

Antisocial personality disorder (ASPD) is defined by chronic, socially unacceptable, exploitive behaviors without guilt or remorse (American Psychiatric Association [APA], 2013). Further, ASPD is associated with criminality, deceit, unemployment, violence, manipulation of others, and unstable interpersonal relationships (APA, 2013; National Institute for Health and Clinical Excellence [NICE], 2010). People with ASPD are prone to aggressiveness, irritability, lack of remorse, glib superficial charm, and affective instability (APA, 2013). These individuals have increased risks of substance use disorders, co-occurring mental health disorders, and premature death (NICE, 2010). Approximately 4 percent in the general population to 70 percent of the prison population meet the diagnostic criteria for antisocial personality disorder and the disorder is more common in men than in women (APA, 2013; NICE, 2010). People with ASPD are treated by mental health professionals in multiple settings, including mental health and substance use treatment centers, crisis centers, incarceration settings (e.g. prison, jail), and hospital emergency departments (NICE, 2010).

The best predictor of positive counseling outcomes is the strength of the therapeutic relationship (Lambert & Barley, 2001). However, mental health professionals are notoriously pessimistic about clients with personality disorders (Black et al., 2011; Eren & Sahin, 2016), specifically ASPD (Bowers et al., 2006; Schwartz, Smith, & Chopko, 2007). This pessimism often sabotages therapeutic relationships with clients having ASPD, negatively influencing therapy outcomes (NICE, 2010). These pessimistic attitudes cause a self-fulfilling prophecy in the treatment of clients with ASPD. Poor treatment outcomes are expected when mental health professionals are untrained, suspicious, (Martens, 2004) and lack the optimistic outlook necessary to treat this population (NICE, 2010). When poor treatment outcomes result, clients' symptomatic behaviors (e.g. violence, manipulation) reinforce mental health professionals' pessimistic attitudes

toward clients with ASPD (Wilson, 2014), and the prophecy is fulfilled. Although previous studies have explored mental health professionals' attitudes toward clients with personality disorders (Bowers et al., 2006; Catthoor, Schrijvers, Hutsebaut, Feenstra, & Sabbe, 2015; Eren & Sahin, 2016) few are specific to ASPD and none have addressed underlying social learning factors that may contribute to mental health professionals' attitudes toward clients with these specific disorders. Given the lack of previous research available for guiding the current study, an exploratory research design was chosen. The intent of exploratory research is to determine the best research design, participant selection methods, and data-collection methods (Colman, 2015; Shields & Rangarajan, 2013). The purpose of this study was to explore whether mental health professionals' attitudes toward clients with ASPD were influenced by two factors: (a) Mental health professionals' levels of clinical contact with such clients, and (b) Mental health professionals' personal histories of criminal victimization.

Clinical Contact and Mental Health Professionals' Attitudes toward Individuals with Antisocial Personality Disorder

Clinical contact with clients having ASPD influences mental health professionals' attitudes (Evans, 2011). Schwartz and colleagues (2007) found that counselors-in-training felt dominated, deceived, and manipulated when they viewed a recorded session with a client having ASPD. Their study indicated that these feelings negatively influence therapeutic relationships, potentially sabotaging therapeutic outcomes (Schwartz et al., 2007). Bowers and colleagues (2005) examined the attitudes of prison officers and nurses who interacted with prisoners having personality disorders including ASPD and psychopathy, a variant of ASPD. Study participants reported feelings of frustration and disinterest toward the prisoners. They also reported feeling

annoyed as a result of being manipulated, or when prisoners displayed overt acting out behaviors such as violence, threats, and self-harm (Bowers et al., 2005).

Bowers et al. (2006) examined the relationship between job performance, burnout, personal well-being, and prison officers' attitudes toward clients with personality disorders. Officers were given the *Attitude to Personality Disorder Questionnaire* (APDQ) at three fixed points: baseline, eight months, and sixteen months after beginning employment in a secure personality disorder treatment unit within a prison. Findings indicated that the lower the officers' score on the APDQ, the poorer their job performance and satisfaction, the higher their levels of burnout, and the lower their overall well-being. Moreover, during the first eight months of the study, officers' attitudes remained stable. At eight months however, their attitudes declined (Bowers et al., 2006).

Bowers and colleagues' (2005; 2006) findings suggest that immersion in an environment where ASPD is common negatively influenced the prison officers' and nurses' attitudes. However, a time variable (i.e., length of employment) does not precisely quantify the level of contact officers had with clients having ASPD. Further, Bowers and colleagues (2005; 2006) did not differentiate other environmental issues (e.g., work setting) which may have negatively influenced officers' attitudes; nor did the study account for historical social learning experiences, such as the officers' histories as crime victims. Further, both studies examined prison officers and nurses only, thus their findings may not be generalizable to mental health disciplines (e.g., counseling, psychiatry, social work).

Effects of Criminal Victimization

Violent crimes have longstanding negative effects on society, victims, and families (Ruback, Clark, & Warner, 2014). Victims of violent crimes have increased rates of anxiety, depression, and physical health issues (Ruback et al., 2014). Further, Ruback and colleagues

(2014) found that those who experience a violent crime tend to be repeatedly victimized; this means a relatively small number of people comprise a large percentage of the total number of violent crime victims. Similarly, a small proportion of criminals commits the majority of antisocial crimes (Black, 2013; Hare, 1993). Although studies suggest that crimes have longstanding negative effects on victims (Posick, 2013; Ruback et al., 2014), research specific to the effects of violent crime on mental health professionals is sparse.

As discussed, mental health professionals interact with clients who commit violent crimes in a variety of settings (NICE, 2010). The current study therefore examined the influence of criminal victimization on mental health professionals' attitudes toward clients with ASPD. Its focus on this client population is because those with ASPD are often perpetrators of crime (APA, 2013; Black, 2013).

Research Questions

This exploratory study examined mental professionals' attitudes towards clients with antisocial personality disorder (ASPD). Specifically, whether these professionals' attitudes are influenced by client contact or personal experiences with criminal victimization—their own or that of people close to them, professionally or personally. The study sought to answer the following questions: (1) Is there a main effect for the level of clinical contact (No Contact, Low Contact, High Contact) on mental health professionals' attitudes toward antisocial personality disorder, as measured by the *Adapted-Attitudes toward Personality Disorders Questionnaire*? (2) Is there a main effect for the history of criminal victimization (Yes Victimization versus No Victimization) on mental health professionals' attitudes toward antisocial personality disorder as measured by the *Adapted-Attitudes toward Personality Disorders Questionnaire*? (3) Is there an interaction between level of clinical contact and a history of criminal victimization on mental health

professionals' attitudes toward antisocial personality disorder, as measured by the *Adapted-Attitudes toward Personality Disorders Questionnaire?*

Method

Participants

Participants (N = 98) were Medicaid-approved mental health providers authorized by the North Carolina Department of Health and Human Services to provide mental health and/or substance use disorder services in North Carolina. Study inclusion criteria was: (a) being independently licensed (i.e., not requiring clinical supervision) to practice mental health or substance use therapy in North Carolina; (b) having approval by the North Carolina Department of Health and Human Services as a treatment provider for individuals with Medicaid benefits; and (c) having at least a master's degree in counseling or other helping related fields. This study's inclusion criteria did not require participants to have experience working with clients with ASPD.

The sample was comprised of the following professional disciplines: (a) professional counselors (n = 48; 49.0%), (b) social workers (n = 26; 26.5%), (c) psychologists (n = 17; 17.3%), (d) psychiatrists (n = 3; 3.1%), and (e) other disciplines (n = 4; 4.1%). Participants' years of professional experience ranged from 4 to 50 with a mean of 23.1 (*SD* = 10.8) years. Participants work settings included: (a) private outpatient (n = 64; 65.3%), (b) public outpatient (n = 21; 21.4%), (c) private inpatient (n = 4; 4.1%), (d) forensic setting (n = 2; 2.0%), (e) public inpatient (n = 1; 1.0%), and (f) other (n = 6; 6.1%). The majority of participants (n = 65) reported between 11 and 30 years of experience and account for 66.2% of the sample. The mean age for this sample was 53 years (*SD* = 10.5). Participants 60 to 69 years old comprised the largest age group (n = 29; 29.6%). Participants age 20 to 29 comprised the lowest percentage of participants (n = 1; 1.0%). Female participants (n = 67) represented 68.4% of the sample, and male participants (n = 31)

represented 31.6%. Participants identified as White/Caucasian (n = 78; 79.6%), Black/African American (n = 15; 15.3%), Hispanic Latino (n = 2; 2.0%), Native American/American Indian (n = 1; 1.0%) and Other (n = 2; 2.0%).

Procedures

This exploratory, online survey examined the influence of social learning factors (i.e., clinical contact and criminal victimization) on mental health professionals' attitudes toward clients with ASPD. This study was approved by the Institutional Review Board at East Carolina University. Participants were emailed a link to an online survey containing an author-developed *Demographic Questionnaire* and an adapted version of the *Attitudes to Personality Disorders Questionnaire (APDQ)* (Bowers & Allan, 2006). Completed surveys were analyzed with statistical processing software.

Participants' email addresses were obtained from the North Carolina Department of Health and Human Services' online provider directory (North Carolina Department of Health and Human Services [NCDHHS], 2016). To compensate for low response rates inherent in online survey research, (Heppner et al., 2008) all Medicaid-approved mental health providers (N = 5679) in North Carolina were invited to participate. An a priori power analysis was conducted using G*power and Cohen's (1992) criteria for an effect size of .2 and a power of .8. The analysis suggested that a minimum sample size of 46 was needed to detect moderate to large group differences defined by the independent variables.

Instrumentation

Self-selected participants (i.e., those who chose to participate) completed an author-developed *Demographic Questionnaire* containing the independent variables and the Adapted-

APDQ, which measured the dependent variables. Participants' responses were untimed. The instruments were administered online through computer-based survey delivery software.

Demographic questionnaire. The author-developed *Demographic Questionnaire* provided descriptive data (participants' age, gender, race, licensure, professional discipline, years of experience, and work setting) and included questions ascertaining participants' levels of clinical contact with clients having ASPD and their histories of criminal victimization. To obtain participants' levels of clinical contact with clients having ASPD, the following question was included on the demographic survey: "During an average 5-day workweek, how many clients with ASPD do you treat?" To obtain participants' histories of criminal victimization, the following question was included on the demographic survey: "Have you, a significant other/family member, or close friend ever been the victim of a violent crime?"

The level of clinical contact was operationalized by placing participants in one of three groups based on a tertiary split: (a) No Contact group; (b) Low Contact group (seeing one or two clients a week with ASPD); and (c) High Contact group (seeing ≥ 3 clients with ASPD a week). The categorical boundaries were determined after analyzing the data distribution and placing participants based on the number of clients they treated during an average five-day work week. Treating ≥ 3 clients with ASPD weekly was determined to be the high contact group cutoff score because participants in this category, on average, interacted with people having ASPD for more than 50 percent of their workdays (i.e. 3/5). Although a tertiary split does not account for all the data's variability, it aids in interpretability in comparison to a regression formula (MacCallum, Zhang, Preacher, & Rucker, 2002).

Independent variables. There were two categorical independent variables: clinical contact and criminal victimization. Clinical contact consisted of the three levels (a) No contact (b) Low

contact and (c) High contact. Criminal victimization had two levels; (a) Yes Victimization, included participants and/or their family members who had been crime victims and (b) No Victimization, included participants and/or their family members who had not been crime victims. The influence of the independent variables was measured by the Adapted-*APDQ*.

Attitudes toward personality disorders questionnaire. The *Attitudes toward Personality Disorder Questionnaire (ADPQ)* is a 35-item Likert scale which measures mental health professionals' attitudes toward people with personality disorders (Bowers & Allan, 2006), based on participants' responses to statements. The responses include: 1 = "never", 2 = "seldom", 3 = "occasionally", 4 = "often", 5 = "very often", 6 = "always". Participants select one response for each item. The *APDQ* items addresses positive and negative feelings toward people with personality disorders (Bowers & Allan, 2006). For example, item 1, "I like PD patients", is a positive feeling statement, whereas item 12, "I feel pessimistic about PD patients", is a negative feeling statement (Bowers & Allan, 2006, p. 23).

Adaptations. The *APDQ* has traditionally been a pen-and-paper instrument (Bowers & Allan, 2006). For the current study, the *APDQ* was adapted for computer-based administration by entering items into a computer-based survey delivery system. Participants answered questionnaire items in the same sequence as the pen-and-paper version, and each item was modified to specify ASPD, rather than all personality disorders.

Mental health professionals' attitudes toward clients with ASPD may contribute to their attitudes toward clients with personality disorders in general, however, the original *APDQ* - while a robust instrument - does not specify ASPD's influence alone. Mental health professionals who often treat clients with narcissistic personality disorder, for example, may respond differently to the *APDQ* than those exposed mostly to clients with ASPD (Bowers & Allan, 2006). Therefore,

“AS” (i.e., antisocial) was added before each “PD” abbreviation to provide specificity. For example, item 14 originally read “I admire PD people”. It was modified to read “I admire ASPD people”.

Psychometric properties. The strong psychometric properties of the *APDQ* make it ideal for measuring attitudes toward personality disorders (Bowers & Allan, 2006). Test-retest reliability scores range from .72 to .85 on the five subscales (Bowers & Allan, 2006). Principal components analysis and follow-up confirmatory factor analysis have yielded five distinct subscales with eigenvalues greater than 1 (Bowers & Allan, 2006).

Dependent variables. This study included five continuous dependent variables. The dependent variables were the five factor (i.e., scales) scores from the Adapted-*APDQ*. Each item was scored according to the Likert responses (i.e., 1 = never to 6 = always), and scores were summed to yield scale scores. Negative feeling questions were reverse scored to ensure that higher scores reflect positive attitudes (Bowers & Allan, 2005). In addition, all scales were standardized by dividing participants’ scores on each scale by the number of scale items, since each scale contains a different number of items. This standardization yielded scale scores for each participant on a range from 1 to 6, aiding comparisons across the scales. The five dependent variables were: (a) Enjoyment versus Loathing, (b) Security versus Vulnerability, (c) Acceptance versus Rejection, (d) Purpose versus Futility, and (e) Enthusiasm versus Exhaustion.

Enjoyment versus loathing. The enjoyment/loathing scale measures feelings of warmth and positive regard toward clients with ASPD. This scale consists of 15 items that are standardly scored rather than reverse scored as are the other *APDQ* scales (Bowers & Allan, 2006). For example, item 1, “I like ASPD patients” and item 4, “I respect ASPD patients”, examine participants’ positive emotions toward clients with ASPD.

Security versus vulnerability. The security/vulnerability scale measures feelings of physical and emotional safety toward clients with ASPD (Bowers & Allan, 2006). This scale consists of 10 items that are reverse scored. For example, item 32, “I feel exploited by ASPD patients”, and item 16, “I feel frightened by ASPD patients”, examine participants’ negative emotions toward clients with ASPD.

Acceptance versus rejection. The acceptance/rejection scale measures feelings of anger and rejection toward clients with ASPD (Bowers & Allan, 2006). This scale consists of five items that are reverse scored. For example, item 17, “I feel angry toward ASPD patients”, and item 21, “ASPD patients make me feel irritated”, examine participants’ negative emotions toward clients with ASPD.

Purpose versus futility. The purpose/futility scale measures feelings of hopelessness and pessimism toward clients with ASPD (Bowers & Allan, 2006). This scale consists of three items that are reverse scored. For example, item 12, “I feel pessimistic about ASPD patients” and item 13, “I feel resigned about ASPD patients”, examine participants’ negative emotions toward clients with ASPD.

Enthusiasm versus exhaustion. The enthusiasm/exhaustion scale measures feelings of dissatisfaction when working with clients having ASPD (Bowers & Allan, 2006). This scale consists of two items that are reverse scored. Item two, “I feel frustrated by ASPD patients” and item three, “I feel drained by ASPD patients”, examine participants’ negative emotions toward clients with ASPD.

Analysis

A 3 X 2 factorial multivariate analysis of variance (MANOVA) was used to examine the influence of the independent variables (i.e., level of clinical contact and history of criminal

victimization) on mental health professionals' attitudes toward clients with ASPD, as measured by the Adapted-*APDQ*. Data were analyzed to ensure MANOVA assumptions were adequately met. Follow-up univariate ANOVAs were used to determine which of the five Adapted-*APDQ* subscales were significantly influenced by the factors.

Level of clinical contact with clients having antisocial personality disorder. The “No Contact” group was comprised of participants (n = 45; 45.9%) who reported no contact with clients having ASPD. The “Low Contact” group was comprised of participants (n = 34; 34.7%) who reported having clinical contact with one to two clients with ASPD per week. The “High Contact” group was comprised of participants (n = 19; 19.4%) who reported interacting with ≥ 3 participants with ASPD per week.

History of criminal victimization. Sixty-five participants (n = 65; 66.3%) comprised the “No Victimization” group. Thirty-three participants (n = 33; 33.7%) reported that they, a family member, or significant other had been victimized by violent crime and comprised the “Yes Victimization” group. Table 1 illustrates the 3 X 2 relationship between the independent variables.

Table 1
Level of Clinical Contact and History of Criminal Victimization

	No Victimization	Yes Victimization	Total
No Contact	27	18	45
Low Contact	24	10	34
High Contact	14	5	19
Total	65	33	98

Results

Researchers cleaned data, discarded incomplete surveys ($n = 58$), and omitted invalid/blocked email addresses ($n = 1750$). The final sample consisted of 98 ($N = 98$) participants, yielding a response rate of 2 percent. A low response rate is common in exploratory research, and findings may not be generalizable to the population (Colman, 2015; Shields & Rangarajan, 2013).

A factorial MANOVA revealed a significant multivariate main effect for level of clinical contact (Wilkes $\lambda = .785$, $F [10.0, 176.0] = 2.27$, $p < .05$. Partial $\eta^2 = .114$) with an observed power of .916, indicating a moderate to large effect size and a low probability of type I error (Cohen, 1992). Given the significant multivariate results of level of clinical contact on Adapted-APDQ scores, the univariate main effects were examined with follow-up univariate ANOVAs. Univariate ANOVAs were used to determine which of the five Adapted-APDQ subscale scores showed significant differences based on levels of clinical contact (i.e., No Contact, Low Contact, High Contact).

Results indicate group differences were statistically significant for the *Enjoyment* ($F [2, 92] = 7.95$, $p < .05$ partial $\eta^2 = .15$), *Acceptance* ($F [2, 92] = 5.20$, $p < .05$ partial $\eta^2 = .10$) and *Purpose* ($F [2, 92] = 4.03$, $p < .05$ partial $\eta^2 = .08$) A-APDQ subscale scores. Differences in the *Security* ($F [2, 92] = 2.12$, $p > .05$ partial $\eta^2 = .04$) and *Enthusiasm* ($F [2, 92] = 1.81$, $p > .05$ partial $\eta^2 = .04$) subscales were non-significant. Cohen's (1992) rule of thumb for effect sizes indicates large effect sizes for the *Enjoyment* (partial $\eta^2 = .15$) *Acceptance* (partial $\eta^2 = .10$) and *Purpose* subscale scores (partial $\eta^2 = .08$). Observed power for the *Enjoyment* (.95) *Acceptance* (.82) and *Purpose* (.71) subscale scores indicate a low probability of Type I error. Means, standard deviations, and confidence intervals are shown in Table 2 to indicate directionality.

Table 2
Mean A-APDQ scores for Level of Clinical Contact

Dependent Variable	Contact Group	Mean	Std. Deviation	95% Confidence Interval	
				Lower Bound	Upper Bound
Security	No Contact	4.44	.89	4.21	4.68
	Low Contact	4.72	.64	4.43	5.01
	High Contact	4.87	.58	4.47	5.27
Enjoyment	No Contact	2.58	.67	2.39	2.77
	Low Contact	2.82	.55	2.58	3.06
	High Contact	3.35	.66	3.02	3.67
Acceptance	No Contact	4.33	.90	4.09	4.57
	Low Contact	4.87	.75	4.57	5.17
	High Contact	4.92	.60	4.50	5.33
Purpose	No Contact	3.53	1.23	3.21	3.85
	Low Contact	4.08	.85	3.68	4.48
	High Contact	4.32	.90	3.77	4.87
Enthusiasm	No Contact	3.38	1.01	3.08	3.67
	Low Contact	3.71	1.01	3.35	4.07
	High Contact	3.85	.65	3.35	4.35

Pairwise comparisons were analyzed post-hoc with a Bonferroni adjustment to determine which groups (i.e., No Contact, Low Contact, High Contact) were significantly different along the Adapted-APDQ scales. Only scales containing statistically significant ($p < .05$) were included. Therefore, the *Security* and *Enthusiasm* subscales were not included.

Results indicated that the significant ($p < .05$) main effect for level of clinical contact measured by the *Enjoyment* subscale reflected a significant difference between the No Contact group ($M = 2.58$) and the High Contact group ($M = 3.35$). There was also a significant difference between the Low Contact group ($M = 2.82$) and the High Contact group ($M = 3.35$). However, the difference between the No Contact group ($M = 2.58$) and the Low Contact group ($M = 2.82$) along the *A-APDQ Enjoyment* subscale scores was not significant.

The significant main effect for level of clinical contact measured by the *Acceptance* subscale reflected significant differences between the No Contact group ($M = 4.33$) and High Contact group ($M = 4.92$). However, the differences between No Contact group ($M = 4.33$) and Low Contact group ($M = 4.87$) were non-significant. Similarly, the differences between Low Contact group ($M = 4.87$) and High Contact group ($M = 4.92$) were non-significant.

The significant main effect for level of clinical contact as measured by the *Purpose* subscale on the *A-APDQ* reflects differences between the High Contact group ($M = 4.32$) and No Contact group ($M = 3.53$). However, differences between Low Contact group ($M = 4.08$) and No Contact group ($M = 3.53$) showed no significance. The differences between the Low Contact group ($M = 3.53$) and High Contact group ($M = 4.32$) were non-significant.

A one-way factorial MANOVA indicated a non-significant main effect for history of criminal victimization along the five scales of the *A-APDQ* (Wilkes $\lambda = .97$ $F [5, 88] = .47$ $p > .05$, partial $\eta^2 = .03$). Results indicate a non-significant main interaction effect between level of clinical contact and history of criminal victimization along the five scales of the *A-APDQ* (Wilkes $\lambda = .91$ $F [10, 176] = .85$ $p > .05$, partial $\eta^2 = .05$). Non-significant findings were not further analyzed.

Discussion

This exploratory study examined mental professionals' attitudes towards clients with antisocial personality disorder (ASPD). Specifically, whether these professionals' attitudes are influenced by client contact or personal experiences with criminal victimization—their own or that of people close to them, professionally or personally. Results suggested that mental health professionals' attitudes toward clients with ASPD were influenced by their level of clinical contact with clients having ASPD. Mental health professionals who frequently interacted with clients having ASPD were associated with more positive attitude scores in terms of *Enjoyment*, *Acceptance*, and *Purpose* toward clients with ASPD than mental health professionals who never or rarely interacted with clients having ASPD. These findings are consistent with findings of Black and colleagues (2011), who found that mental health professionals' attitudes toward clients with personality disorders were more positive among mental health professionals with high levels of clinical contact with clients having personality disorders. Findings from the current study, coupled with findings from Black and colleagues (2011) suggest that increased clinical contact positively influence mental health professionals' attitudes toward clients with personality disorders, specifically ASPD. Increased clinical contact may help mental health professionals normalize behaviors of clients with ASPD and decrease emotional and behavioral reactivity toward them. These findings indicate that the initial shock which mental health professionals-in-training experience toward symptoms of ASPD (Schwartz et al., 2007) decreases or becomes adaptive rather than maladaptive as mental health professionals have increased clinical contact with clients having ASPD.

The current study also found that history of criminal victimization was not significantly correlated with mental health professionals' attitudes toward clients with ASPD, as measured by

the Adapted-*APDQ*. These findings suggest that mental health professionals' attitudes toward clients with ASPD are not influenced by their own histories as crime victims. Mental health professionals often help others to make meaning from their own past experiences (Corey & Corey, 2011). Mental health professionals who are crime victims may enter helping professions to better cope with past victimization. Therefore, mental health professionals who are crime victims may be empathetic toward criminal perpetrators, rather than punitive (O'Toole & Sahir, 2014). Factors such as parental bonding (Posick, 2013), socioeconomic status, belief systems, media, religion, type of crime, and culture, also affect how criminal victims' attitudes and behaviors are influenced by criminal acts (Bandura, 1977). The findings from the current study provide insight into mental health professionals' attitudes toward individuals with ASPD. Due to the study's exploratory nature, however, further research is needed.

Implications

Mental Health Professionals

Although clients with ASPD are prone to aggression, distrust, and deceit (APA, 2013; NICE, 2010), findings from the current study suggest that mental health professionals' attitudes are more positive with increased contact with this population. Further, mental health professionals' positive attitudes toward clients with ASPD strengthen therapeutic alliances, improve treatment retention, and enhance treatment outcomes. Continued education and clinical supervision specific to the needs of mental health professionals treating clients with ASPD increases positive attitudes (Black et al., 2011).

Continued education is often delivered through training programs or workshops. Mental health professionals who attend workshops specific to clients with personality disorders report increased self-efficacy, improved attitudes, and increased client empathy (Black et al., 2011).

Continued education can improve treatment professionals' attitudes regardless of their levels of clinical contact with clients having ASPD (Black, et al., 2011). However, factors such as educational delivery method (i.e., online or in person), theoretical approach, and workshop content may influence the duration of these positive effects (Black et al., 2011). More research on continued education delivery is needed to determine optimal duration, frequency, and content for positive attitude effects. Additionally, workshops specific to ASPD are limited (NICE, 2010). Mental health professionals are encouraged to attend workshops that address issues common for people having ASPD such as treatment for criminal offenders, addictions issues, and anger management trainings to improve their knowledge and skills (NICE, 2010).

Mental health professionals who treat clients with ASPD are encouraged to undergo regular clinical supervision (NICE, 2010; Evans, 2011). Findings from the current study, and those from Schwartz and colleagues (2007), indicate that mental health professionals early in their careers or with limited experience with clients with ASPD have increased vulnerability to negative attitudes. Therefore, clinical supervision is imperative novice counselors. Further, NICE (2010) recommends treatment professionals who counsel clients having ASPD receive clinical supervision from supervisors outside their employing agency to avoid the influence of agency interests and protocols in the clinical supervision process. Multicultural issues may also influence treatment professionals' attitudes toward clients having ASPD (NICE, 2010).

In the current study, Caucasian females were overrepresented, which underscores the importance of the influences of race and gender differences on therapeutic relationships with clients having ASPD. Despite attitudinal similarities between women and men and among racial groups, mental health professionals working with clients having ASPD can benefit from ongoing multiculturalism training. This training may include methods for discussing gender and racial

differences with clients and the role of privilege, social class, and stereotypes in therapeutic relationships.

Mental Health Supervisors and Educators

Most developmental models of supervision indicate that inexperienced supervisees undergo feelings of anxiety and uncertainty when they begin practicing mental health counseling. As they gain experience, these feelings of anxiety decrease (Rønnestad & Skovholt, 2003). Findings from the current study suggest that this developmental process is similar for mental health professionals treating clients with ASPD. Mental health professionals who had higher levels of clinical contact with clients having ASPD were associated with more positive attitude scores than mental health professionals with no contact. Although mental health professionals' levels of clinical contact may result from various factors - such as work setting, scope of practice, and career choice - Bandura and Adams (1977) posit that these attitudes are moderated by perceived self-efficacy. For example, mental health professionals who believe they are effective at treating clients with ASPD may choose to work with clients having this disorder, whereas mental health professionals who believe they are less effective at treating clients with this disorder may choose to avoid them. Researchers have yet to examine mental health professionals' self-efficacy specific to ASPD. However, findings from studies examining mental health professionals' perceived self-efficacy toward other personality disorders suggest that self-efficacy influences mental health professionals' attitudes, career decision making, and clinical interactions (Black et al., 2011; Bruton, 2013). These choices influence their levels of clinical contact with clients having ASPD, and thus influence their attitudinal development toward clients with ASPD.

Supervisors can enhance supervisees' perceived self-efficacy through a strengths-based approach. Supervision may include education on ASPD, discussion of realistic therapeutic

expectations of clients with ASPD, and the normalization of common struggles treating clients with ASPD. Additionally, supervisors can help supervisees process their emotional and cognitive reactions to clients with ASPD (Bernard & Goodyear, 2014; Dunbar & Sias, 2015; Evans, 2011).

Mental health counselor educators may also influence mental health professionals' attitude development toward clients with ASPD. Prior research indicates that mental health professionals-in-training experience negative reactions toward clients with ASPD (Schwartz et al., 2007). The current study suggests that increased clinical contact with clients having ASPD improves mental health professionals' attitudes toward these clients. Therefore, mental health counselor educators may normalize mental health professionals-in-trainings' aversive reactions toward these clients, by educating them on the attitudinal development process. Mental health counselor educators may also educate mental health professionals-in-training on the role of attitudes in therapeutic relationships.

Therapeutic optimism is integral to success in treating clients with ASPD (Martens, 2004; NICE, 2010). As discussed, treatment professionals-in-training, such as students in practicum and internships, are especially vulnerable to negative attitudes toward clients with ASPD (Schwartz et al., 2011). Mental health counselor educators can instruct mental health professionals-in-training on strength identification for clients with ASPD, such as creativity, persuasiveness, and resilience (Black, 2013). Mental health counselor educators can help students in practicum and internship develop realistic expectations for treating clients having ASPD. Additionally, mental health counselor educators can avoid stigmatizing language which influences mental health professionals-in-trainings' attitudes (Cathoor et al., 2015). Stigmatizing language specific to clients with ASPD might include "difficult", "resistant", and "unmotivated".

Future Research

As previously discussed, research on mental health professionals' attitudes toward ASPD is scarce. The current exploratory study contributes to the study of mental health professionals' attitudes toward clients with ASPD by including two social learning factors: level of clinical contact, and personal history of criminal victimization. Future research can build upon these findings through alternative study designs, the development of interventions, and by adapting instrumentation.

The current study examines highly experienced ($M = 23.19$ $SD = 10.08$ yrs.) mental health professionals' attitudes toward clients with ASPD. Although findings suggest that increased levels of clinical contact are associated with positive attitudes toward clients with ASPD, future research should include less experienced professionals, such as professionals-in-training and newly licensed professionals, to provide a developmental perspective. A nationwide sample would also allow researchers to account for geographical and developmental influences, which the current study omits.

Future studies should also address multicultural issues, by examining the racial and gender influences in therapeutic relationships with clients having ASPD. The current study includes mostly white female mental health professionals, whereas many clients with ASPD are minority males. Future research might explore how racial and gender differences influence therapeutic relationships by examining those relationships in terms of race, gender, client satisfaction, and outcome measurements.

The current study suggests that increased levels of clinical contact with clients having ASPD influence mental health professionals' attitudes. However, it does not account for other influences, such as supervision and training. For example, participants with more positive attitude

scores may have had adequate supervision, whereas participants with lower attitude scores may have had poor supervision. Future studies need to explore supervisory and training interventions with experimental designs, to determine their influence(s) on mental health professionals' attitudes toward clients with ASPD. Finally, the specific influence of crime victimization on mental health professionals' attitudes towards those with ASPD needs to be further illuminated by studying the type of crime, time frame of crime, and whether the crime was directly (self) or indirectly (friend or family member) experienced.

Limitations

The current exploratory study has specific limitations that must be considered when reviewing findings. First, this study's cross-sectional design limits causative inferences. For this study, the cross-sectional design does not account for changes in mental health professionals' attitudes over time, how these attitudes shape participants' decision making (e.g., career decision making), or how participants' attitudes affect therapeutic relationships. Additionally, the study's low response rate yielded a high non-response bias which likely influenced this study's reliability and validity (Heppner et al., 2008). The cause of the non-response bias cannot be determined but may reflect this study's lack of monetary incentive or mental health professionals' disinterest in clients with ASPD.

As previously discussed, subgroups were not equally represented in this study. For example, sample subgroups such as professional counselors (n = 48; 49.0%) were overrepresented, whereas psychiatrists (n = 3; 3.1%) were underrepresented. Similarly, mental health professionals working in private outpatient settings (n = 64; 65.3%) were overrepresented, whereas mental health professionals working in public inpatient settings (n = 1; 1.0%) were underrepresented. A probability sampling design such as stratified random sampling would protect against unequal

group representation (Trochim, 2006). As previously discussed, these findings may reflect polarization effects rather than causative effects with regards to levels of clinical contact.

Finally, although the *APDQ* (Bowers & Allan, 2005) is used to examine attitudes toward all personality disorders, it was not developed to specify for ASPD. Author adaptations may have influenced the instruments' psychometric properties. To better understand mental health professionals' attitudes toward clients with ASPD, instruments specific to mental health professionals and clients with ASPD are imperative. Future research may include instrument development that accounts for social learning factors such as education, training, supervision, media, political, and geographical influences.

Conclusion

This study provides insight into mental health professionals' attitudes toward clients with ASPD. That is, mental health professionals with higher levels of clinical contact with clients having ASPD were associated with more positive attitudes toward this client population than mental health professionals with little or no clinical contact with clients having ASPD. This study did not determine causative influences relating to mental health professionals' attitudes toward ASPD, nor did this study account for attitudinal development over time. Future research with a longitudinal design might better account for a developmental perspective. Additionally, this study's examination of the influence of criminal victimization on attitudes toward ASPD is exploratory, and follow-up randomized control studies may better account for the influence of criminal victimization on mental health professionals' attitudinal development.

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