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The need for effective mental health interventions for specific offender populations has become clear in recent decades. In particular, individuals who engage in stalking and harassment have increasingly attracted the attention of the public and mental health and criminal justice professionals, however no evidence-based treatment currently exists for this population. We adapted Dialectical Behavior Therapy (DBT) for the treatment of this offender group, in part because of the high prevalence of personality disorders. This study describes the application of a 6-month treatment program to a sample of 29 individuals, 14 of whom completed treatment. Treated offenders were significantly less likely to re-offend with another stalking offense (0 of 14) compared to treatment drop-outs (26.7%) or to published recidivism data (47%). Measures intended to help determine the nature of changes revealed increased thought suppression, but are qualified by the high degree of defensive responding. These preliminary data suggest that DBT holds promise for reducing stalking behaviors and warrants further study.

ADAPTING DIALECTICAL BEHAVIOR THERAPY FOR THE TREATMENT OF STALKING OFFENDERS

Over the past decade, the problem of stalking and harassment has emerged as a significant source of concern among mental health professionals and criminal justice officials. This concern has been reflected in the passage of anti-stalking legislation by every state in the U.S. and many developed countries, and in the rapid growth of research in forensic psychology. Despite this growing interest and concern, empirically supported mental health interventions designed to address these problematic behaviors have not yet emerged. To date, only one group of Australian clinicians described a treatment model for stalking offenders. Warren and colleagues (2005) described the development of a clinic for “stalkers and threateners” using what they identified as “the problem behavior model.” They argued for an approach that focuses on behaviors rather than a particular diagnostic category, due in part to the

heterogeneity of this offender population. However, these authors acknowledged that their treatment approach was still under development and provided no empirical data to support their methods.

In response to the need for an empirically grounded treatment approach for this unique and problematic subgroup of criminal offenders, we sought to develop a structured, intensive behavioral intervention specifically tailored to the needs of stalking offenders. Several seemingly robust research findings helped shape the treatment development process. First, a number of research studies have demonstrated that individuals with a personality disorder comprise the largest and most problematic subgroup of stalking offenders (e.g., Meloy et al., 2000; Rosenfeld, 2004). Of these, offenders with “Cluster B” personality disorder (primarily Anti-social, Borderline, and Narcissistic) diagnoses appear particularly problematic, characterized by high rates of violence and recidivism (Rosenfeld, 2003; Rosenfeld & Harmon, 2002). A second line of research that influenced the development of this

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treatment model was the burgeoning literature supporting Dialectical Behavior Therapy (DBT; Linehan, 1993) as an effective treatment for individuals with Borderline Personality Disorder (BPD) and multiple other problem behaviors (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Koons et al., 2001; Verheul, Van den Bosch, Koeter, de Ridder, Stijnen, & van den Brink, 2003). This treatment model is particularly appealing for two reasons. First, DBT has demonstrated efficacy with highly refractory, difficult to manage, complex clients such as substance-abusing individuals with BPD (Linehan et al., 1991). An application of DBT to high violence couples also appears promising (Fruzetti & Levensky, 2000). Although no randomized trial has evaluated the efficacy of DBT with forensic populations, both adult (McCann, Ball & Ivanoff, 2000) and juvenile (Trupin, Stewart, Beach, & Boesky, 2002) implementations have shown potential. In fact, more than a dozen forensic applications of DBT have been developed during the past decade (Berzins & Trestman, 2004). Second, DBT focuses on problematic behaviors as the primary target of change rather than insight or attitude change. This is consistent with known “best practices” in correctional interventions (Anders et al., 1990).

Dialectical Behavior Therapy (DBT) was originally developed as a treatment for chronically suicidal women suffering from BPD (Linehan, 1993). At its core, DBT uses a biosocial framework to explain the development of complex behavior problems. Specifically, this intervention assumes that problem behaviors are the result of a transaction between a biologically-vulnerable individual and an environment that is not sufficiently responsive to the individual’s needs. Thus, treatment focuses on helping the individual develop skills to effectively manage the frustrations and challenges they encounter in daily life. The manualized treatment, which includes weekly individual and group sessions as well as telephone “coaching” and supervision/support for clinicians, is organized into stages, with the primary goal of “Stage One” interventions (which is the focus of our six-month treatment) being the development of behavioral control: eliminating dangerous behaviors.

Within Stage One of DBT, behavioral targets for the individual sessions are prioritized according to a

hierarchy, such that life threatening behaviors (to self or others) are given the highest priority, followed by behaviors that interfere with the delivery or success of treatment. Behaviors that interfere with the individual’s quality of life (e.g., illegal drug use, educational or employment problems) are addressed only after the higher priority target behaviors. In addition to the weekly individual session, DBT also includes a weekly didactic component that teaches behavioral skills (e.g., mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness), which was supplemented by problem-solving skills, that have been previously included in other forensic DBT adaptations. For example, participants might be taught to simply observe their urges and thoughts related to contacting the target of their harassment, without ruminating or acting on them. This exercise incorporates mindfulness, as well as enhancing the individual’s ability to tolerate distressing thoughts (e.g., anger, frustration, loneliness). The use of behavior chain analysis as a primary method of assessing and intervening with target behaviors, and weekly diary cards were utilized, as in standard DBT. Of note, although both standard DBT and our adaptation are manualized, the individual treatment component is principal-driven. It incorporates specific protocols when needed rather than a prescriptive (session-by-session) approach, as is used in the weekly Skills group.

Each of the elements of standard DBT (weekly individual DBT, group skills training, telephone coaching when needed, and consultation group for therapists) were retained in our adapted approach, but were modified to better fit the cultural and educational background of an offender population (e.g., examples and exercises utilize content that are more salient to an urban, offender population). In addition, we reduced the individual DBT sessions to 45 minutes once per week, and scheduled these sessions for the same day as the skills group session. This reduction allowed us to maintain a schedule roughly comparable to other interventions for criminal offenders (e.g., anger management or “accountability” programs).

The importance of engagement and motivation in mandated treatment and offender treatment settings cannot be overstated. Non-compliance, as demonstrated by lack of attendance and/or compromised session participation (e.g., no participation,

highly guarded participation, “gaming” participation) is common and presents an ongoing challenge. Hence, treatment interfering behaviors are given high priority and flexible guidelines developed to facilitate clinicians’ work with unmotivated or commitment-challenged individuals rather than simply terminating those who were absent or late for a pre-determined number of sessions. In order to maximize the opportunity to shape attendance behaviors and meaningful participation, we adopted a liberal policy for terminating non-participants (three successive unexcused absences, rather than focusing solely on the total number of absences or the quality of participation).

This study describes the initial evaluation of this treatment program, including an assessment of overall feasibility and effectiveness. In addition, a number of possible variables that could potentially mediate treatment response (i.e., the purported mechanism of change) were examined by comparing pre-treatment and post-treatment responses to a series of self-report measures. Although preliminary, these data represent the first systematic assessment of a stalking treatment approach and one of the first evaluations of a DBT-based intervention in an outpatient forensic setting.

METHOD

Participants

Stalking offenders under the supervision of the Department of Probation for New York (Manhattan) and Kings (Brooklyn) counties of New York City were referred for treatment, typically as a condition of probation. All prospective participants were informed of the nature of the treatment program and accompanying study, and were offered participation. Although most individuals were mandated to some form of treatment, participation in this program was voluntary. Individuals who declined participation were referred back to Probation for an alternative treatment option. Prospective participants were informed that treatment was free and would meet the requirements of their probation mandate, and that data collected through the course of the intervention would be protected and used without individual identification in research publications and presenta-

tions. Inclusion criteria included English fluency, male gender, over 18 years of age, and a history of stalking as defined by either a violation of an order of protection or conviction for a crime involving multiple (3 or more) contacts with the same victim. This threshold was set deliberately low (e.g., Mullen, Pathé, Purcell, & Stuart, 1999, used 10 or more incidents as their criteria for classifying “stalking”) in order to be more inclusive and avoid turning away potential participants until they had committed “enough” acts of harassment, particularly given the likelihood that official records might under-report the frequency and duration of harassment and focus solely on the most recent precipitating events. Exclusion criteria were the presence of either significant, imminent risk of violence (e.g., as evidenced by aggressive or threatening behavior during the intake interview) or disorganized psychosis such that participation in the skills group would be disruptive to other members (determined by an experienced clinician conducting the intake evaluation). The study was approved by the institutional review boards of Fordham University, Columbia University, and the John Jay College of Criminal Justice.

In the first two years of data collection, 48 individuals were referred for treatment as stalking offenders. Two of these individuals were women and therefore were not scheduled for an intake appointment as the decision had been made to initially maintain only single sex groups (given the small number of women referred, it was not feasible to create a separate group for females). An additional nine referrals either did not respond to attempts to schedule an intake evaluation ($N = 4$), successfully challenged the conditions of their probation ($N = 2$), had conflicting work obligations ($N = 1$), or did not speak English ($N = 2$). Thus, a total of 37 individuals completed an intake evaluation, 29 of whom were subsequently referred to the treatment program. The remaining eight individuals were excluded because they were subsequently identified as primarily Spanish-speaking ($N = 2$), they refused to attend the treatment program despite having consented to the intake assessment ($N = 4$), or were re-arrested before treatment began ($N = 1$); one individual was excluded because of psychosis and a seemingly high potential for violence. All subsequent analyses are based on the subset of 29 individuals who began treatment.

Procedures

All individuals referred for treatment were first scheduled for an intake evaluation. Following informed consent, prospective participants were interviewed by the first author in order to assess inclusion/exclusion criteria, establish a preliminary clinical diagnosis, and assess potentially relevant covariates (e.g., demographic characteristics, legal history). Following completion of this intake interview, participants completed a series of self-report and behavioral rating scales including the Millon Clinical Multiaxial Inventory, 3rd edition (MCMI-III, Millon, 1994), the Aggression Questionnaire (AQ, Buss & Perry, 1992), the Empathy Questionnaire (EQ, Mehrabian & Epstein, 1972), the Means Ends Problem Solving Scale (MEPS, Platt, Spivack, & Bloom, 1971), the Paulhaus Deception Scales (PDS, Paulhaus, 1998), the State-Trait Anger Expression Inventory (STAXI; Spielberger, Jacobs, Russell, & Crane, 1983), the White Bear Suppression Inventory (WBSI, Wegner & Zanakos, 1994), and the Ways of Coping Checklist (WCCL, Folkman & Lazarus, 1988). In addition, all individuals were rated by the interviewer using the Psychopathy Checklist, Screening Version (PCL-SV, Hart, Cox & Hare, 1995) and the Spousal Assault Risk Assessment guide (SARA, Kropp, Hart, Webster, & Eaves, 1995); because no risk assessment measure specific to stalking was available at the time this study was conducted, a measure developed for identifying domestic violence risk appeared to be the most appropriate alternative. Further, the limited sample size for whom two interviewers were present ($N = 7$) precluded estimating the inter-rater reliability of these psychopathy and risk assessment ratings.

Treatment was comprised of 24 weekly sessions (group and individual), excluding the initial intake evaluation and pre- and post-treatment assessments. The treatment program, termed Project SHARP (Stopping Harassment and Relationship Problems), consisted of a weekly one-hour skills group and 45 minute individual session as described above. Treatment was conducted by either experienced DBT clinicians (who are also DBT trainers, $N = 2$) or trained graduate students ($N = 6$) who underwent extensive pre-treatment training in the principals and techniques of DBT and received ongoing supervision by an experienced DBT clinician. Group leaders and

individual therapists made weekly reminder calls to maximize participation; participants who missed 3 successive weekly sessions, or were consistently unwilling to address treatment-interfering behaviors (based on the consensus of treatment staff) were terminated from the program. However, participants who were terminated were eligible to apply for re-admission, provided they resumed the program from the beginning (including repeating all of the intake and baseline measures). Following successful completion of the program, all participants completed the same battery of self-report measures with the exception of the MCMI-III. Outcome data, along with information regarding prior criminal history and stalking-related behaviors, was elicited from Probation records.

Statistical Analysis

In addition to frequency and descriptive statistics, the primary outcomes analyzed were treatment program completion and recidivism. The former was analyzed as a simple dichotomous variable, contrasting those who finished the entire treatment program versus those who did not. This approach was selected because the non-completer group encompassed several subgroups (i.e., participants terminated for treatment interfering behavior that did not respond to contingencies, those re-arrested during treatment, and individuals who simply stopped attending the program) and the sample was too small to reliably analyze differences between these subgroups. The second level of analysis was recidivism, which was coded in two different ways: re-arrest or re-incarceration for *any* criminal offense or violation of probation (termed “any recidivism”) and re-arrest for offenses related to renewed or continued harassment (“stalking recidivism”). Univariate associations were assessed using frequency analyses (using the chi-square test of association) and independent sample t-tests. Multivariate associations were assessed using logistic regression, including only those variables that demonstrated a significant univariate association with the outcome variable. Finally, within group change on the series of self-report measures was used to identify mechanisms of change in individuals who completed treatment.

RESULTS

Subject Characteristics

Of the 29 males who began treatment, the average age was 36.7 ($SD = 11.7$, range: 17 to 70) and they reported an average of 12.0 years of education ($SD = 2.5$, range: 8 to 18). The majority of participants were of minority ethnic background, with 45% black ($N = 13$), 41% Hispanic ($N = 12$), and 14% ($N = 4$) Caucasian. Roughly two thirds of the sample ($N = 19$, 70%) had been charged with violating an order of protection; the remainder were charged with offenses ranging from harassment to assault. All were sentenced to a period of probation and were referred by their Probation Officer.

Most of the participants had been accused of targeting a former intimate partner ($N = 25$, 86%), whereas two individuals (7%) targeted professional acquaintances (a co-worker; a nurse that had cared for him in the hospital), one (4%) targeted a family member, and one (4%) had targeted a seemingly random stranger. Half of the sample ($N = 15$, 54%) expressed a motivation to maintain or renew an intimate relationship, while four (14%) appeared motivated by revenge or anger and the remainder ($N = 9$, 32%) had mixed or idiosyncratic motives (e.g., maintaining contact with a child shared by the target). Eight individuals (28%) had prior stalking arrests and 16 (55%) had prior arrests for violence, although not necessarily against the target of their stalking. With regard to stalking behaviors, nine (31%) were known to have made overt threats toward the target of their harassment and one (4%) had made a threat to a third party, however 19 (66%) had assaulted the target of their harassment, often during the incident that led to the index offense. Eleven individuals (38%) had engaged in actual “stalking” (following the target of their harassment), eight (28%) had made repeated telephone calls, and one (4%) had sent multiple letters.

Clinical diagnoses, psychopathy ratings, and violence risk assessment ratings were based on clinical interviews conducted by the first author. These interviews revealed a wide range of diagnoses including psychosis (schizophrenia or schizoaffective disorder, $N = 6$, 21%), mood disorders (dysthymia and bipolar II disorder, $N = 2$, 7%), a primary substance abuse disorder ($N = 5$, 17%), and

personality disorders with primarily (but not exclusively) “Cluster B” traits ($N = 14$, 48%); no diagnosis was assigned to two individuals (7%). The mean psychopathy rating (based on PCL-SV scores) was 12.8 ($SD = 5.4$, range: 0 to 23) and five individuals (17%) had PCL-SV scores above 18, suggestive of possible psychopathy. The majority ($N = 18$, 64%) were also rated as being at low risk for violence based on the SARA although two (7%) were classified as posing a high risk of violence and 8 (29%) were rated as moderate risk. Finally, defensive responding, as evidenced by scores on the PDS Impression Management scale score of 10 or greater, was observed in 21% of cases ($N = 6$), suggesting a level of defensiveness that likely invalidates any interpretation of the self-report measures administered concurrently.

Treatment Outcome

Despite being mandated to attend treatment, more than half of the individuals who began treatment either failed to attend ($N = 2$), dropped out prior to completion ($N = 7$), were terminated from treatment ($N = 4$), or were re-arrested while still in the program ($N = 2$). The average number of groups attended by program completers was 19.1 (of 24), versus only 6.4 for those who failed to complete treatment.¹ There were few variables associated with program completion, as most demographic and clinical variables failed to differentiate these two groups (e.g., age, race, years of education, level of psychopathy). There was also no relationship between any of the stalking characteristics (e.g., offender/target relationship, motive, history of threats or assault). The strongest predictor of treatment program completion was whether the participant arrived for the first scheduled intake appointment, $\chi^2(1, N = 29) = 10.21, p = .002$. Of the 14 individuals who completed treatment, 12 (86%) attended the first scheduled appointment whereas only 4 of the 15 individuals (27%) who failed to complete treatment attended the first appointment (these individuals required one or more re-scheduled appointments).

¹ The first 3 program completers were only scheduled to attend 16 weeks; the program was subsequently expanded to 24 weeks when it became apparent that many individuals would require more than 16 weeks of treatment.

In addition, treatment program completers had been rated as posing less risk of violence at intake (based on the SARA summary risk rating of “Low,” “Moderate” or “High”), $t(26) = 2.56, p = .02$. However, in a stepwise logistic regression model predicting treatment outcome, the only significant predictor variable was whether the individual had attended their initial intake appointment, Wald $\chi^2(1, N = 29) = 8.50, p = .004$.

Criminal justice records (including contact with Probation Officers and official records of re-arrests based on the “rap sheet”) were also analyzed to determine case outcome. For treatment program completers, the average length of follow-up (time since completion) was 12.2 months (range: 2 to 21 months), although the time since initial contact with the program was substantially longer (19.1 months, range: 8 to 28 months). Length of time between initial contact and completion of outcome data collection was comparable for the sample who dropped out of treatment ($M = 22.5$ months), $t(27) = 1.47, p = .16$. However, treatment program completers were significantly less likely to be re-arrested for a subsequent stalking offense, $\chi^2(1, N = 29) = 4.33, p = .04$. None of the 14 individuals who completed treatment were re-arrested for a subsequent stalking offense compared to 4 of 15 individuals who did not complete treatment. However, the rate of re-arrest for *any* offense did not differ significantly between these two groups, $\chi^2(1, N = 29) = 1.43, p = .23$, in part because two of the individuals who completed treatment were re-arrested for criminal behavior unrelated to stalking (e.g., one individual was arrested for a drug charge). However, this rate of re-arrest for treatment completers (2 of 14 or 14%) was significantly lower than the 47% re-arrest rate found in previous research (Rosenfeld, 2003), $\chi^2(1, N = 29) = 7.14, p = .008$. In fact, the rate of re-arrest (7 of 29 or 24%) was significantly lower than published recidivism data, even when treatment program dropouts were included in the analysis, $\chi^2(1, N = 29) = 7.76, p = .006$. Unfortunately, when these analyses were re-calculated controlling for time at risk, the resulting models failed to converge and were therefore uninterpretable. However, contrary to expectation, time at risk was significantly lower for individuals who were known to have re-offended with any offense (3.5 versus 11.4 months), $t(26) = -2.56, p = .02$, but not significantly different for those

who re-offended with another stalking offense (4.5 versus 15.5 months), $t(26) = -1.57, p = .13$. Given these findings, it is clear that differences in recidivism are not simply a function of the greater time at risk for non-completers.

Analysis of the self-report variables that changed over the course of treatment generated relatively few significant findings. Only one of the variables analyzed, the White Bear Suppression Inventory, changed significantly over the course of treatment, $t(14) = 2.35, p = .035$. Scores on this scale increased by 0.44 points (on a 5-point scale), with a pre-treatment mean of 2.31 ($SD = 1.08$) and a post-treatment mean of 2.75 ($SD = 0.74$), indicating greater use of thought suppression following treatment. Changes on the State-Trait Anger Expression Inventory also approached significance, $t(14) = 1.96, p = .07$, with average scores on this scale rising 0.08 points after treatment (on a 4-point scale), indicative of greater acknowledgement of anger expression. Inspection of the data on other scales revealed considerable defensiveness on the part of participants (as noted above), as 20% of the study participants obtained elevated PDS scores, indicating deliberate minimization on the self-report scales. Unfortunately, the small sample size precluded inclusion of PDS scores as a covariate in these analyses.

DISCUSSION

This study represents the first systematic evaluation of a treatment program specifically designed to address the needs of stalking offenders. Although previous reports have described treatment approaches for stalking offenders (Mullen, Pathé, & Purcell, 2000; Warren et al., 2005), none have reported any effectiveness data. Despite the small, non-randomized sample, participants who completed treatment were significantly less likely to re-offend compared to either those who failed to complete treatment or published recidivism data (Rosenfeld, 2003). The latter, while representing a heterogeneous group, is analogous to a “treatment as usual” comparison sample since many of the individuals studied by Rosenfeld (2003) were referred for some form of mental health intervention (e.g., anger management or accountability programs, outpatient

psychotherapy, and inpatient psychiatric hospitalization). Thus, despite the preliminary nature of these data, the results suggest significantly better outcomes for those individuals referred to Project SHARP and better still among those who complete treatment.

Identifying variables that differentiate those who are more or less likely to respond to treatment is more difficult than establishing benefits from treatment. In the present study, the strongest predictor of treatment outcome was whether the individual attended the initial scheduled intake appointment. Although this “predictor” provides little clarity regarding the reasons why stalking offenders differ in their response to treatment, it does suggest that robust efforts to engage clients, even prior to intake interviews, are warranted. It also indicates that individuals at higher risk of non-completion can probably be identified early in the treatment process. On the other hand, the lack of association between psychopathy ratings and treatment outcome might indicate that this intervention is equally effective with both psychopathic as well as non-psychopathic offenders. This conclusion is premature given the small sample size, but certainly warrants further research.

Self-report measures intended to help identify the nature of changes following treatment also revealed few significant findings. The only significant change was observed on the White Bear Suppression Inventory (WBSI), a measure of thought suppression. However, the direction of change on this measure is hard to interpret given the scale author’s assumption that greater thought suppression corresponds to greater obsessional thinking (i.e., higher scores would typically be interpreted negatively). On the other hand, treatment also focused on teaching offenders to suppress their thoughts and impulses that might lead to further harassment behaviors. Thus, this significant increase in thought suppression may reflect an improved ability to manage unwanted or intrusive thoughts. Of course, interpretation of these self-report measures must also be qualified by the obvious incentive for offenders to distort their personality and behavioral characteristics, both before and after treatment. Indeed, research with domestic violence offenders has demonstrated that change in self-report measures does not correspond to reduced recidivism (Saunders & Azar, 1989). Without a sufficiently large

sample to permit statistically controlling for the defensiveness and distortion that is common among offender treatment settings, these results must be considered tentative.

There are, of course, a number of obvious limitations in the present study, not least of which is the lack random assignment to either an alternative treatment or waiting list control group. Despite the comparison to treatment drop-outs and a published “treatment as usual” sample, the absence of random assignment to a comparison condition precludes analysis of whether any systematic differences existed between the present sample and the comparison samples. Indeed, such differences are quite likely, as offenders referred to an outpatient treatment program may be less pathological and/or treatment refractory than those described by Rosenfeld (2003). Although the inability to systematically control for time at risk in estimating the effects of treatment, which is no doubt due to the small sample size and small number of individuals who were known to re-offend, further limits the interpretation of these modest results, the finding that individuals who re-offended had less time at risk than those who did not re-offend suggests that differences in time at risk does not “explain” the treatment effects observed.

A second limitation of the present study pertains to the evolving treatment intervention. Because the first year of this treatment program involved considerable changes and adaptations, the treatment described in this study was essentially a “work in progress.” These changes have resulted in a cohesive, standardized intervention, but may have adversely affected the benefits of treatment for the first few participants. Clearly, further investigation of this intervention with a larger sample, a subset of whom are randomly assigned to treatment, is needed before efficacy can be truly established. Such an investigation is currently ongoing, but will not be complete for several years.

Finally, a number of additional limitations impact on the reliability of the descriptive data upon which analyses are based. For example, the lack of systematic diagnostic data on the sample (e.g., diagnosis established through a structured diagnostic inventory) and estimates of inter-rater reliability for the clinician-rated measures (e.g., diagnosis, psychopathy rating) leave unanswered questions as

to the whether this intervention was more effective with some types of offenders rather than others. Because of the diagnostic heterogeneity, as well as the defensive responding on self-report measures (e.g., the MCMI-III), it did not seem appropriate to present data on the association (or lack thereof) between treatment outcome and diagnostic categories and traits. Finally, the length of follow-up, while adequate for many of the individuals referred early in the course of the program, was quite limited for the last few individuals. Thus, it is possible that some individuals classified as “successful” in these analyses may have gone on to re-offend in the months that followed data collection (although as of manuscript preparation, we are unaware of any such cases). Despite the fact that most recidivism occurred within the first few months at risk, a longer follow-up time would certainly provide more a conclusive determination of which individuals truly represent treatment “success.”

Despite these limitations, these analyses provide preliminary evidence of the effectiveness of Dialectical Behavior Therapy adapted for the treatment of stalking and harassment offenders. Given the many challenges posed by this difficult offender population, as well as the substantial damages that are suffered by the victims of these crimes, these preliminary results are encouraging. More systematic research with a larger sample, using a more thorough set of evaluation and outcome measures may help ascertain both the extent and basis for any clinical benefits from this intervention.

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