

Antisocial Personality Disorder (ASPD) is characterized by a lifelong pattern of exploitive, socially unacceptable, and impulsive behaviors without feelings of guilt or remorse (American Psychiatric Association [APA], 2013). Approximately 4% of the general population and greater than 50% of the prison population meet the diagnostic criteria for ASPD (APA, 2013). People with ASPD have increased rates of criminality, violence, unemployment, co-occurring mental health and addictive disorders, and premature death (APA, 2013; National Institute for Health and Clinical Excellence [NICE], 2009). They are often involuntarily committed or coerced into mental health and addictions treatment by friends, families, and legal professionals such as judges, lawyers, and probation/parole officers (Black, 2013; NICE, 2009).

People who have ASPD are treated in many clinical settings including emergency departments, addiction treatment centers, mental health agencies, vocational settings, and forensic settings such as prisons, jails, and pre-release centers (NICE, 2009; Black, 2013). Therefore, they are treated by clinical professionals such as professional counselors, social workers, vocational counselors, addictions counselors, psychiatrists, and psychologists (Kurtz & Turner, 2007; NICE, 2010). Clinicians often lack knowledge, skills, and self-efficacy for treating clients who have ASPD because clinical training programs typically provide limited supervision and education specific to this population (Black, 2013; Martens, 2004). Consequently, these clinicians often experience burnout, job dissatisfaction, and negative attitudes when they treat clients who have ASPD (Bowers et al., 2006; Carr-Walker, Bowers, Callaghan, Nijman, & Paton, 2004).

Clinicians' negative settled ways of thinking and feeling (i.e. attitudes) toward clients who have ASPD are termed clinical pessimism (Salekin, 2002). Clinical pessimism is cyclical; in that clinicians' negative attitudes are reinforced by clients' chronic antisocial behaviors such as violence, bullying, and manipulation (Dunbar, 2017; Salekin, 2002). Subsequently, clinicians

often exacerbate these clients' symptoms by using punitive or overly confrontational treatment approaches (APA, 2013; Black, 2013; Martens, 2004). Clinical supervisors can disrupt this negative cycle by promoting supervisees' clinical optimism.

Researchers recommend clinicians treating clients with ASPD undergo regular clinical supervision to prevent clinical pessimism and burnout (Black, 2013; Dunbar & Sias, 2015; Evans, 2011; NICE, 2010). However, clinical supervisors lack strategies, models, and tasks for supervising these clinicians (Dunbar & Sias, 2015). The purpose of this article is to identify strategies and tasks clinical supervisors can use to promote supervisees' optimism toward clients who have ASPD. We classify clinicians' attitudes toward clients with ASPD as overt and covert attitudes and illustrate our recommended supervision strategies within Bernard's (1979) discrimination model of supervision.

### **Clinicians' Attitudes toward Clients with Antisocial Personality Disorder**

As previously discussed, clinicians treat clients who have ASPD in various settings (NICE, 2009). People who have ASPD usually seek treatment for co-occurring mental health, addiction, and career issues rather than their personality disorder because they do not think anything is wrong with their personality (Black, 2013). They are often relegated to public treatment agencies (NICE, 2009) where clinical pessimism and burnout is common (Lent & Schwartz, 2012). Their poor interpersonal skills, lack of insight, and empathy deficits often impede treatment progress and frustrate clinicians (Black, 2013; NICE, 2009).

Clients who have ASPD may bully, manipulate, and threaten other people, including clinicians (Black, 2013; Evans, 2011; NICE, 2009). Treatment progress for clients with ASPD is often slow (Black, 2013) and may include setbacks such as clients' anger outbursts, violence, exacerbation of addiction issues, new criminal charges, job loss, and family issues (Black, 2013;

NICE, 2009). Further, clients with ASPD are often distrustful of authority figures, which inhibits therapeutic alliances (Martens, 2004). Treating clients who have ASPD can be tiresome and frustrating for clinicians lacking supervision and training specific to this population (Black, 2013; Martens, 2002).

Clients with ASPD often explain their behaviors in terms of cause and effect, with little consideration for how their behaviors affect others (Black, 2013; NICE, 2010). Their concrete, logical reasoning can be off-putting for clinicians and contribute to clinical pessimism (Evans, 2011). For example, a client who has ASPD may describe assaulting a peer as a means of gaining respect. They may also graphically describe their assaultive behaviors which can intimidate or disgust clinicians (Black, 2013; Evans, 2011; NICE, 2009). Clinicians' negative attitudes toward clients who have ASPD can lead to job dissatisfaction, ineffective treatment provision, burnout, and negative stigmas toward clients who have ASPD (Salekin, 2002; Kurtz & Turner, 2007).

Clinicians-in-training are especially vulnerable to negative attitudes toward clients who have ASPD (Schwartz, Smith, Chopko, 2007). Typically, clinicians' self-efficacy (i.e. belief in their clinical effectiveness) increases as they gain clinical experience, supervision, and training (Bernard & Goodyear, 2014; Gibson, Dollarhide, & Moss, 2010; Skovholt & Ronnestad, 1992; Stoltenberg & McNeill, 2010). However, clinicians receive limited training and supervision specific to ASPD and, thus, lack knowledge and skills for treating clients who have this disorder (Evans, 2011; Schwartz et al., 2007). Clinicians may form negative attitudes toward clients who have ASPD because they perceive these clients' needs as incongruent with their clinical abilities (Leach, Stoltenberg, McNeill, & Eichenfield, 1997). Simply put, many clinicians-in-training believe they cannot help clients who have ASPD. Clinicians-in-training feel intimidated by clients who have ASPD and often avoid working with this population (Schwartz et al., 2007).

We classify clinicians' attitudes toward clients who have ASPD as overt attitudes and covert attitudes. Overt attitudes are thoughts and feelings of which clinicians are aware. These include clinicians' thoughts and feelings during treatment sessions. Covert attitudes are subtle reactions of which clinicians are unaware or those that go unspoken. These include clinicians' thoughts and feelings toward themselves, supervisors, or their employing agency. Additionally, covert thoughts and feelings may be directed inward such as feeling intimidated or low self-efficacy.

### **Clinicians' Overt Attitudes**

Clinicians' overt attitudes include thoughts and feelings of which they are aware. These thoughts and feelings are often externalized and directed toward clients who have ASPD. Clinicians treating individuals with ASPD may experience disgust, hatred, shock, outrage, distrust, and fear toward their clients (Evans, 2011; Schwartz et al., 2007). Clinicians often lack knowledge and skills for integrating these attitudes into their treatment provision (Evans, 2011; Schwartz et al., 2007). Resultantly, clinicians respond harshly to these clients' behaviors and reinforce their clients' distrust of authority figures and their own clinical pessimism (Evans, 2011; Schwartz et al., 2007). For example, a clinician experiencing anger and frustration toward a client who has ASPD might respond punitively to the client's behaviors. If the client responds aggressively or is deceptive in response to the clinician's punitive stance, these behaviors further reinforce the clinician's pessimism (Bandura, 1978; Salekin, 2002).

### **Clinicians' Covert Attitudes**

Clinicians' covert attitudes are subtle responses of which they are unaware or those that go unspoken. These internalized experiences include clinicians' feeling intimidated, demeaned, and outmaneuvered by clients who have ASPD (Evans, 2011; Schwartz et al., 2007). Additionally,

covert attitudes include self-doubt and emotional vulnerability (Evans, 2011; Schwartz et al., 2007). Clinicians' internalized reactions can negatively influence their attitudes and lead to burnout when they are not addressed in clinical supervision (Evans, 2011; NICE, 2009).

Clinicians' covert attitudes also include their thoughts and feelings toward supervisors and their employing agency. Clinicians treating clients who have ASPD may become distrustful of their employing agencies or supervisors (Kurtz & Turner, 2007). This may result from clinicians' unresolved thoughts and feelings toward clients who have ASPD, lack of effective clinical supervision, or lack of resources for treating these clients (Evans, 2011; Kurtz & Turner, 2007). Additionally, clients who have ASPD often portray themselves as victims of unfair societal systems and clinicians who overidentify with this plight may experience societal and systemic distrust (Black, 2013; Kurtz & Turner, 2007; NICE, 2009). Resultantly, supervisees may not trust their clinical supervisors and be hesitant to provide session recordings or discuss their treatment approaches (Bernard & Goodyear, 2014; Evans, 2011; Kurtz & Turner, 2007). Clinical supervisors can improve supervisees' overt and covert attitudes by teaching, counseling, and consulting (Bernard, 1979; Bernard & Goodyear, 2014, Kurtz & Turner, 2007).

### **Clinical Supervision and Antisocial Personality Disorder**

Researchers and treatment developers recommend clinicians undergo clinical supervision when they treat clients who have ASPD (Black, 2013, Evans, 2011; NICE, 2009). Treatment for clients who have ASPD includes talk therapy, medications for co-occurring issues, and systemic interventions such as family counseling and case management (Black, 2013; NICE, 2009). Treatments differ between clinical disciplines and an interdisciplinary treatment approach is recommended (Black, 2013; NICE, 2009). Clinical supervisors may supervise clinicians from

various disciplines and theoretical approaches. However, supervisors lack models and strategies for supervising clinicians in their treatment of clients who have ASPD (Dunbar & Sias, 2015).

### **Clinical Supervision Models for Antisocial Personality Disorder**

Clinical supervision for clinicians treating clients who have ASPD is often conceptualized from the psychoanalytic perspective (Evans 2011; NICE, 2010). Clinicians experience negative countertransference reactions which are subconscious generations of thoughts and feelings toward clients (Evans, 2011; Schwartz et al., 2007). Left unattended, these thoughts and feelings contribute to clinical pessimism toward clients with ASPD (Evans, 2011). Psychoanalytic clinical supervision explores these thoughts and feelings to increase clinicians' insights into clients' behaviors (Evans, 2011). Additionally, psychoanalytic supervision explores parallel processes; an intrapsychic dynamic where the relationship dynamics between clinicians and clients manifest between clinicians and supervisors (Bernard & Goodyear, 2014). These relational dynamics between clinicians and clients occur on an unconscious or subconscious level (Koltz, Odegard, Feit, Provost, & Smith, 2012). The lack of awareness about the relational dynamics allows them to replicate in supervisory relationships. For example, a clinician treating a client with ASPD may become distrustful of her supervisor if the client with ASPD is distrustful of the clinician. This may manifest as the clinician being hesitant to discuss her thoughts and feelings about the client, being unprepared or disengaged in supervision sessions, or being resistant to showing her clinical work including recorded sessions and documentation.

Although psychoanalytic supervision explores underlying concepts such as countertransference and parallel processes (Evans, 2011), it may not address overt themes such as ASPD education, interventions for ASPD, and holistic conceptualization of ASPD. Additionally,

psychoanalytic supervision may be less effective for clinicians using non-psychoanalytic treatment approaches such as person-centered therapy, cognitive behavioral therapy, or reality therapy.

Supervision from Bernard's (1979) discrimination model allows supervisors to adapt their supervisory interventions to supervisees' professional disciplines (e.g., psychologist, counselor, social worker) theoretical orientations, and developmental levels. Additionally, the discrimination model allows supervisors to address psychoanalytic concepts such as countertransference and parallel processes while teaching practical skills, promoting optimism, and processing clinicians' thoughts and feelings (Bernard, 1979; NICE, 2010). Clinical supervisors can adapt Bernard's (1979) discrimination model to clinicians treating clients who have ASPD by addressing clinicians' overt and covert attitudes as one of the primary supervisory tasks.

### **The Discrimination Model of Clinical Supervision**

Bernard's (1979) discrimination model of clinical supervision promotes competent clinicians by distinguishing clinical supervisors' various functions and roles. The functions or tasks of supervision are divided into three areas: intervention (formerly known as process), conceptualization, and personalization (Bernard, 1979; Bernard & Goodyear, 2014). Once the supervisees' abilities have been assessed in the function areas of supervision, supervisors choose from three roles to accomplish supervisory goals (Bernard & Goodyear, 2014). Supervisor roles consist of teacher, counselor, and consultant. This model promotes simple feedback and evaluation; and clear communication between supervisors and supervisees (Bernard, 1979).

Additionally, given the proclivity toward counter-transference and parallel process between clinicians and clients with ASPD (Evans, 2011), isomorphs may emerge in supervision. In the context of clinical supervision, isomorphs extend the concept of a parallel process, where the supervisor perpetuates the unconscious dynamic within in the clinical and supervisory

relationships (Bernard & Goodyear, 2014; Edwards & Chen, 1999; Koltz et al., 2012). To continue the example from above, the supervisor senses the distrust coming from the supervisee and becomes more distrustful toward himself or projects the distrust back toward his supervisee. The supervisor can address this mistrust with the supervisee, and explore how the supervisee can shift the dynamic with her client. Supervisors can use Bernard's (1979) discrimination model to avoid the isomorphic pattern in treating clients who have ASPD.

### **Clinical Functions**

The clinical functions are areas of foci used to examine supervisees' skills within the supervision session. Supervisors can explore the three function areas – intervention, conceptualization and personalization – within a session and across sessions. When attending to intervention, supervisors observe the skills supervisees are using or not using during sessions with clients. Supervision sessions from an intervention perspective examine supervisees' choices, rationale and implementation of skills, education, or interventions (Bernard, 1979; Koltz, 2008). Conceptualization refers to supervisees' abilities to identify, understand, and organize clients' information (Bernard, 1979). This includes organizing clinical information into themes and patterns. Finally, personalization refers to supervisees' personal experiences with and about clients (Bernard, 1979). This function addresses personal issues and areas of countertransference supervisees experience with clients.

### **Supervision Roles**

The supervisory roles within the discrimination model (Bernard, 1979; Bernard & Goodyear, 2014) represent the approaches supervisors use with supervisees; therefore, how the roles are used within the supervisory relationship should emerge from supervisees' developmental



needs. Supervisors discriminate between the roles across sessions and within sessions (Nelson, Johnson, & Thorngren, 2000) based upon trainees' abilities within each function or focus area (Bernard & Goodyear, 2014). The teacher role is used when supervisees need further instruction or assistance in the three areas of function (Bernard, 1979). The counselor role is used when supervisees need assistance in identifying their blind spots or unconscious reactions to clients or interventions. Supervisors take caution to remember the purpose of engaging in this role is to identify, not necessarily work through, issues impeding the therapeutic process. Finally, the consultant role is used when supervisors and supervisees collaborate. This role is often used at later stages of supervisees' development (Bernard & Goodyear, 2014) when the needs for teaching or counseling roles have decreased; however, when supervisors perceive that supervisees are lacking in self-efficacy, they may engage in a consultation role. Utilizing these roles requires supervisors to avoid overemphasis or rigid focus in one area at the expense of supervisees' developmental needs. The three supervisory roles (teacher, counselor, consultant) and three clinical focus areas of the discrimination model (intervention, conceptualization, personalization) provide supervisors a matrix of nine distinct domains from which to provide supervisory interventions to clinicians treating clients who have ASPD. Table 1 outlines supervisory tasks addressing clinicians' attitudes toward clients with ASPD through the discrimination model (Bernard, 1979). The case illustration following the table provides an example of the discrimination model applied to the treatment of a client with ASPD.

Table 1

*Supervision Tasks for Attitudes toward Clients with ASPD*

	Teacher	Counselor	Consultant
Intervention	Supervisor teaches: The role of clinical optimism/attitudes; potential harm of confrontational approaches; culturally appropriate intervention selection; how overt/covert attitudes influence interventions	Supervisor explores: Supervisees' overt/covert attitudes and how they affect intervention selection/application; attitudinal barriers to using specific interventions; supervisees attitudes' about intervention effectiveness	Supervisor consults: About skills and strategies used with past clients that may work with current client; challenges and success the supervisor experiences treating clients with ASPD; advice for working with clients with ASPD
Conceptualization	Supervisor teaches: How to organize and synthesize clients' presenting issues and cultural identity into themes and patterns within ASPD; how interpersonal characteristics of ASPD manifest between clients-clinicians and how this impacts clinicians' attitudes	Supervisor explores: Supervisees' overt/covert attitudes and how they can help to understand the client and ASPD; supervisees' aversive reactions and clients' ongoing interpersonal challenges	Supervisor consults: About additional resources and reading about ASPD; emerging conceptual themes; model/ theory application
Personalization	Supervisor teaches: Normalizes supervisees' negative thoughts and feelings when working with ASPD; how to work with resistance in the relationship; the role of countertransference in treating and understanding ASPD	Supervisor explores: Supervisees' countertransference and its effects on their overt/covert attitudes; The manifestation of countertransference within sessions and across sessions	Supervisor consults: About supervisees' strengths and skills; personal characteristics that can enhance treatment (e.g. humor, genuineness)

## **Case Illustration**

### **Client Description**

Carlos is a 42-year-old heterosexual, married, Latino male who has been involuntarily committed to a residential mental health and addiction treatment center following assaulting his wife and threatening to murder their child. He has been incarcerated for violent crimes in the past and stated that while he was in prison he regularly fought with guards and prison staff. He denied needing mental health and addiction treatment, stating that the arresting officers exaggerated the incident and were “trying to get me locked up”. He has been diagnosed with ASPD based on his lifelong pattern of violent and impulsive behaviors, empathy deficit, lack of remorse, and irresponsibility.

### **Clinician Description**

David is a 24-year-old heterosexual Caucasian male with a master’s degree in Clinical Mental Health Counseling. He recently completed graduate school and accepted a clinical counselor position at the treatment center where he has been working for three months. He is provisionally licensed and receives weekly clinical supervision from Karla who also works at the treatment center as a clinical supervisor.

After counseling Carlos for one month, David informs his clinical supervisor, Karla, that he would like to transfer Carlos to a more experienced counselor because he does not think counseling is helping Carlos. David feels frustrated toward Carlos because he is unwilling to complete homework assignments, does not attend group therapy, and denies any responsibility for his past behaviors. David reports avoiding Carlos and no longer looks forward to coming to work because Carlos frequently requests sessions with David. During these sessions, Carlos consistently portrays himself as a victim of circumstances who experiences unfair persecution from others.

When confronted with discrepancies, Carlos becomes angry and makes jokes about David's lack of clinical experience. In a treatment team meeting that included multiple clinicians, Carlos requested to receive counseling from someone with more experience than David and stated that David lacks the expertise to help him.

David has called in sick three times in the past month and recently missed a scheduled supervision session with Karla. Karla notices that David has not completed his case notes in his usual timely manner and he has not presented any recorded sessions with Carlos as Karla had requested. During supervision, David often discusses clients other than Carlos and is evasive about his treatment approach with Carlos. Karla has also received two calls for professional references for David as he has applied for other jobs without informing Karla.

### **Cultural Consideration**

Before examining the application of the discrimination model and the nine possible domains of supervision focus, it is important to note the cultural differences that exist between Carlos and David. The American Counseling Association Code of Ethics (ACA, 2014), the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2015) and the Association for Multicultural Counseling and Development (AMCD, Arredondo, Toporek, Brown, Jones, Locke, Sanchez, & Stadler, 1996) emphasize the importance of counselors including a client's environmental and cultural context in their clinical conceptualization and interventions to provide appropriate treatment (Arredondo et al., 1996). Cultural similarities and differences between counselors and clients should be evaluated throughout the counseling and supervision processes (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016; Thomas & Schwarzbaum, 2017). This evaluation promotes safety and connection between clinicians and

clients, and ensures clinicians are not unintentionally engaging in oppressive interactions by ignoring or minimizing cultural differences (Thomas & Schwarzbaum, 2017).

Carlos and David have different ethnic backgrounds. Carlos was born and raised in America by second-generation Guatemalan immigrants, while David was raised by Irish Catholic parents. In addition to the cultural values associated with how they were raised, there is also the distinction in how each man was socialized, where David has existed as a member of the ethnic majority and has never experienced oppression, Carlos has been marginalized based on his darker skin tone and racial assumptions that were made about him throughout his life. Other demographic factors to consider in examining the counselor-client relationship are age (24 versus 42) and social class (upper-middle versus lower). These considerations will continue to be identified in the following section.

### **Application of the Discrimination Model of Clinical Supervision**

David is experiencing negative attitudinal reactions (i.e. thoughts and feelings) stemming from his interactions with Carlos. His overt attitudinal reactions include anger toward Carlos for Carlos' lack of participation in treatment and Carlos' portrayal of himself as a victim. David's covert attitudinal reactions include feelings of inadequacy, embarrassment, distrust of his supervisor for not providing him with specific guidance, and distrust of his employing agency. These attitudes have resulted in David calling in sick to work, applying for jobs at other agencies, avoiding counseling sessions with Carlos, and failing to fulfill work duties (e.g. case notes and recorded sessions).

Clinical supervisors can address supervisees' overt and covert attitudes from the nine domains of the discrimination model (Bernard, 1979). Examples illustrate how supervisors might intervene based on the case illustration examples of Karla supervising David. The examples

include suggested intervention concepts and resources based on each role and function of the discrimination model (Bernard, 1979).

**Teacher role.** Tasks for supervisors in the teacher role of the discrimination model (Bernard, 1979) include exploring how supervisees conceptualize clients' presenting and underlying issues, what interventions the supervisees have been using, and what they notice about their efficacy. From there, supervisors educate supervisees about possible effective interventions for clients with ASPD such as cognitive and systemic interventions (i.e. intervention); exploring the chronic nature of ASPD (i.e. conceptualization); discussing the etiology of ASPD and the types of interventions that may be met with resistance; or providing supervisees information about how clinicians' attitudes influence the treatment of clients who have ASPD (i.e. personalization) (Black, 2013; NICE, 2010). Because clinicians often lack knowledge and skills for treating clients with ASPD (Black, 2013; NICE, 2009), clinical supervisors can use the teacher role to provide education which may increase clinicians' knowledge, skills, and self-efficacy and improve their attitudes toward clients who have ASPD. Supervisors can address counselors' and clients' cultural identities and how these cultural factors affect treatment.

**Example.** Karla can address David's overt and covert attitudes from the teacher role of the discrimination model (Bernard, 1979). Because clinicians often lack knowledge and skills for treating clients who have ASPD, Karla might improve David's attitude through any of the three functions of the discrimination model by educating and instructing David.

**Intervention.** The teacher role - intervention function of the discrimination model (Bernard, 1979) addresses supervisees' clinical skill applications by teaching supervisees about clinical interventions and techniques. Clinicians' pessimism often results in their intervening with clients who have ASPD from a punitive or authoritative stance that can worsen clients' symptoms

and lead to poor treatment outcomes (Martens, 2002; NICE, 2009). Karla can, first, call David's attention to potentially punitive or overly confrontational interventions used. Then Karla can educate David on the ineffectiveness of such interventions for clients who have ASPD (Martens, 2002; NICE, 2009), and help him develop interventions that result in more successful treatment outcomes. Karla can also educate David on the importance of clinical optimism in treating clients who have ASPD (NICE, 2009).

David's cultural considerations in choosing interventions with Carlos need to be evaluated, and Karla can educate David on cultural discrepancies between him and Carlos. Additionally, Karla might educate David on techniques for counseling clients with high levels of resistance such as Motivational Interviewing (Miller & Rollnick, 2013). Specifically, Karla can educate David on identifying what motivates Carlos and help David respond appropriately to disruptive and resistant behaviors rather than engaging in arguments with Carlos (Miller & Rollnick, 2013).

***Conceptualization.*** Supervising from the teacher role - conceptualization function of the discrimination model (Bernard, 1979), Karla can address David's ability to organize and synthesize information about Carlos. Karla can educate David on how the motivations of clients with ASPD may differ from other clients he works with and how to address Carlos' goals. Karla can also explore the role of clinicians' overt and covert attitudes in treating clients who have ASPD. Specifically, Karla can help David understand his reactions to Carlos by educating him on how his attitudes may be similar to other people in Carlos' life and using his reactions to better understand Carlos. Additionally, Karla can educate David about the chronic nature of ASPD and how David's behaviors in treatment are a microcosm of a chronic disorder.

Through a systemic lens, Karla can encourage David to incorporate cultural considerations into his conceptualization and diagnosis. Karla can facilitate exploration of Carlos' cultural

identity, the cultural messages he has received about mental health issues and vulnerability, environmental sources of stress presently and in his past, and cultural elements of the therapeutic relationship (ACA, 2014).

***Personalization.*** Supervising from the teacher role - personalization function of the discrimination model (Bernard, 1979), Karla can increase David's knowledge and skills relating to countertransference in treating clients who have ASPD. Karla may educate David about the role of countertransference in treating clients who have ASPD and how countertransference can be used to better understand clients when it is processed in supervision versus how it can lead to negative attitudes when it is not addressed in supervision (Schwartz et al., 2007). To address his overt and covert attitudes, Karla can educate David on clinicians' common attitudinal responses toward clients who have ASPD and how these attitudes can cause burnout, job dissatisfaction, and poor treatment provision. She can also explore David's awareness of his own ethnic identity and experience of privilege and marginalization and how this aligns or diverges from what he knows of Carlos's experiences with adversity. Although the counseling profession advocates for the importance of multicultural competence in clinicians, some counselors are defensive about acknowledging their privilege or positional power (Thomas & Schwarzbaum, 2017; Sue & Sue, 2016). The teacher – personalization domain can help supervisees raise their awareness around the impact of cultural factors on therapeutic relationships and how open or resistant supervisees are to considering this dynamic.

### **Counselor Role**

Tasks for supervisors in the counselor role of the discrimination model (Bernard, 1979) might include prompting discussion of clinicians' perceived risks and benefits of specific interventions (i.e. intervention); using questions to explore how clinicians react to symptoms of



ASPD manifesting in the treatment environment (i.e. conceptualization); or exploring supervisees' internal reactions toward people with ASPD to help supervisees better understand clients' interpersonal relationships (i.e. personalization).

**Example.** Karla can address David's overt and covert attitudes toward Carlos from the counselor role of the discrimination model (Bernard & Goodyear, 2014). Although Karla can use the teacher role to increase David's knowledge about how attitudes influence treating clients who have ASPD, the counselor role can help David identify his subconscious reactions to Carlos and how these reactions influence David's treatment approach. Additionally, Karla can help David use his reactions to Carlos productively through reflective questioning (Evans, 2011; Schwartz et al., 2007).

**Intervention.** Karla can supervise from the counselor role – intervention function of the discrimination model (Bernard, 1979) to help David understand the risks and benefits of specific interventions and the role of his attitude in his treatment approach with Carlos. Karla can supervise from the counselor role – intervention function through questions such as:

- How do you think your thoughts and feelings about Carlos are influencing your treatment approach with him?
- What have you done well so far in your treatment of Carlos? What might you improve upon? How can we use supervision to help you improve this?
- What are some treatment techniques you would like to try with Carlos?
- What prevents you from trying these treatment techniques with Carlos?
- How are your thoughts and feelings about ASPD influencing your treatment of Carlos?

**Conceptualization.** Karla can supervise from the counselor role – conceptualization function of the discrimination model (Bernard, 1979) to increase David's awareness of his overt

and covert attitudes toward Carlos and how these attitudes can be used to better understand Carlos and ASPD. Specifically, Karla can help David understand how Carlos' behaviors are symptomatic of ASPD's chronic and pervasive nature.

- How do Carlos's behaviors here in treatment fit with other behaviors throughout his life?
- How do Carlos's behaviors align with his diagnosis of ASPD?
- How have Carlos's behaviors caused him problems? How might these behaviors affect Carlos after he leaves this treatment center?
- What might Carlos be thinking and feeling when he interacts with you? What might Carlos be thinking and feeling when he interacts with other people?
- How might your relationship with Carlos be similar to other relationships throughout Carlos' life?

***Personalization.*** Karla can supervise from the counselor role – personalization function of the discrimination model (Bernard, 1979) to increase David's awareness of his overt and covert attitudes toward Carlos by exploring David's countertransference. Questions Karla might use to explore David's countertransference include:

- What thoughts and feelings do you experience when you interact with Carlos?
- Tell me what thoughts and feelings you were experiencing when you were arguing with Carlos.
- How might your thoughts and feelings toward Carlos' be similar to other people in Carlos' life? How have your responses to Carlos' been similar to other people in his life? How have they been different?

- How have your thoughts and feelings toward Carlos similar to other people in your life? How have your responses to Carlos been similar to other people in your life?
- How are your negative thoughts and feelings about Carlos manifesting during counseling sessions?
- When you struggle to connect with Carlos, what messages do you send to yourself about what that means?

### **Consultant Role**

Tasks for supervisors in the consultant role of the discrimination model (Bernard, 1979) might include brainstorming sessions for creative interventions for clients with ASPD (i.e. intervention); collaboratively exploring symptomatic presentations of clients with ASPD (i.e. conceptualization); examining co-occurring issues such as depression, anxiety, addiction; or providing examples of supervisors' reactions toward clients with ASPD (i.e. personalization). This role will likely happen with supervisees who have knowledge about ASPD and need increased self-efficacy treating clients who have ASPD, or supervisors can use the consultant role to increase clinicians' self-efficacy by exploring supervisees' experiences with similar clients.

**Example.** As David increases his ability to work effectively with Carlos and understands his attitudes toward Carlos, Karla can transition to the consultant role. Karla can use a collaborative approach with David within the consultant role rather than an expert (i.e. teacher role) or therapist (i.e. counselor role) approach (Bernard & Goodyear, 2014). Because David is early in his professional development and has limited knowledge and skills for treating clients who have ASPD, Karla is likely to supervise David from either the teacher or counselor role (Bernard, 1979). However, Karla can help David develop creative interventions with David and discuss personal

reactions and traits that can influence Carlos' treatment (Bernard, 1979; Koltz, 2008; Nelson et al., 2000).

***Intervention.*** Karla can supervise from the consultant role – intervention function by helping David identify skills and strategies he has used with other clients that may work with Carlos (Bernard, 1979). Additionally, Karla may help David customize his approach by collaboratively sharing intervention ideas, suggestions, and advice for working with Carlos. Karla will assume a non-expert stance within the consultant role to promote David's decision making regarding his treatment interventions with Carlos. Karla may also engage David in dialogue regarding the cultural implications and appropriateness of his interventions.

***Conceptualization.*** Karla can supervise from the consultant role – conceptualization function once David has a basic understanding of ASPD. Karla might collaborate with David on reading and research on ASPD to enhance his conceptualization. Additionally, she might collaborate with David as he forms a theoretical conceptualization and model for his work with Carlos that incorporates his new understanding of ASPD. If Carlos's family is involved in treatment, Karla may consult with David on how to incorporate a systemic focus in Carlos's treatment. At this point in the supervision, Karla is supporting David's self-efficacy by switching from teaching and/or counseling roles to the consultant role.

***Personalization.*** Karla can supervise from the consultant role – personalization function by helping David identify his skills and strengths that he can use in his treatment of Carlos (Bernard & Goodyear, 2014). She might identify personal characteristics she has observed while supervising David and collaboratively discuss how these characteristics can be used to help Carlos. Additionally, Karla can provide examples of her own experiences and reactions toward clients

who have ASPD to normalize David's experience. Karla may also invite David to consider his implicit biases and how those may impact his work with Carlos.

### **Implications and Future Research**

This article identifies supervisors' primary task as addressing supervisees' overt and covert attitudes toward clients who have ASPD and illustrates how supervisors can use Bernard's (1979) discrimination model to address these attitudes. Despite researchers' recommendations that clinicians receive clinical supervision when they treat clients with ASPD (Black, 2013; Evans, 2011; NICE, 2010; Schwartz et al., 2007), supervisors lack specific strategies, models, and tasks for supervising these clinicians. Further, supervisory recommendations are often conceptualized through a psychoanalytic framework (Evans, 2011; NICE, 2010) which may not address practical strategies, skills, and education that can contribute to clinicians' pessimism and burnout. Although the discrimination model is used to supervise various disciplines and clinical issues (Bernard, 1979; Byrne & Sias, 2010; Koltz, 2008) its application to ASPD and has not been addressed. This article provides supervisors a framework to address supervisees' attitudes toward clients with ASPD which may improve treatment outcomes for this underserved population.

Clinicians often lack knowledge and skills for treating clients with ASPD, similarly, supervisors lack specific supervision strategies for supervising clinicians' treatment of clients who have ASPD. This clinical and supervisory deficit, compounded by the prevalence of ASPD, warrants further research into this topic. Future researchers can build upon this conceptual article by exploring the effects of clinical supervision on supervisees' attitudes toward clients who have ASPD. Additionally, future researchers can assess the role of clinicians' attitudes on the treatment outcomes of clients who have ASPD and these clients' perceptions of clinicians.

## **Conclusion**

Clinicians treating clients who have ASPD are at risk for clinical pessimism, burnout, and job dissatisfaction (Bowers et al., 2006; Carr-Walker et al., 2004; Schwartz et al., 2007). Although researchers suggest these clinicians undergo regular clinical supervision (Evans, 2011; NICE, 2009; Schwartz et al., 2007) supervisors may lack strategies and models for supervising clinicians specific to this issue. The discrimination model (Bernard, 1979) provides clinical supervisors with an atheoretical framework that can be used with treatment professionals at multiple developmental levels and from various professional disciplines. Further, we suggest supervisors' primary task in supervising these clinicians is exploring their attitudes towards clients with this disorder and promoting clinical optimism to combat burnout, distrust, and job dissatisfaction. The discrimination model's (Bernard, 1979) practicality is ideal for addressing clinical pessimism, moral outrage, feelings of insecurity, and frustration which lead to clinical pessimism (Carr-Walker et al., 2004; Schwartz et al., 2007).

## References

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