

*Information on the psychological consequences of stalking on victims is scarce. The present study aimed to investigate whether stalking victims have a heightened prevalence of psychopathology and the extent to which symptom levels are associated with stalking features. Stalking victims (N = 241) completed the General Health Questionnaire and provided information on specific features of their stalking experiences. High levels of psychopathology were found among stalking victims. Symptom levels were comparable with those of psychiatric outpatients. The frequency, pervasiveness, duration, and cessation of stalking were associated with symptom levels but explained only 9% of the variance of the level of distress. It is concluded that stalking victims generally have many symptoms of psychopathology. The symptoms are largely independent of features of their stalking experience. These findings indicate that better therapy outcomes can be expected from therapies focusing on boosting general coping skills and on decreasing general vulnerability than from therapies focusing on specifically dealing with the stalking situation.*

## ***The Toll of Stalking***

### ***The Relationship Between Features of Stalking and Psychopathology of Victims***

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***Stalking is an old behavior*** but a new crime (Meloy, 1998). Several countries (e.g., Australia, Canada, United States, United Kingdom, and the Netherlands) have recently developed stalking laws or are in the process of developing laws directed at criminalizing stalking behaviors. Stalking is “the willful, malicious and repeated following and harassing of another person that threat-

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JOURNAL OF INTERPERSONAL VIOLENCE, Vol. 17 No. 1, January 2002 50-63  
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ens his or her safety” (Meloy & Gothard, 1995, p. 258). Despite controversy over the precise boundaries of stalking behaviors, there is consensus that such behaviors can include loitering nearby, following, harassment by telephone or mail, ordering goods on the victim’s behalf, making threats, physical and sexual assaults, and even murder attempts or actual murder (Harmon, Rosner, & Owens, 1995; Meloy & Gothard, 1995; Mullen & Pathé, 1994; Zona, Palarea, & Lane, 1998). The lifetime prevalence has been estimated at 8% among women and 2% among men (Tjaden & Thoennes, 1998), but higher prevalence estimates have been found (Fremouw, Westrup, & Penny-packer, 1997; Sheridan, Davies, & Boon, 2001) indicating that millions of people become victims of stalking at some time in their lives (see also Allen, 1996; De Becker, 1997; Hall, 1998; Tjaden & Thoennes, 1998).

Several studies have provided information about characteristics of stalkers and their victims. For instance, an extensive study in Canada examined data from the Uniform Crime Reporting Survey, an annual review of crimes reported to 130 police departments throughout Canada. The study, which included 7,472 victims’ reports to police of stalking, found that the majority of the victims were women (80%) and that many (47%) had had an intimate relationship with the stalker (Jones, 1996). Another extensive study was commissioned by the U.S. National Institute of Justice. In the study, a representative random sample of 8,000 women and 8,000 men participated in telephone-based interviews (Tjaden & Thoennes, 1998). The study found that women were more likely to be victims of stalking (78%) than were men, that the majority of victims were between 18 and 29 years old when the stalking first commenced, and that the vast majority of the stalkers were men (87%). For 59% of female and 30% of male victims, the stalker was a prior intimate partner.

Despite the growing awareness that stalking is a considerable public health issue, there is little information available about the toll that stalking inflicts on the victims (Meloy, 1996; Pathé & Mullen, 1997). It is often stated that stalking causes harm to victims (e.g. Fremouw et al., 1997; Jones, 1996; Tjaden & Thoennes, 1998), but only a few studies have actually addressed the economic and social effects of stalking and even fewer studies have addressed the psychological or psychiatric consequences of stalking. In the United States, Brewster (1997) interviewed 187 women who were recent former-intimate stalking victims in Pennsylvania identified through victim service agencies or law enforcement agencies. In another study in the United States, Hall (1998) questioned 145 people who perceived themselves to be the victim of stalking and had made themselves known at one of the regional voice mailboxes that had been set up in seven target cities. In Australia, Pathé

and Mullen (1997) distributed questionnaires among 100 stalking victims who contacted the authors or who were referred to the authors' clinic.

The aforementioned studies consistently showed that many stalking victims experience economic and social difficulties as a result of stalking: many victims suffer financial losses (Brewster, 1997), quit jobs or cease school attendance, change names, go underground or relocate residence, change their appearance, avoid social activities, take additional security measures, and so forth (Brewster, 1997; Hall, 1998; Pathé & Mullen, 1997; Tjaden & Thoennes, 1998). The studies also showed that almost all victims suffer from deleterious psychological effects of the stalking experience. Brewster (1997) found that many stalking victims noted that they had become very distrustful or suspicious (44%), fearful (42%), nervous (31%), angry (27%), paranoid (36%), and depressed (21%) and that victims generally had high scores on items of the Trauma Symptom Checklist (Briere & Runtz, 1989) that reflected sadness, insomnia, tension, and restless sleep. Hall (1998) found that 86% of the victims reported that their personalities had changed as a result of being stalked. Many of the victims reported that they had become extra cautious (73%), more easily frightened (48%), more paranoid (39%), less outgoing (37%), and more aggressive (10%). Pathé and Mullen (1997) found that many stalking victims reported heightened anxiety (83%), chronic sleep disturbance (74%), excessive tiredness or weakness (55%), appetite disturbance (48%), frequent headaches (47%), and persistent nausea (30%). At some point during their ordeal, 24% seriously considered or attempted suicide. Pathé and Mullen (1997) also found that 37% of the victims fulfilled the criteria of the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (DSM-IV) (American Psychiatric Association, 1994) for a diagnosis of post-traumatic stress disorder and that an additional 18% fulfilled all criteria except the stressor A1 criterion (Pathé & Mullen, 1997).

Despite the fact that the studies yield consistent findings about economical, social, psychological, and psychiatric consequences of stalking, there is no information about the degree to which stalking is associated with a heightened prevalence of psychopathology among victims. All studies indicate that stalking poses a serious mental health threat to victims. However, with one exception, none of the studies reported standardized measures of psychopathology or the prevalence of such pathology in the general population. In addition, little is known about the impact of specific stalking behaviors and the impact of the frequency and duration of stalking. Meloy (1996) stated that stalking behaviors are related to the type of relationship between stalkers and their victims, but he did not address whether certain stalking behaviors are also related to heightened symptom levels. Pathé and Mullen (1997) noted that victims were more likely to experience post-traumatic stress symptoms

if they had been followed or exposed to violence, and if they had a prior intimate relationship with the stalker. Pathé and Mullen (1997) noted that “victims indicated that they might have coped better with the more tangible damage of physical assault” than with the “stalker’s constant intrusions and menace” (p. 15). However, Pathé and Mullen did not provide data or statistics to substantiate these statements nor did they address relationships between stalking and other symptoms of psychopathology. This article addresses the degree to which stalking is associated with a heightened prevalence of psychopathology among victims. Attention is given to the question of whether the psychological effects of stalking behaviors are dependent on certain features of stalking and the type of relationship with the stalkers.

## METHOD

### Respondents

The sample consisted of 241 victims who reported stalking episodes over a minimum of one month, and involving more than one intrusive behavior. Eighty-nine percent were female and 11% were male. The youngest victim was 19 years old and the oldest 82 years ( $M = 43.4$  years,  $SD = 10.1$  years). Most victims were living alone (70%), employed (59%), and had children (76%). Eleven percent were local or national celebrities, one of whom had become a national celebrity after she killed her stalker. In 68% of the cases, there was a prior intimate relationship with the stalker, 26% were prior acquaintances, and 6% of the stalkers were strangers. Eighty-eight percent of the victims were stalked by a male stalker.

### Materials

Features of stalking behavior were explored using a questionnaire that was based on questionnaires developed by Pathé and Mullen (1997) and Wright et al. (1996). In addition to one open-ended question on stalking behaviors, the questionnaire contained closed-ended questions on the nature of nine features of stalking behavior: telephone calls, letters, surveillance of victim’s home, following, unlawful entry, destruction or theft of property, direct unwanted approach, threats about bodily harm or death, and physical assault (including sexual assault). Closed-ended questions explored 11 countermeasures: seeking mental health care assistance, turning to the police, starting a lawsuit, acquiring an unlisted telephone number, relocating residence, going underground, quitting job or working less, changing jobs,

avoiding social outings, taking additional security measures, and assaulting the stalker. Finally, the questionnaire contained questions on the frequency of stalking in the beginning and end of the stalking episode, duration of stalking, cessation of stalking, date of onset, date of cessation, and the relationship between the victim and the stalker.

Psychiatric symptoms were assessed using a Dutch translation (Koeter & Ormel, 1991) of the 28-item version of the General Health Questionnaire (GHQ-28) (Goldberg & Hillier, 1979). The GHQ-28 is a self-administered questionnaire designed to identify individuals with a diagnosable psychiatric disorder (for further information see Goldberg & Hillier, 1979; Goldberg & Blackwell, 1970; Koeter & Ormel, 1991). The GHQ-28 has been found to be a valid and reliable instrument in many different samples and countries (Goldberg et al., 1997; Koeter & Ormel, 1991). Items reflect symptoms that can be present in four different degrees: *less than usual*, *as usual*, *more than usual*, and *much more than usual*. As suggested by several authors (Goldberg & Hillier, 1979; Koeter & Ormel, 1991), the GHQ scoring method (0-0-1-1) was used to calculate the total score and a Likert-type scoring method (0-1-2-3) was used for the subscales. The often-recommended (Goldberg & Hillier, 1979; Koeter & Ormel, 1991) threshold score of 5/6 was chosen as a predictor of the existence of a diagnosable psychiatric disorder. The GHQ-28 total scale and subscales were highly reliable in the present study (all Cronbach's alphas  $\geq .89$ ).

## PROCEDURE

By mediation of the Dutch Anti-Stalking Foundation (SAS), the sample was drawn from all 470 persons who were registered as victims at this foundation. The SAS strives toward public recognition of stalking as a public health issue and the criminalizing of stalking behaviors by providing victim support and information to the public. A self-report questionnaire, including the GHQ-28, was sent to the victims in March 1998. A total of 266 victims returned the questionnaire by mail to the university (57% response). Twenty questionnaires were excluded from the sample because of missing data on the GHQ-28 ( $N = 12$ ), a brief period of stalking ( $N = 1$ ), only one stalking behavior ( $N = 2$ ), or a stalking episode that took place more than 5 years ago ( $N = 5$ ). Another five questionnaires were excluded because they were clearly false claims of victimization (see also Mullen, Pathé, & Purcell, 2000). One woman claimed to be stalked by her gynecologist who "wanted to see her naked again." Another woman claimed to be stalked by the police and two strangers who allegedly spoke to her through the walls of her living room. A

third woman claimed to be followed “everywhere, 24 hours per day by people who were never seen.” A fourth woman saw spies everywhere and had allegedly been stalked starting from birth. A fifth woman living nearby a dancing school claimed that groups of people were sometimes loitering nearby.

## RESULTS

### Features of Stalking Behavior

All victims reported multiple stalking behaviors. Many victims reported receiving harassing telephone calls (see Table 1). More than half of these telephone calls were made at night and included continuous pleas, negative remarks, death threats, or continuous silence. One victim reported receiving approximately 50 telephone calls each day and night. Many victims reported that stalking behaviors included surveillance, unwanted approach, physical assault, unlawful entry into their homes, damage/theft of property, and receiving threats or harassing letters. Approximately half (52%) spontaneously reported other stalking behaviors such as spreading rumors, ordering goods, false accusations, injuring pets, and abduction.

Of the 10 stalking behaviors that were explored in the present study, the victims reported a median number of six (range, 2-10;  $M = 6.1$ ,  $SD = 1.7$ ). Only 7% reported that they were not exposed to intrusive following behaviors (surveillance of victim’s home, following, unlawful entry, unwanted approach) and only 31% reported that they were not exposed to violent behaviors (threats, assaults). The majority of victims reported exposure to several intrusive behaviors (median = 3,  $M = 2.6$ ,  $SD = 1.2$ ) and 29% reported exposure to two violent behaviors (median = 1,  $M = .98$ ,  $SD = .77$ ). These findings indicate that the stalking behaviors were generally pervasive in the present study.

As shown in Table 1, many stalking behaviors have fairly equal distributions in the different samples of victims. The vast majority of the victims in all studies reported that direct unwanted approach, following, surveillance of their homes, and receiving harassing telephone calls were the most common stalking behaviors. Direct unwanted approach and physical assault appear somewhat more common in the Dutch sample, whereas receiving letters appears somewhat less common in the Dutch sample. Because destruction of property also included theft in the Dutch study, this stalking behavior was more common in the Dutch sample. Nonetheless, the fairly equal distributions on the different stalking behaviors indicate that to a large extent, these are similar in different countries.

**TABLE 1: Features of Stalking Behavior (%)**

<i>Stalking Behavior</i>	<i>Present Study</i>	<i>Brewster (1997)</i>	<i>Hall (1998)</i>	<i>Pathé &amp; Mullen (1997)</i>
Telephone calls	86	90	87	78
Sending letters	41	59	50	62
Surveillance of victim's home	74	54	84	—
Following	74	68	80	71
Unlawful entry in home	41	36	39	—
Destruction of property	65 <sup>a</sup>	44	43	36
Direct unwanted approach	92	—	—	79
Physical assault	56	46	38	34
Threats to harm or kill victim	45	53	41	51
Duration of stalking				
Median duration (months)	33	12		24
Range (months)	2-476	1-456	1-372	1-240

a. Including theft of property.

Table 1 shows that stalking victims in the present study reported longer stalking episodes than did victims in other studies. Episodes had an average duration of 4.8 years ( $SD = 5.2$  years). No less than 66% reported a stalking episode of more than 2 years and 13% reported an episode of more than 10 years. In 30% of the cases, the victims were confident or under the impression that their stalking had ceased (on average, the last incident occurred one year ago in this group,  $SD = 273$  days). These findings indicate prolonged and persistent stalking.

In line with findings from other studies (Brewster, 1997; Hall, 1998), many victims in the present study claimed that the frequency of stalking differed from day to day, month to month, and year to year. Several victims stated that their stalking had stopped for several months, only to have the stalker show up again months later. Stalking occurred more often on a daily basis in the beginning (68%) than in the end (34%) of the stalking period. In approximately half the cases (47%), the frequency had decreased; however, in approximately half the cases (48%) the frequency had remained at a fairly stable level (48%) or had intensified (4%), indicating that stalking was often intensive and a long-term experience.

### Countermeasures

All victims had taken one or more countermeasures to deal with the stalking experience (median = 6,  $M = 5.8$ ,  $SD = 2.1$ ). Many had sought help at a

mental health care agency or from a mental health care professional (93%), turned to the police (89%), or started a lawsuit (45%). In line with findings from other studies (Brewster, 1997; Pathé & Mullen, 1997), several victims noted that these actions had not generated the desired results due to disbelief or powerlessness of the police, insufficient evidence for sentencing, unresponsiveness or incompetence of mental health professionals, or ineffectiveness of warnings, arrests, sentences, or restraining orders. Many victims had taken matters into their own hands by acquiring an unlisted telephone number (81%), relocating (44%), going underground (40%), quitting their job or working less (39%), changing jobs (21%), avoiding social outings (63%), taking additional security measures (65%), or even assaulting the stalker (19%). Again, many of these actions had not generated the desired results; many times the victims noted that the stalker had once again obtained the victim's telephone number or work or home address. Many victims reported that "nothing seems to work."

### Symptoms of Psychopathology

The responses to the GHQ-28 showed that victims differed markedly in their reports of psychiatric symptoms (range, 0-28 symptoms). Table 2 shows that stalking victims' average GHQ-28 total score and the scores on the subscales of somatic symptoms, anxiety and insomnia, social dysfunction, and severe depression were much more in accordance with those of psychiatric outpatients than with those of general practitioner patients or the Dutch general population. Moreover, 78% of the stalking victims scored six points or higher on the GHQ-28, indicating the presence of a diagnosable psychiatric disorder. These findings clearly indicate that a large number of stalking victims had psychiatric symptoms. Furthermore, several victims reported a history of attempted suicide and several inpatient admissions and no less than 31% had repeated thoughts about committing suicide.

To investigate relationships between symptoms of psychopathology (GHQ-28 total score) and stalking features (dichotomous variables were created with the use of median splits), *t* tests were conducted. These analyses showed that victims reported higher symptom levels (see Table 3) when stalking behaviors included following,  $t(199) = 1.97, p < .05$  (a similar finding was reported by Pathé & Mullen, 1997), or theft/destruction of property,  $t(239) = 2.29, p < .05$ . Victims also reported more symptoms when stalking consisted of six or more behaviors,  $t(239) = 2.66, p < .01$ . Furthermore, victims reported more symptoms when recent stalking behaviors occurred on a daily basis,  $t(206) = 2.62, p < .01$ , and when the frequency of stalking had not decreased,  $t(210) = 3.56, p < .001$ . Finally, more symptoms were reported by

**TABLE 2: Mean GHQ-28 Scores in Four Samples**

	<i>Stalking Victims</i>		<i>General Population<sup>a</sup></i>	<i>General Practitioner Patients<sup>a</sup></i>	<i>Psychiatric Outpatients<sup>a</sup></i>
		SD			
GHQ-28 total	13.9	9.1	4.6	8.4	15.4
Somatic symptoms	11.3	5.6	6.6	8.1	11.7
Anxiety and insomnia	12.8	5.9	5.9	7.6	12.6
Social dysfunction	10.6	5.3	6.9	8.0	11.9
Severe depression	7.3	6.4	1.6	5.1	9.5

NOTE: GHQ-28 = General Health Questionnaire (Goldberg & Hillier, 1979). Subscale scores were calculated using Likert-type scoring (0-1-2-3), whereas the GHQ-28 total score was calculated using the GHQ scoring method (0-0-1-1).

a. Koeter & Ormel (1991). The mean scores were adjusted on the basis of the gender distribution of stalking victims.

victims who were stalked for a relatively short period,  $t(237) = 2.39, p < .05$ , and by victims who reported to have undertaken six or more interventions to stop stalking,  $t(239) = 3.28, p < .001$ . In contrast with the findings of Pathé and Mullen (1997), symptom levels were not associated with the type of stalker-victim relationship or the occurrence of physical assault per se. In addition, contrary to what was stated by Pathé and Mullen (1997), victims did not cope better with violent behaviors than with constant intrusive behaviors: Neither the number of violent behaviors nor the number of intrusive behaviors was significantly associated with the level of psychopathology. Psychiatric symptoms were not related to cessation of stalking or how recent the stalking experience had started, which can be called remarkable.

Because several stalking features were interrelated, a stepwise regression analysis was used to analyze multivariate relationships between symptoms of psychopathology (GHQ-28 total score) and the seven stalking features (see Table 3) that were related to the symptom levels (median splits were used to create dichotomous predictor variables). The regression analysis showed that 9% of the high levels of symptoms was explained ( $R^2 = .09, F = 9.14, df = 2,180, p < .001$ ) by two indicator variables: a decrease of the frequency of stalking ( $B = 4.31, SE B = 1.38, \beta = .22, p < .005$ ) and the number of countermeasures ( $B = 3.47, SE B = 1.30, \beta = .19, p < .01$ ). The other five predictors, although initially related to psychiatric symptoms, did not explain additional variance in the presence of these two predictors.

**TABLE 3: Mean GHQ-28 Total Scores in Relationship to Features of Stalking**

<i>Stalking Feature</i>	<i>Feature Not Present</i>		<i>Feature Present</i>	
	M	SD	M	SD
Separate stalking behaviors				
Telephone calls	14.2	9.5	13.9	9.0
Sending letters	13.9	9.1	14.2	9.3
Surveillance of victim's home	12.3	9.6	14.5	8.8
Following	11.5	8.9	14.3*	9.2
Unlawful entry in home	13.0	9.2	15.2	8.8
Destruction/theft of property	12.1	8.6	14.9*	9.2
Direct unwanted approach	11.9	8.8	14.3	9.1
Threats	13.3	9.3	14.7	8.7
Physical assault	13.4	9.2	14.3	9.0
Other (spontaneously reported) behaviors	13.2	9.0	14.5	9.1
Combinations of stalking behaviors				
≥ 1 violent behavior (threats, assault)	13.4	9.8	14.1	8.7
≥ 2 intrusions (surveillance, following, entry, approach)	11.9	9.4	14.4	8.9
≥ 6 stalking behaviors (any)	11.9	9.1	15.1**	8.8
Other features of the stalking experience				
Stalked by former intimate	14.4	9.5	13.8	8.8
Stalked longer than 3 years (about median)	15.3	8.8	12.5*	9.1
Stalking started less than a year ago	13.5	9.0	16.7	9.0
Recently stalked daily	12.4	8.7	15.7**	9.2
Frequency decreased	17.2	8.4	12.6**	9.0
Stalking still ongoing	12.6	8.7	14.5	9.2
≥ 6 measures undertaken to stop stalking	11.8	9.2	15.6**	8.7

NOTE: GHQ-28 = General Health Questionnaire (Goldberg & Hillier, 1979). Standard deviations are in parentheses. Means that share an asterisk are found to differ in a *t* test from the means in the same row.

\* $p < .05$ . \*\* $p < .01$ .

## DISCUSSION

The present study reveals strikingly high levels of psychopathology among stalking victims. Not only were their symptom levels found to be more in accordance with those of psychiatric outpatients than with those of general population samples, but three quarters of the victims also displayed a symptom level that indicated the presence of a diagnosable psychiatric disorder. It must be concluded from these findings that other authors (Brewster,

1997; Hall, 1998; Pathé & Mullen, 1997) were right when they stated that stalking victims form a seriously troubled population.

According to the adversity-distress model (Dohrenwend, 1998), toxic exposure to a stressful life event is capable of instigating psychological distress in a dose-response manner: The higher the dose, the stronger the response. Following this model, the high symptom levels of psychopathology among stalking victims may thus be explained by the fact that many victims were exposed to a pervasive, prolonged, persistent, and intensive stressful experience. In addition, the finding that victims reported more symptoms when stalking behaviors were more pervasive, intensive, and persistent may be explained by the fact that they had a higher degree of toxic exposure, which according to the model results in a higher chance of psychological distress or a chance of a higher degree of psychological distress. However, the adversity-distress model cannot explain all findings. First, some of the victims were exposed to a horrifying experience but nonetheless displayed only a few symptoms, whereas others were exposed to only a limited degree of stalking but nonetheless displayed many symptoms of psychopathology. Clearly, these patterns do not follow a dose-response pattern. Second, the duration of exposure is found to have an inverse relationship to the level of psychopathology (a decreased frequency of stalking does not fully account for this finding). Although Dohrenwend (1998) notes that habituation can occur in the presence of a chronic stressor, this finding is difficult to understand from the adversity-distress model. Moreover, all stalking features combined explained only 9% of the variance of the level of distress.

The vulnerability (resilience)-distress model (Bowman, 1997) was introduced into the post-traumatic stress disorder (PTSD) literature after growing discontent with the disappointingly weak relationships between mental health outcomes and life events. Bowman (1997) concludes,

People respond to acute events with great individual variability which arises mostly from individual differences in long-standing qualities . . . When both event and pre-event individual difference factors are included in studying post-event responses, individual differences account for more of the variance in response than event features do. (p. 135)

Individual vulnerability factors provide a good explanation for the fact that a great deal of the variance remains unexplained by the adversity-distress model and for the fact that some victims displayed a discordance between their reports of the horrors of their stalking experience and the seriousness of their psychopathology symptoms. Approximately half the victims reported psychological difficulties in the past (but it is uncertain whether they referred

to the recent past or the period before the stalking episode) and there were some victims who must have been vulnerable prior to their exposure to stalking. One woman had been raped repeatedly and had been forced by her husband to have sex with strangers, another woman had suffered from PTSD symptoms after a car accident, and a third woman claimed that her husband and a psychiatrist had conspired against her during a prior treatment for sexual problems. In addition, the finding that victims reported less pathology when the stalking period was relatively long may be explained by the idea that some of these victims had regained resilience to deal with their stalking. The finding that symptoms were less pronounced when victims had taken relatively few countermeasures makes sense from the idea that these victims still felt that they still had some resilience to deal with their situation.

The concept that the adversity-distress model provides only a limited explanation of the current findings and that the vulnerability (resilience)–distress model, or a combination of the two models, provides better explanations suggests that better therapy outcomes can be expected from therapies focusing on boosting general coping skills and on decreasing general vulnerability than from therapies focusing on specifically dealing with the stalking situation. However, further research is needed to substantiate this suggestion because the present study did not specifically address vulnerability factors, which made it impossible to investigate the validity of the vulnerability (resilience)–distress model as an explanation of the current findings. Further research is also needed because this study was based on information gathered from victims that were registered at the SAS. As with the other studies on stalking victims (Brewster, 1997; Hall, 1998; Pathé & Mullen, 1997), the conclusions cannot be generalized to the total population because it is possible that only victims with a relatively high degree of victimization registered at the SAS. Thus, the present sample may have represented the *tip of the iceberg*. Future research should, therefore, focus on stalking victims in the community. Furthermore, further research is needed to verify whether the current findings also hold true in other countries, even though there are indications that stalking behaviors and their consequences are fairly constant over countries (see also Sheridan & Davies, 2001). Finally, future research is needed on long-term consequences of stalking and the consequences of stalking for the children of the victims, especially because most of the victims had children and were forced to raise these children in difficult circumstances. Nonetheless, it can be concluded that stalking victims generally have many symptoms of psychopathology that are largely independent of features of their stalking experience.

## REFERENCES

- Allen, M. J. (1996). Look who's stalking: Seeking a solution to the problem of stalking. *Web Journal of Legal Issues in Association with Blackstone Press* [Online]. Available: <http://webjcli.ncl.ac.uk/1996/issue4/allen4.html>
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.
- Bowman, M. (1997). *Individual differences in posttraumatic response: Problems with the adversity-stress connection*. Hillsdale, NJ: Lawrence Erlbaum.
- Brewster, M. P. (1997). *An exploration of the experiences and needs of former intimate stalking victims: Final report submitted to the National Institute of Justice*. West Chester, PA: West Chester University.
- Briere, J., & Runtz, M. (1989). The Trauma Symptom Checklist (TSC-33). *Journal of Interpersonal Violence, 4*, 151-163.
- De Becker, G. (1997). *The gift of fear: Survival signals that protect us from violence*. Boston: Little, Brown.
- Dohrenwend, B. P. (1998). *Adversity, distress and psychopathology*. New York: Oxford University Press.
- Fremouw, W. J., Westrup, D., & Pennypacker, J. (1997). Stalking on campus: The prevalence and strategies for coping with stalking. *Journal of Forensic Sciences, 42*, 666-669.
- Goldberg, D. P., & Blackwell, B. (1970). Psychiatric illness in a suburban general practice: A detailed study using a new method of case identification. *British Medical Journal, ii*, 439-443.
- Goldberg, D. P., Gater, R., Sartorius, N., Ustun, T. B., Piccinelli, M., Gureje, O., & Rutter, C. (1997). The validity of the two versions of the GHQ in the WHO study on mental illness in general health care. *Psychological Medicine, 27*, 191-197.
- Goldberg, D. P., & Hillier, V. F. (1979). A scaled version of the General Health Questionnaire. *Psychological Medicine, 9*, 139-145.
- Hall, D. M. (1998). The victims of stalking. In J. R. Meloy (Ed.), *The psychology of stalking* (pp. 113-137). San Diego, CA: Academic Press.
- Harmon, R. B., Rosner, R., & Owens, H. (1995). Obsessional harassment and erotomania in a criminal court population. *Journal of Forensic Sciences, 40*, 188-196.
- Jones, C. (1996). *Criminal harassment (or stalking)*. (See [www.chass.utoronto.ca:8080/~cjones/pub/stalking](http://www.chass.utoronto.ca:8080/~cjones/pub/stalking)).
- Koeter, M.W.J., & Ormel, J. (1991). *General Health Questionnaire: Nederlandse bewerking* [Dutch version]. Lisse, the Netherlands: Swets & Zeitlinger.
- Meloy, J. R. (1996). Stalking (obsessional following): A review of some preliminary studies. *Aggression and Violent Behavior, 1*, 147-162.
- Meloy, J. R. (1998). The psychology of stalking. In J. R. Meloy (Ed.), *The psychology of stalking: Clinical and forensic perspectives* (pp. 1-23). San Diego: Academic Press.
- Meloy, J. R., & Gothard, S. (1995). Demographic and clinical comparison of obsessional followers and offenders with mental disorders. *American Journal of Psychiatry, 152*, 258-263.
- Mullen, P. E., & Pathé, M. (1994). The pathological extensions of love. *British Journal of Psychiatry, 170*, 12-17.
- Mullen, P. E., Pathé, M., & Purcell, R. (2000). *Stalkers and their victims*. Cambridge, UK: Cambridge University Press.
- Pathé, M., & Mullen, P. E. (1997). The impact of stalkers on their victims. *British Journal of Psychiatry, 170*, 12-17.

- Sheridan, L., & Davies, G. M. (2001). Stalking: The elusive crime. *Legal and Criminological Psychology, 6*, 133-147.
- Sheridan, L., Davies, G. M., & Boon, J.C.W. (2001). Stalking: Perceptions and prevalence. *Journal of Interpersonal Violence, 16*, 151-167.
- Tjaden, P., & Thoennes, N. (1998). *Stalking in America: Findings from the National Violence Against Women Survey*. Washington, DC: National Institute of Justice and Centers for Disease Control and Prevention.
- Wright, J. A., Burgess, A. G., Burgess, A. W., Laszlo, A. T., McCrary, G. O., & Douglas, J. E. (1996). A typology of interpersonal stalking. *Journal of Interpersonal Violence, 11*, 487-502.
- Zona, M. A., Palarea, R. E., & Lane, J. C. (1998). Psychiatric diagnosis and the offender-victim typology of stalking. In J. R. Meloy (Ed.), *The psychology of stalking: Clinical and forensic perspectives* (pp. 69-84). San Diego, CA: Academic Press.

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