an initial diagnosis of major depression, but I believe he also suffered from PTSD resulting from trauma in childhood.

He was in his 30s, a refugee from a war-torn country and a graduate student at Stanford University. I believed he should come into the hospital because he was suicidal and impulsive. But I remember it quite clearly. I told him that he needed to go to the hospital, but I couldn't be his doctor because I was assigned to the clinic. But I could visit. He felt I had betrayed him. When I saw him on the floor, he was enraged with me. He signed out of the hospital after one-and-a-half weeks.

I began receiving menacing letters and calls. They were accusatory: "I had ruined his life...I know where you are...You should suffer as I had." It was vengeful. I felt guilty though I knew that I had done the right thing, clinically. He was suicidal and impulsive and needed hospitalization. Still, I felt horrible. I thought, maybe I shouldn't have hospitalized him. I was terrified because I knew he was violent, or came from a culture where violence was commonplace. I was afraid of him. I didn't know where he was. There was no direct, "I am going to kill you," or I would have called the police. I used a great deal of denial as I think back to this. I was vigilant going in and out of my office, but otherwise I used denial. Every time I came to my office, I'd look to see if anyone was lurking. This went on for a

year or two. And I'd be getting angry calls on my answering machine and threatening letters. Fortunately, I was on a wide street and had a doorman. I was young—maybe that's why I didn't get help. I was not just inexperienced, I was young and had the sense of being invulnerable that somehow co-existed with feeling terrified.

One day two years later after I had hospitalized him, I got a phone call and picked up. He called to say he had slit his wrists and intended to kill himself. I spoke to him, keeping him on the line while I motioned to my office mate, jotting him a note. He called 911 and the police traced the call. After a few minutes, he cried out that a siren was approaching. He demanded to know what that was. I said I called the police. He dropped the phone and I never knew what happened. The police said there was no one there. A few days later he called and left a message that he was sorry for frightening me. I never heard from him again.

I didn't know how to understand that last call. Why would he apologize?

I had a lot of patients in that clinic who threatened me, but this stands out because I may have done something wrong. At the time, I think that he had been raped or tortured as a child. Now, I see his distress and his coming after me as the consequence of early trauma. Objectively, I did nothing wrong, but the force of his accusation threw me into doubt.

This is a painful memory.

6. Getting a Gun

Faced with a threat from a vengeful homicidal patient, this psychiatrist was advised to get a gun and learn how to use it.

You think it's the young psychiatrists, in training or newly out of training, who are subject to dangerous patients. I was in my 35th year as a psychiatrist and in private practice when I saw in consultation a depressed and cranky young man. He complained about his girlfriend, his mother, and the world. I thought he had a borderline personality disorder with paranoid traits.

He had grown up in Denver. His father was in the utility business and the young man briefly worked with his father. That didn't work out and he decided to go out on his own. I saw him weekly for about a year. He complained that I wasn't helping him and asked me to refer him to someone else. I referred him to a younger psychiatrist whom I respected and they began working together. Another six months passed. He discontinued therapy and began writing letters to the other psychiatrist and to me. He intended to kill us and blow up buildings in Washington, D.C. I contacted the police. They could do nothing. I hired a private detective. He advised me to get a gun and learn how to use it—and to get a camera system so I'd know who was at my office door. I did both things. The calls kept coming.

We got a restraining order. He turned up at my colleague's office. We got a second restraining order. The young man was told by the court that if he turned up a third time, he'd go to jail indefinitely.

My younger colleague said that since the man intended to set fires in Washington, we should contact the FBI. He made that contact, but I don't know what, if anything, came of it.

Twenty-two years later and I still have the gun.

7. A Pregnant Psychiatrist

Informing her male patient that she was pregnant and would need to take time off, this psychiatrist was astounded and horrified to learn that her patient then killed his pregnant girlfriend. She feared she could be next, a fear that continued for many years. Though the psychiatrist was never stalked, she feared the possibility.

I was working in a clinic. It was my fifth year as a psychiatrist. This event occurred 40 years ago. He was a house painter. I saw him earlier as a resident and then took him into my private practice. He may have been my first patient and maybe I somehow intercepted his spiraling into psychosis. He thought he was Christ, but not with the thought disorder of a schizophrenic. Probably, he had a delusional disorder and a bipolar syndrome. I am no longer sure. I was 25. Looking back, I realize there was an erotic transference, unappreciated by me at the time. Earlier, he was always coming on to me, but also to the nurses. He was very charming. I didn't discuss this with my supervisor because I felt I had it well in hand. Anyhow, he got better. In one session, I told him I was pregnant and may need to cancel at some point. He said, fine, but then he failed to come to his next session, which would have been several weeks later.

In my work, I rely on my feelings and intuitions. I was very uncomfortable when he didn't show up to that next session. There was something horribly wrong and I felt it intensely. After a few days, I called his mother. She said he had killed his pregnant girlfriend because he believed she was unfaithful to him. I felt terribly guilty that I hadn't prepared him for my pregnancy well enough.

Sometime later, the family's lawyer got in touch with me. I testified in court. Ironically, at the time of my court appearance I was pregnant again. I testified that he was very confused and that he was not a murderer. The court asked if I would take him on as a patient. Roiled with my own confusion, I uttered though my terror, yes, I'd be happy to see him. A few months later, he was released. He called to ask for an appointment. I agreed, but said I wanted his brother to come with him. When he came—his brother staying in the waiting room—he asked if I was afraid of him. I said, yes. He nodded. It was very important that I answer honestly—it was important that he trusted me. Afterwards, I felt less afraid, but a shadow hung over

me for years to come. I'd see him once or twice a year for many years. I last saw him 15 years ago by which time he had married and had a daughter. He never showed further signs of psychosis.

I remember always checking to see if he had a gun. *<You were courageous.>* No, I was afraid. I felt I had no choice but to continue to be available to him. I had no vivid recalls, but I could never forget this. The only way I thought I could protect myself was to testify on his behalf in court and then see him in treatment. *<You saved his life.>* I think I did. My husband was angry and scared that I was seeing him. I wouldn't want him wandering the streets thinking—whatever. I've often thought I could have done it differently, but I chose a course that worked out. I have been in psychiatry for 48 years.

8. A Twinship Experience

This psychiatrist and those in her immediate community received phone calls from a stranger over a period of years. The stranger presented herself as a close friend and pried information about the psychiatrist and the psychiatrist's family.

I was not stalked by a patient—and I suppose if you use some strict definition of stalking that requires explicit threats, I probably was not stalked, at all. But it sure felt that way. This all started about 30 years ago.

Before I began my psychiatric residency, I trained in another specialty. Toward the end of this other residency, I received the first of many phone calls. The caller represented herself as an alum of the same college I attended. She was new to the city where I currently lived and asked for suggestions about one thing and another. I had a nice conversation with her.

The next call was picked up by our nanny. The caller now claimed to be my friend and seemed to know a lot of details about my life and my children. I didn't recognize the woman's name when my nanny told me about the call. After she called a few more times, I began to worry and wonder if I was crazy. She called others, my secretary, my brother, and because she sounded so convincing—she knew so much about me—she found out more and more about me. I changed my unlisted number to another, and then to still another. When we moved, she discovered my new address. Who was this?

She'd call the nanny and tell the nanny how well the kids were doing. In the days before easily available video cams, it was as if she had one somewhere in my home. The police said there was nothing they could do. I had my phone tapped to see if that would help. She seemed to have tentacles into every section of my life. The woman would call when she knew I wasn't around. It was pervasive. I felt frustrated and fearful and wondered what she could do—take my children, kill me, hurt me? But somehow, I

did not access anger toward her—rather fear and wonderment at her persistence and ingenuity.

Finally, someone in the ER where I was working got a phone call from her that I could trace. This led to a series of clues and, finally, I learned who she was. She was married to a government official. My husband decided to call this woman's husband. My husband was frightened and angry. I was scared. I was ambivalent about his getting involved. I was afraid his getting involved would escalate her behavior. The caller's husband showed no distress by what he was told, saying he'd talk to his wife at dinner. After that, the phone calls became more intermittent. My husband called again, this time threatening legal action. Then the calls stopped.

I learned from other sources, as best as I could infer, that this woman wanted to be me, to be in my family. She grew up in the same community as I did. My father was a lawyer and she saw him on one occasion. As a young child, I experienced the loss of my mother. I felt envious of all other children. Later, I had a series of successes, mostly academic. My siblings were attractive and successful; my stepmother and my father were well-known professionals in their fields. It may have seemed to her that we were an ideal family. Perhaps, I thought, the caller was envious of my successes, thinking that I had a charmed life. As I was envious of others as a child, she was now envious of me. Was her stalking me, her frightening me, a kind of payback for my later successes and my envy of other girls? From my own early childhood loss, I could resonate with that feeling of envy and the wish to be part of an intact, ideal family. I knew the kind of hunger I imagined she experienced. The woman, perhaps, had become kind of a twin and I think this is what made it difficult for me to feel angry with her.

Perhaps there was something gratifying for me about having someone so completely obsessed with me since I felt emotionally deprived and disregarded as a child, and, as a result, became hyper-competent as an adult. Here was someone who was paying attention to me, following my every move and wanting to know every detail about my life and my children's lives. This experience was what I fantasized a mother would do—know every detail about me, pay acute attention to my comings and goings and be intimately involved with my children and extended family. As a child, I was drawn to and curious about other girls' relationships with their mothers. I had idealized fantasies about what those relationships were like. I also felt envious and resentful of particular girls who seemed to have charmed lives—much as this woman felt toward me.

The whole episode lasted about eight years. I never saw a picture of her. I haven't wanted to look her up. I am avoidant of having anything to do with her—of googling her. It would be an acknowledgement that there is still a connection. I don't want that. It almost seems like a dream. Yet, I still feel a residue of that fear. As I was then, I am still worried about my children's safety. I guess it's a form of PTSD.

One consequence of this experience for me was that it allowed me to reconnect with powerful maternal yearnings that I had worked on in my first analysis. Issues of intense envy of my analyst's children, wishes to insert

myself into her life, a desire to know what each member of her family was like and how they compared to me, how to draw a line between thought and action and how to understand what appropriate boundaries were in this and other relationships were major issues that were reactivated and reworked for me in a vivid way as a result of this experience.

<Since her husband showed no distress when your husband spoke with him, is it possible that you were one of a series of persons she did this with?> No, I never thought I was one of several. For whatever consolation that was, I think that at least I had a sense of being special. But that was not my husband's belief. He believed by the lack of shock or concern on the part of her husband that I was one of a number of people she stalked. I cognitively knew this was possible or even likely but never quite psychologically believed it—probably because I thought her dynamics meshed so well with my own. It's as if she had some sixth sense for the psychological fit.

9. To Be Spied Upon...Maybe

Sensing without certainty that his patient was hoping to spy on him, this first-year psychiatric resident transferred her to a colleague.

Not long after I began my first year as a psychiatric resident, I was assigned a clinic patient. That was over 50 years ago. The patient, a woman in her late 20s, was paranoid and lived a rather isolated existence. She was probably schizophrenic. I learned that she had rented an apartment across from my residence and at a higher floor than my own apartment. Her apartment overlooked mine. She could readily peer into my apartment and spy on me. I was dating actively at the time and, even if I was not, I valued my privacy. I did believe she was spying on me or could if she chose to. It was uncomfortable to think that she had gone to these lengths. We had only met for a couple of months in therapy, so transferring her to another resident was easy to do. I don't think I asked her about her renting that particular apartment or whether she was hoping to spy on me. I don't think I confronted her. I never confirmed with certainty that I was being stalked, if stalking is what it might be called, but it was not something I cared to worry about when transferring her to another clinician was available.

10. Does Internet Prying Constitute Internet Stalking?

This psychiatrist had thought of "stalking" as applying only to threatening behavior and communications. When asked if he had ever been stalked, he realized that prying into another's life on the Internet also counted as stalking.

I've had five instances of being Googled. And not just by simple Googling, but by way of what comes up through Googling. It seems that every available link to obtain information about my life has been tried. Just a few facts are needed and you're wide open. You ask if I've been "stalked." I hadn't quite thought that term applied until you asked. But, yes, if you count actively finding out about my life and the lives of my family and the lives of my partner, it might. Mostly, I'd say I was surprised, even amazed, by the experience. But the feeling of being stalked is in there too. My patients, the patients who did the stalking, told me what they had done. I've been in practice for about 40 years and these are the only occasions I've felt something akin to being stalked.

My partner and I have close relations with our sibs and their kids and, more recently, their grandkids. We vacation together and they spend time with us at our summer place. Our pictures are online. You won't find them if you look me up. You'd have to work at it. These five patients did.

What is the impact on our work when our personal lives are exposed? What is the impact on us? On our patients? And what if it's our patients who expose us? When one patient told me he had seen photos of my sister and her kids and grandkids with me and my partner at our summer home, I felt intruded upon. I felt a sense of betrayal. The patient, of course, had looked for those pictures. He also found pictures of me as a child and of my deceased parents. Another patient, a solitary gay man, was so deeply envious of what he correctly regarded as my happy family life that the treatment went haywire. We were never able to recover a workable therapeutic alliance after that. He was bitten with envy. I not only felt intruded upon but as though I should have been more protective of him.

In each of the five instances, my patients expressed some level of guilt in spontaneously acknowledging what they had done. In all but that one case, we came out okay. In all the other instances, we'd explored the motives and feelings associated with the prying. To a greater or lesser degree, it made for some difficulty for the patients and for me. But over time, I've adapted to this world where privacy is so much more difficult to achieve. In general, I've experienced it as grist for the mill. But I've also taken pains to more thoroughly privatize my online presence.

<Do you invite your patients at the outset of treatment to Google you or to let you know if they learn about you online?> No, I don't do that. If they bring it up, I deal with it then. That's how I handle it.

DISCUSSION

The Uncertain Effectiveness of Third-Party Assistance

We observe in this collection of narratives the help psychiatrists sought in dealing with their experiences. In Example 1, a resident receives a gift from a patient, creating a claim or entitlement. We

observe his receiving demands and threats over many years, but in diminishing frequency. Shortly after the harassment commenced, a supervisor suggested that the psychiatrist simply avoid responding. By contrast, Example 2 relates a profoundly distressing clinical difficulty in which the threat of suicide was paramount. Here, the invitation to a patient to see the psychiatrist in an office near the psychiatrist's home seemed to consolidate a profound erotomanic delusional disorder that lasted for 30 years with no signs of ending. Consultations failed to provide effective counsel. In Example 3, we also observe erotomanic delusional disorder. The threat in this instance was not suicide, but instead manifested as actual complaints to the state medical board. As with Example 2, eventual transfer to another psychiatrist relieved the distress. In Example 4, the predatory threat to the young psychiatrist who was stalked by a paranoid schizophrenic patient was distinctly homicidal. The strongly protective efforts by the hospital administration protected the psychiatrist and managed the return of the patient to hospital care. The support and exemplary care for the psychiatrist created for her a lasting sense of safety and regard. The ineffectiveness of complaining to the police is illustrated by Example 6. The psychiatrist contacted a private investigator who advised the installation of a video camera and recommended that the psychiatrist acquire and learn to use a gun. As in Example 6, in Example 8, the failure of the police to be of help prompted further action. In this instance, the threat of legal action intercepted further stalking.

Self-Doubt and Psychic Defensive Operations

In a number of instances, the psychiatrists believed they brought the problems on themselves, or may have. The psychiatrist of Example 1 who accepted a gift believed he made an error in judgement, creating a claim the patient now had on him. The psychiatrist of Example 2 recognized that by inviting an erotically disposed patient to an office near his home he may have consolidated an erotic delusion. The psychiatrist of Example 3 thinks perhaps she should have ended treatment with her patient more cleanly. In Example 5, perhaps difficulties would not have developed, says the psychiatrist, if she had not hospitalized her patient—although hospitalization was indicated. We observe in Example 7 the pregnant psychiatrist who identifies with the pregnant girlfriend who had been murdered by the psychiatrist's patient. The psychiatrist defended the patient in court and offered treatment to the patient. She was terrified equally by the option on one hand of

defending the patient and providing treatment, or on the other hand of doing neither. Perhaps, states the psychiatrist, if she had prepared her patient better for the fact of her pregnancy matters would have worked out differently. The psychiatrist of Example 8 identifies with the stalker, reporting her feeling that as she, the psychiatrist, was deeply envious of others during childhood, now her stalker was deeply envious of her. She felt special to the stalker, that there was an understanding and a twinship they shared. The psychiatrist of Example 10 who experienced exposure by his patients through Internet searches thought that he might have somehow been more protective toward a solitary man who was envious of his psychiatrist's happy family life.

At least one other observation emerged in these narratives. Two of the examples, 2 and 3, both instances of grim and prolonged erotic delusions, shared an unexpected commonality. In both, the psychiatrists volunteered in the interview that they had made a point of retaining documented material from their clinical work with the patient. In one instance, patient notes and related documents hang untouched in a bag on a closet door. In the other, the psychiatrist states, "I've kept her file all these years." The first psychiatrist regards the "untouched" bag quite openly as a kind of protective talisman. The spontaneous and seemingly unnecessary statement by the second psychiatrist may lead us to ask, why say that? What is the purpose of pointing out that you are saving the files? Perhaps in both instances, there is a talismanic protection the saving of files conjures for these psychiatrists. To the extent that we live in a world of objects, each of which is infused with qualities of meaning, the motive for preserving these notes seems to extend beyond any protective legal or administrative value.

It is presumptuous to judge these psychiatrists' views of how they may have contributed to the difficulties they encountered or to question their defenses against anxieties prompted by their stalking experiences. Rather, we may suppose that the attribution to oneself of possible error may serve to gain psychic mastery over unfortunate outcomes. Regardless, as Maclean, Reis, Whyte, Christopherson, Petch, and Penny (2013) write, "Given their presumed competence in managing disturbed behavior, mental health professionals are more prone to self-blame and self-reproach in these situations . . ." Similarly, the deep knowledge of negative and erotic transferences render these clinicians less willing to discharge patients who are resistant or otherwise challenging. Concern that patients may do harm to themselves or to the psychiatrist inclines the conscientious psychodynamic psychiatrist to continue treatment in the belief that treatment will yield benefit. Besides, the decision to terminate treatment does not foreclose stalking behavior.

CONCLUSION

Psychiatrists are among the most likely targets of stalking. The greater intensity of the therapeutic relationship likely to be engaged by psychodynamic psychiatrists—to the extent this small survey suggests—neither reduces nor increases vulnerability to stalking when compared with that of general psychiatrists (Abrams & Robinson, 2011; Maclean, Reis, Whyte, Christophers, Petch, & Penny, 2013). It seems likely that while training in psychodynamics offers understanding of patient psychodynamics, that same training imbues an insistent dedication to patient care and consequently a hesitation to disengage from the potential patient/stalker.

We may speculate that through transference assignment, the psychiatrist becomes the central actor as the abandoning, rejecting, or betraying parent—a parent who in the transference iteration nevertheless is regarded as necessary to psychic survival. Stalking may be regarded then as a profoundly ambivalent attachment characterized by intense rage and yet is accompanied by the fear that the analyst will be hurt or lost. As the demanding behavior of the stalking patient becomes apparent, the victim—here, the psychiatrist—does indeed experience predatory aggression coupled with an insistence for intense attachment, eroticized, vindictive, or both. Put differently, the psychiatrist becomes the archaic selfobject, the rejecting parental figure both loved and hated. We glimpse this explicitly in Example 5 where after terrifying her psychiatrist, the stalking former patient apologizes for frightening her (Connors, 1997; Gaensbauer & Jordan, 2009; McWilliams, 2006).

Years of experience are not as protective against stalking as might be supposed. Of the ten psychiatrists presented here, four were or were about to become first-year residents, two others experienced the onset of stalking from patients in clinic settings in the fifth and sixth years of professional work. Three psychiatrists were in their 10th, 22nd, and 35th years of private practice. The remaining psychiatrist with over 40 years clinical experience reports that only when he was asked if he had been stalked did he realize that Internet prying constituted a form of stalking. Though we might anticipate that the ease of Internet searching might greatly promote stalking behavior, this limited survey did not elicit such responses.

Strict definitions of stalking understandably assign criteria for stalking behavior: contact or communication with the stalker is

required. However, the immediate experience of being stalked does not reliably comport with these definitions. Three of the ten narratives presented illustrate that feeling stalked may occur when these criteria are not fully met. In these examples, there were no threats, only the perceived possibility of danger (as in Example 7) or the invasion of privacy (as in Examples 9 and 10). From the point of view of the victim, feeling stalked suffices.

Psychiatry is often regarded as a medical career that affords security and good quality of life without the rigors of on-call schedules and disrupting emergencies. It is a field where the clinician gets to know people intimately, and gets to know oneself.

Nevertheless, psychiatrists—including psychodynamic psychiatrists trained in both psychoanalytic and neuropsychiatric perspectives—often work with persons who suffer with serious mental disorders or are burdened by profoundly stressful circumstances. The psychic protection against distressing personal impingement afforded by clinical understanding and the psychiatrist's defined professional role may readily fail in the face of perceived victimization by a stalker. Of the ten narratives presented, five sought assistance from consultants or supervisors. This third-party assistance often proved of limited help. Despite ample evidence that stalking of psychiatrists has sufficient prevalence to warrant attention, no formalized support is available through the American Psychiatric Association (E. Jaffe, personal communication, 2017). Perhaps because of greater societal concern about stalking in the United Kingdom which passed the Protection From Harassment Act in 1995 (Claydon, 2017), the Royal College of Psychiatrists formally offers support. Its website provides a concise report on the nature of stalking, its impact on the psychiatrist, means for management, and other related matters (Mullen, Whyte, & McIvor, 2017). Recognition of the prevalence of psychiatrists as victims of stalking and provision of support by organized psychiatry in the United States is justified.

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