Mental Health Professionals' Attitudes toward Clients with Antisocial Personality Disorder

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ABSTRACT

Clients with personality disorders are treated throughout the United States' healthcare system. Research suggests that mental health professionals' attitudes' toward clients with personality disorders are poor. However, research specific to clients with antisocial personality disorder was lacking. The current study examined the influence of social learning factors (i.e., level of clinical contact and history of criminal victimization) on mental health professionals' attitudes toward clients with antisocial personality disorder.

The population of study was Medicaid-approved providers. The purposive sample included 98 Medicaid-approved mental health providers in North Carolina. The study used an online survey design, and participants completed an author-developed *Demographic Questionnaire* and the *Adapted-Attitudes toward Personality Disorders Questionnaire.* Three research questions examined the main effects of level of clinical contact, history of criminal victimization, and interaction effects on mental health professionals' attitudes toward clients with antisocial personality disorder. A factorial MANOVA and follow-up univariate ANOVAs revealed a statistically significant main effect for level of clinical contact with clients with antisocial personality disorder on participants' attitudes scores as measured by the *Adapted-*

Attitudes toward Personality Disorders Questionnaire. No main effect for history of criminal victimization nor interaction effect was detected.

Findings support that the social learning factor of level of clinical contact significantly influences mental health professionals' attitudes toward clients with antisocial personality disorder. Findings hold implications for mental health professionals, mental health supervisors, mental health educators, and mental health researchers.

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CHAPTER 1: INTRODUCTION

This chapter serves as an introduction to the study investigating mental health professionals' attitudes toward clients with antisocial personality disorder (ASPD). Chapter one provides a background of the study, statement of the problem, study justification, theoretical rationale, research questions, study significance, definition of terms, and a chapter review.

Background of the Study

In his seminal book, *The Mask of Sanity-An Attempt to Clarify Some Issues About the So-Called Psychopathic Personality*, Hervey Cleckly (1988) describes clients with antisocial personality disorder (ASPD) as "the forgotten men of psychiatry" who "probably cause more unhappiness and more perplexity to the public than all other mentally disordered patients combined" (p. 16). He further posits that the disorder is resistant to treatment and efforts to rehabilitate these clients are futile. Cleckly's (1988) work was first published in 1941 and outlines the pessimism, confusion, and frustration mental health professionals experience in clinical settings over 70 years later.

Although defining ASPD is a topic of debate, the current definition comes from the American Psychiatric Association (APA) (Horley, 2014). "The essential feature of antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. This pattern has also been referred to as *psychopathy*, *sociopathy*, or *dissocial personality disorder*" (American Psychiatric Association [APA], 2013, p. 659). People with ASPD are prone to aggressiveness, irritability, lack of remorse, glib superficial charm, and affective instability (APA, 2013). They have an increased risk of substance use disorders, co-occurring mental health disorders, and premature death (National Institute for Health and Clinical Excellence [NICE], 2010).

Mental health professionals (e.g., professional counselors, social workers, nurses psychiatrists, psychologists, marriage and family therapists) treat individuals with ASPD in a variety of inpatient, outpatient, and forensic settings (e.g., prisons, jails) (APA, 2013; NICE, 2010). The disorder's chronicity and symptoms (e.g., violence, impulsivity, and deceit) contribute to mental health professionals' negative outlooks toward clients with ASPD (NICE, 2010). Believing clients with ASPD are difficult to treat negatively influences mental health professionals' attitudes toward clients with the disorder and may contribute to poor treatment outcomes (Koekkoek, Hutschemaekers, Van Meijel, & Schene, 2011; NICE, 2010).

Negative attitudes toward clients with ASPD are termed clinical pessimism or therapeutic pessimism (Salekin, 2002). Research indicates that the best predictor of therapy outcomes are the strength of the therapeutic relationships between clients and mental health professionals (Lambert & Barley, 2001). However, mental health professionals' therapeutic pessimism often sabotages therapeutic relationships with clients with ASPD, thereby negatively influencing therapy outcomes (Martens, 2004; NICE, 2010; Salekin, 2002). These pessimistic attitudes can result in a self-fulfilling prophecy in the treatment of ASPD, in that poor treatment outcomes are perpetuated by mental health professionals who are untrained, suspicious, (Martens, 2004) and lack the optimistic outlook necessary to treat this population (NICE, 2010). Poor treatment outcomes and symptoms manifesting in treatment (e.g., violence, manipulation) reinforce mental health professionals' beliefs that clients with ASPD are difficult to treat (Wilson, 2010).

Outcome Studies

Determining the treatability of ASPD based on outcome studies is difficult (Black, 2015; NICE, 2010). Confounding factors such as co-occurring disorders (e.g., depression, substance use disorders) and transient lifestyles (Black, 2013) affect clinical outcomes and follow-up

studies (Salekin, 2002; Wilson, 2010). Additionally, there is little agreement on what constitutes treatment success for clients with ASPD (Wilson, 2010). The majority of studies examine criminal offenses, substance abuse, co-occurring mental health issues, and employment outcomes (Black, 2015; NICE, 2010). Although ASPD affects every functional domain of individuals with the disorder, outcome research often addresses a single domain which may leave underlying factors unexplored (Wilson, 2010). The atomistic approach to measuring treatment outcomes reflects a lack of holistic methods for conceptualizing and measuring symptoms of people with ASPD (Salekin, 2002; Wilson, 2010). As a result, mental health professionals are uncertain about treatment efficacy and approaches for clients with ASPD (Black, 2013; NICE, 2010).

Early publications on ASPD offered little hope for positive treatment outcomes (Cleckly, 1988; Hare, 1993). However, recent research supports the treatability of ASPD (Black, 2015; Easton, Scott, Babuscio, & Carroll, 2012; Krampten, 2009; Salekin, 2002). Although studies show clients with ASPD can achieve symptom reduction and increase adaptive functioning, therapeutic pessimism persists (Salekin, 2002; Wilson, 2014). This pessimism may be due to the effects clients with ASPD have on clinicians with whom they interact (Evans, 2011).

Clinical Variables Influencing Treatment Pessimism

Although poor treatment outcomes are attributed to clients with ASPD (Black, 2015; Hare, 1993; Krampten, 2009), little consideration is given to how clients with ASPD affect mental health professionals (Bowers et al., 2006; Evans, 2011). Symptoms of ASPD such as violence and manipulation perpetuate mental health professionals' negative beliefs about clients with ASPD (Glenn & Raine, 2013; Van Beek & Verheul, 2008). Mental health professionals' negative beliefs about clients with ASPD cause feelings of shock, outrage, and hatred toward

these clients which negatively influences their therapeutic relationships (Schwartz, Smith, & Chopko, 2007). Additionally, clients with ASPD use concrete reasoning, manipulation, violence, and threats, which are aversive to most mental health professionals (Evans, 2011).

Direct experience with clients with ASPD can have a powerful influence on attitudes of mental health professionals with whom they interact (Evans, 2011). Mental health professionals report feelings of anger, helplessness, and anxiety when working with clients with ASPD (Evans, 2011), which creates negative attitudes toward clients with the disorder. Eren and Sahin (2016) examined the attitudes of mental health professionals toward clients with personality disorders. Their study included psychiatrists (n = 38), psychiatric residents (n = 32), psychologists (n = 30), nurses (n = 88), psychiatric nurses (n = 140), and social workers (n = 4). Eren and Sahin (2016) found that mental health professionals experienced high levels of perceived difficulty and emotional reactions toward clients with ASPD as compared to other personality disorders (e.g., narcissistic personality disorder, schizoid personality disorder, etc.) and preferred to avoid them.

Mental health professionals working with clients with ASPD may be bullied, threatened, demeaned, or manipulated (Bowers, 2003; Evans, 2011; Kurtz & Turner, 2007). These interactions negatively influence mental health professionals' attitudes toward clients with ASPD, which sabotages the therapeutic process (Schwartz et al., 2007). Therefore, poor treatment outcomes may result from mental health professionals' attitudes toward clients with ASPD rather than ASPD being untreatable (Schwartz et al., 2007). The antisocial behaviors that result from poor treatment outcomes affect individuals, families, and society (Black, 2013).

Social Variables Influencing Treatment Pessimism

The term antisocial refers to behaviors opposing social norms and expectations (APA, 2013; Black, 2013). Because individuals with ASPD consistently behave in ways that oppose

social norms, they are often viewed negatively by society (APA, 2013; Black, 2013; NICE, 2010). Many people with ASPD are incarcerated because of their chronic inability to live up to social norms and expectations (APA, 2013; NICE, 2010). The United States' punitive approach to criminal behavior has resulted in over 1.5 million prisoners being held in state and federal prisons (Carson, 2015), of whom up to 70% meet the criteria for ASPD (APA, 2013). Aggregate estimates of the cost of crime in the United States exceed 1 trillion dollars, funded mostly by taxpayers (Piquero, Jennings, & Farrington, 2013). People with ASPD commit crimes that involve violence, conning, and preying on others (NICE, 2010). The social effects of crime contribute to negative views of individuals with ASPD by society and mental health professionals (Kurtz & Turner, 2007). Media portrayals of antisocial acts, such as violence and terrorism, further fuel social outrage (Black, 2013). Often, this social outrage is rooted in feelings of fear and vulnerability to the predatory nature of people who commit chronic antisocial acts (Black, 2013). This social outrage permeates clinical settings (Black, 2013; NICE, 2010) and may negatively influence mental health professionals' attitudes toward clients who have ASPD.

People with ASPD "plow their way through life, leaving a broad trail of broken hearts, shattered expectations, and empty wallets" (Hare, 1993, p. xi). They interact with their environment from a predatory perspective (Black, 2013). Their predatory nature means they often exploit or abuse others for their own personal gain (NICE, 2010). This predatory stance results in increased rates of violent crime, theft, fraud, threats, and domestic abuse (NICE, 2010; Black, 2015). After being incarcerated many individuals with ASPD reoffend, resulting in longer prison sentences (NICE, 2010). Furthermore, they are more likely to be denied parole or sentenced to death because of their dulled sense of empathy and inability to express remorse for the crimes they commit (Edens, Davis, Fernandez Smith, & Guy, 2013).

To explore attitudes toward individuals with psychopathy, a severe form of ASPD, Edens and colleagues (2013) examined mock juror responses to three criminal trial vignettes. Each vignette was similar, however one vignette included a diagnosis of psychopathy (Edens et al., 2013). Findings indicated that participants were more likely to sentence the subject with a diagnosis of psychopathy to death (Edens et al., 2013). Additional findings indicated that participants had a strong aversive reaction to affective characteristics of ASPD (e.g., glib superficial charm, lack of remorse, grandiosity).

In addition to criminal costs, clients with ASPD have high rates of hospitalization and low rates of employment (NICE, 2010). They often depend on public assistance (e.g., welfare, disability) to meet their basic needs (Black, 2013). They are commonly involved in disability and welfare scams and are experts at system navigation and manipulation (Black, 2013; Samenow, 2014). By adulthood, clients with ASPD have often experienced multiple clinical and legal settings, which are instrumental in honing their ability to maneuver systems for personal gain (Bowers, 2003).

Clients with ASPD rarely seek treatment for their personality disorders rather they seek treatment for co-occurring issues such as substance use disorders, depression, or medical issues (NICE, 2010). Therefore, they may be seen in substance use treatment centers, employment agencies, mental health clinics, and emergency departments (NICE, 2010). They are involved in multiple systems (e.g., family, legal, welfare) where mental health professionals are affected by their disordered behaviors (APA, 2013). Clients with ASPD are frequently seen in public agencies that are underfunded, understaffed, and poorly equipped to meet their needs (NICE, 2010). The lack of effective treatment for clients with ASPD forms a negative cycle; with poor treatment provision leading to poor treatment outcomes (Black, 2013; Martens, 2004; NICE,

2010). The resulting increased treatment attrition and recidivism reinforces mental health professionals' pessimism toward clients with ASPD, which can negatively influence mental health professionals' treatment provision (NICE, 2010).

Statement of the Problem

Mental health professionals are notoriously pessimistic about clients with personality disorders (Black et al., 2011; Eren & Sahin, 2016; Salekin, 2002; Wilson, 2014) specifically, antisocial personality disorder (ASPD) (Bowers et al., 2006; Schwartz et al., 2007). Negative attitudes toward clients with ASPD reflects clinical uncertainty, societal fear, and moral outrage toward clients with the disorder. Although studies suggest mental health professionals' attitudes toward clients with ASPD are negative (Bowers et al., 2006), no studies examine social learning factors associated with these negative attitudes (Bowers et al., 2006; Eren & Sahin, 2016). Underlying social learning factors, such as level of clinical contact and history of criminal victimization may contribute to mental health professionals' negative attitudes toward clients with ASPD. Clients with ASPD are treated in virtually all clinical settings including prisons, jails, substance abuse treatment centers, emergency departments, and public outpatient clinics (Black, 2013; NICE, 2010). However, knowledge about clients with ASPD is limited (Black, 2015). Similarly, little is known about factors associated with mental health professionals' attitudes toward clients with ASPD.

Symptoms of ASPD result in criminal recidivism, accidental death, substance abuse, and acts of violence toward others (APA, 2013). These severe and chronic symptoms coupled with unclear treatment efficacy negatively influence mental health professionals' attitudes (Salekin, 2002).). Negative attitudes toward personality disorders are common among a variety of professional disciplines (Black et al., 2011; Bowers & Allan, 2006; Eren & Sahin, 2016)

however, studies specific to mental health professionals attitudes toward ASPD are sparse and do not include underlying social learning factors. Using quantitative methods, this study will examine mental health professionals' attitudes toward clients with ASPD and the influences of social learning factors (i.e., level of clinical contact and criminal victimization).

Justification of the Study

Clients with personality disorders display cognitive rigidity, poor emotional regulation, and have unstable interpersonal relationships (APA, 2013). Previous studies have explored mental health professionals' attitudes toward clients with personality disorders (Catthoor, Schrijvers, Hutsebaut, Feenstra, & Sabbe, 2015; Eren & Sahin, 2016). Mental health professionals with medical, social work, and nursing backgrounds characterize clients with personality disorders as "difficult to manage" and often express a preference to avoid contact with them (Newton-Howes, Weaver, & Tyrer, 2008, p. 572).

Eren and Sahin (2016) found that mental health professionals (i.e., psychiatrists, psychologists, nurses, and social workers) consider ASPD difficult to treat and have negative attitudes toward clients with this disorder. These mental health professionals experienced feelings of anger, helplessness, and frustration when working with clients with ASPD. Similarly, Schwartz and colleagues (2007) found that counselors-in-training felt dominated, deceived, and manipulated when exposed to a recorded session with a client with ASPD. These emotions may negatively influence therapeutic relationships (Evans, 2011). For example, mental health professionals who experience emotions such as anger and frustration toward clients with ASPD may be less engaged in the therapeutic process, or express their frustration toward clients by belittling them or engaging in power struggles. Findings from these studies indicate how mental health professionals' attitudes are influenced by clinical contact with clients with ASPD.

In a study examining the attitudes of prison officers working in a forensic psychiatric setting, Bowers and colleagues (2005) suggest that the level of exposure to clients with ASPD may influence the attitudes of those with whom they interact. Bowers and colleagues' (2005) longitudinal study indicated that prison officers' maintained positive or neutral attitudes toward inmates with ASPD during their initial 8 months of exposure to clients with severe ASPD. However, after 8 months the officers' attitudes became increasingly negative. These findings imply that staff who are frequently exposed to clients with ASPD may have an increased risk for negative attitudes (Bowers et al., 2005). Bowers and colleagues (2005) suggest that mental health professionals with negative attitudes are more likely to engage in negative interactions with clients, adopt a punitive or authoritarian interaction style, be disrespectful toward clients, and lose their temper with clients.

A systematic review by Freestone et al. (2015) found that mental health professionals view clients with personality disorders and legal charges negatively. In addition, mental health professionals who work with clients with personality disorders have higher rates of burnout/stress and are more likely to engage in negative clinical interactions (e.g., verbal altercations, threats, etc.). As a result, mental health professionals working with clients with ASPD often experience increased frustration and decreased trust toward the agency in which they work, which further exacerbates their negative outlooks (Kurtz & Turner, 2007).

Although these studies are helpful in increasing awareness of mental health professionals' attitudes toward clients with personality disorders, specific research concerning mental health professionals' attitudes toward clients with ASPD is sparse. The majority of studies examine mental health professionals' attitudes toward all personality disorders and are not specific to ASPD (Black et al., 2011; Bowers, 2006; Freestone et al., 2015; Shanks et al.,

2011). These studies fail to explore underlying social learning factors such as level of clinical contact and criminal victimization. This study will assist helping professional training programs conceptualize how mental health professionals' attitudes are influenced by clients with ASPD and underlying social learning factors (i.e., level of clinical contact and criminal victimization).

Theoretical Rationale

Mental health professionals' attitudes toward clients with antisocial personality disorder (ASPD) can be understood from a social learning perspective. According to social learning theory, "man is neither driven by inner forces nor buffeted helplessly by environmental forces. Rather psychological function is best understood in terms of a continuous reciprocal interaction between behavior and its controlling conditions" (Bandura, 1971, p. 2). Attitudes are shaped through direct and observed experience in a social context and are reinforced by observing the consequences of the attitude or behavior (Bandura, 1971).

Direct and observed experiences make up a continuous process that shape attitudes and behaviors (Bandura, 1977). Prior to social learning theory, learned behavior was attributed to unconscious drives or behavioral reinforcement, and people were passive learners (Bandura, 1977). Social learning theory describes learning occurring experientially and through observing the behavior of others (Bandura, 1978). People choose to repeat behaviors that produce desired outcomes; therefore, they learn through their own behavior or by observing the consequences of how others behave. These desired consequences subsequently reinforce the learned behavior, belief, or attitude (Bandura, 1977).

The direct experiences of mental health professionals treating clients with ASPD affects their clinical attitudes (Evans, 2011). Clients with ASPD use concrete reasoning and have a predatory outlook, which can be off-putting to mental health professionals (Bowers, 2003;

Evans, 2011; Thompson, Ramos, & Willet, 2014). Their use of superficial charm to manipulate mental health professionals or evade diagnostic criteria leaves mental health professionals with feelings of resentment and hostility when they realize they have been duped (Bowers, 2003). Clients with ASPD often trigger thoughts and emotions in mental health professionals that negatively influence their beliefs about clients with ASPD (Evans, 2011). This negative influence is because of dissonance between the beliefs and behaviors of the client to those of the helping professional (Schwartz et al., 2007). For example, mental health professionals may be morally opposed to harming others whereas clients with ASPD may harm others and experience no guilt or remorse. Mental health professionals may be appalled at the ease with which clients with ASPD commit violent and predatory acts, leading to their development of negative beliefs about clients with the disorder (Evans, 2011; Schwartz et al., 2007).

Mental health professionals' beliefs about clients are developed through education, training, and experience in a social context (Koekkoek, et al., 2011). Additionally, mental health professionals' beliefs about clients are formed and reinforced by traditional healthcare roles; where clients seek help from professionals because they cannot solve their own problems (Koekkoek et al., 2011). Clients display their willingness to accept professionals' help by complying with treatment recommendations and being cooperative (Koekkoek et al., 2011). Mental health professionals expect clients to be motivated to improve some aspect of their life, which is displayed through clients' adherence to treatment recommendations and cooperation with mental health professionals (Koekkoek et al., 2011). When clients fail to comply with these expectations or show little effort toward getting better, they are seen as difficult, troublesome, or unmotivated by mental health professionals (Koekkoek et al., 2011). Clients with ASPD rarely

adhere to treatment goals or expectations resulting in a pattern of poor treatment adherence, staff pessimism, and distrust in the therapeutic relationship (Black, 2013; Evans, 2011; NICE, 2010).

Observed experience also contributes to mental health professionals' negative views of clients with ASPD through diagnostic stigma (Eren & Sahin, 2016). Blais and Forth (2014) identified that mock jurors assigned clients with ASPD higher guilt ratings than clients with no diagnosis. These findings suggest a negative social stigma associated with an ASPD diagnosis, which is likely mirrored in clinical settings and helping professional training programs. Mental health professionals' observed experiences occur through education, training, clinical language, and interaction with peers and supervisors.

The reinforcement of mental health professionals' pessimism toward individuals with ASPD occurs through symptom manifestation (Kurtz & Turner, 2007). Mental health professionals prescribe an inherent badness to clients with ASPD and view them from a pessimistic perspective (Black, 2013). This attitude is supported when clients' symptoms manifest during the treatment process as part of the social learning cycle (Bandura, 1971). For example, mental health professionals with negative attitudes toward clients with ASPD have their negative beliefs reinforced when clients with the disorder act out violently, manipulate staff, or bully others. The current study examines the influence of social learning factors (i.e., clinical contact and criminal victimization) on mental health professionals' attitudes toward clients with ASPD.

Research Questions

Negative attitudes toward clients with ASPD are common among mental health professionals (Eren & Sahin, 2016; Salekin, 2009; Wilson, 2014). Clients with ASPD are often perceived by mental health professionals as unmotivated, resistant, or noncompliant with

treatment when their symptoms (e.g., violence, bullying, deceitfulness) manifest in treatment environments (Bowers, 2003; NICE, 2010). Furthermore, clients with ASPD often receive services in agencies that are underfunded and by professionals who are unable to provide services that meet their specific needs (NICE, 2010). Lent and Schwartz (2012) found that mental health professionals working in public outpatient agencies experienced higher levels of stress and burnout than those who work in private outpatient settings, or public inpatient settings. The transient nature, impulsivity, and inconsistent participation of clients with ASPD can make treatment challenging and may also impair outcome research (APA, 2013).

The majority of research concerning ASPD focuses on causal factors of the disorder and developing treatment models based on outcome studies. Few studies examine ASPD through the lens of mental health professionals' attitudes. Resultantly, few validated instruments exist that measure mental health professionals' attitudes toward clients with ASPD (Bowers & Allan 2006). The current study examines the influence of clients with ASPD on mental health professionals' attitudes using the *Adapted-Attitudes toward Personality Disorders Questionnaire* (*A-APDQ*) (Bowers & Allan, 2006). More specifically, research question one addresses direct experiences with clients with ASPD, and research question two addresses indirect or observational experiences with clients with ASPD. The research questions are:

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*?

Study Significance

The number of professional mental health counselors with a master's degree is expected to increase nearly 20% by 2025 (United States Department of Labor, 2015). Mental health professionals will interact with clients with antisocial personality disorder (ASPD) in a variety of settings because approximately 4% of adults meet the criteria for ASPD (APA, 2013). Mental health professionals often describe clients with ASPD as difficult, unmotivated, and treatment resistant (Black, 2013; NICE, 2010). Clients with ASPD often behave in ways that oppose mental health professionals' values and beliefs, which contributes to mental health professionals' negative attitudes toward these clients (NICE, 2010).

As previously discussed, the attitudes of nurses, psychiatrists, psychologists, professional counselors, social workers and prison officers toward clients with ASPD are negative (Bowers et al., 2006; Eren & Sahin, 2016; Schwartz et al., 2007). This study builds upon prior research by examining social learning influences (i.e., level of clinical contact and criminal victimization) on mental health professionals' attitudes toward clients with ASPD. Research into the influence of social learning factors (i.e., level of clinical contact and criminal victimization) on mental health professionals' attitudes may improve training, education, and development opportunities for mental health professionals treating this population.

This study serves to increase mental health professional training programs' awareness of mental health professionals' attitudes toward clients with ASPD. By examining mental health professionals' attitudes toward clients with ASPD, these training programs can begin to identify gaps in knowledge, training, and experience that may affect treatment provision to clients with ASPD. Additionally, this study provides a lens into ASPD symptomatology by examining factors (i.e., level of clinical contact and criminal victimization) that may be associated with mental health professionals' attitudes.

The dearth of research specific to mental health professionals' attitudes toward clients with ASPD indicates a need for this study. Although psychiatry (Catthoort al., 2015), nursing (Bowers & Allan, 2006), and criminal justice disciplines (Blais & Forth, 2014; Bowers et al., 2006) have examined staffs' attitudes, this research is not specific to ASPD and focuses on all personality disorders. Because mental health professionals work in a variety of treatment settings they will vary in their levels of clinical contact with clients with ASPD. This study provides insight into how varied levels of clinical contact with clients with ASPD and participants' history of criminal victimization influences mental health professionals' attitudes toward clients with ASPD. Additionally, because social attitudes toward antisocial behaviors are negative (O'Toole & Sahar, 2014), this research will help identify how these attitudes may permeate clinical settings.

The National Institute for Health and Care Excellence (2010) encourages a systemic view of clients with ASPD that considers family, legal, supervisory, agency, and community systems as part of a treatment team. However, little attention is given to the mental health professional-client system. Dunbar and Sias (2015) posit that the thoughts and emotions generated by mental health professionals during their interactions with clients with ASPD hold important clues for

effective treatment. Furthermore, mental health professionals' attitudes influence the treatment of ASPD and provide a glimpse into the development of effective interventions (Evans, 2011).

Definition of Terms

Antisocial Personality Disorder (ASPD): The acronym ASPD is used to refer to individuals who are diagnosed as having antisocial personality disorder. The diagnostic criteria for this disorder are from *The Diagnostic Statistical Manual of Mental Disorders-5 (DSM-5)* (APA, 2013).

Attitude: A persons' way of thinking and feeling about someone or something.

Mental Health Professional: A professional who works directly with clients receiving treatment services for mental health issues.

Chapter Review

People with ASPD have a powerful effect on families, victims, and society (Black, 2013; NICE, 2009). Mental health professionals experience resentment, hostility, pessimism, and dislike toward clients with ASPD (Evans, 2011). To date, there is little research on attitudes toward clients with ASPD, and no research that examines the influence of social learning factors (i.e., level of clinical contact and criminal victimization) on mental health professionals' attitudes toward clients with ASPD. The current research seeks to fill the gap in the literature by exploring mental health professionals' attitudes toward clients with ASPD. More specifically, this study explores how attitudes toward clients with ASPD can be understood through social learning theory by examining the influence of level of clinical contact and history of criminal victimization (Bandura, 1977).

CHAPTER 2: LITERATURE REVIEW

Introduction to the Chapter

The previous chapter established that negative attitudes toward clients with personality disorders are pervasive throughout helping disciplines. Although attitudes toward personality disorders are examined, most studies are not specific to ASPD and do not examine the influence of social learning factors such as level of clinical contact and criminal victimization (Bowers et al., 2006; Lewis & Appleby, 1988; Newton-Howes et al., 2008). The widespread effects of ASPD and criminality, coupled with unclear treatment guidelines and confusing diagnostic criteria, indicate a need for further research. The previous chapter established social learning theory is an effective theoretical framework from which to view mental health professionals' attitudes toward clients with ASPD.

This chapter contains a review of: (a) attitudes toward antisocial behavior as explained through a social learning theory lens, (b) the origins of antisocial behaviors, (c) societal attitudes toward antisocial behavior, (d) mental health professionals' attitudes toward symptoms of ASPD and (e) how socially learned beliefs and behaviors affect mental health professionals. A summary is included that reiterates the relevance of this study.

Social Learning Theory

Albert Bandura (1971) developed social learning theory to understand how people interact with, and learn from, their environment. Prior to his work, human learning was attributed to subconscious drives (Freud, 1961) or unresolved issues (Bandura, 1971). Through social learning theory, Bandura (1989) conceptualized the motivations of behavior and how behaviors affect others. Social learning theory is especially applicable to antisocial behaviors and mental health professionals' responses to these behaviors (Bandura, 1977; 1989). Antisocial behavior is

a key feature of ASPD because people with the disorder commit antisocial acts throughout their lifespan (APA, 2013). Social learning theory provides insight into the etiology, effects, and perpetuation of antisocial behaviors. Additionally, the tenets of social learning theory explain how uncertainty in etiology, diagnosis, and treatment negatively influence mental health professionals' attitudes toward clients with ASPD.

Direct Experience

Bandura (1977) posits that the most basic form of learning comes from direct experience. Direct experience includes any situation where people are required to take decisive action (Bandura, 1977). Each chosen action brings a unique set of rewards and punishments (Bandura, 1977). People learn which actions promote desired outcomes and minimize negative consequences by trying out new behaviors (Bandura, 1977).

Reinforcement of direct experience. The rewards and punishments that accompany behaviors and beliefs determine how long the behaviors and beliefs persist (Bandura, 1977). Individuals progress toward making decisions that bring favorable consequences and eliminate negative consequences (Bandura, 1977). However, humans possess the capability of foresight, or what they believe will happen in the future, which is usually based on their past experience (Bandura, 1977). When their beliefs are correct individuals deem the beliefs successful and they are retained (Bandura, 1977). When the beliefs are incorrect individuals deem the beliefs unsuccessful and they begin to eliminate said beliefs (Bandura, 1977). Therefore, attitudes and behaviors can be self-reinforcing regarding clients with ASPD.

The hallmark of ASPD is a chronic inability to live up to social norms and expectations (APA, 2013). Mental health professionals often directly experience clients with ASPD as having vastly different worldviews than society. The term antisocial infers that the personalities of

people with ASPD are not acceptable in society (Black, 2013). Therefore, mental health professionals form negative attitudes about clients with ASPD when these clients engage in symptomatic behaviors such as manipulating, demeaning, or threatening others. When these behaviors manifest repeatedly, mental health professionals' attitudes are reinforced. For example, if a helping professional attempts to counsel a client with ASPD, and the client is belligerent, hostile, or demeaning, the helping professional's attitudes toward clients with ASPD are formed based on this direct experience. The helping professional also forms beliefs about future clients with ASPD, thereby generalizing their beliefs about all clients with ASPD based on this experience (i.e., foresight). When the helping professional experiences another belligerent, hostile, or demeaning client with ASPD these beliefs are reinforced. This reinforcement of negative beliefs can affect professional judgment, optimism, and interactions with coworkers.

Observational Learning

Although some learning takes place through direct experience, the majority of learning takes place through observational learning, or modeling (Bandura, 1977). Observational learning occurs by observing the behaviors modeled by others and their associated consequences of the behaviors (Bandura, 1977; 1989). People use these observed consequences to form the basis of their own behaviors and as a motivation to try new behaviors (Bandura, 1977). Observational learning consists of four subcategories.

Attentional processes. Individuals learn from models on which their attention is focused (Bandura, 1977). Individuals learn most from models that capture their focus due to recognized behaviors and personality characteristics, rather than any model to which they are exposed (Bandura, 1971). For example, when mental health professionals' attention is focused on clients with ASPD, they may unknowingly develop similar interpersonal interaction styles, and

cognitive patterns as clients with ASPD due to observational learning. Furthermore, mental health professionals may unknowingly develop negative opinions of clients with ASPD when they experience other staff members negatively discussing clients with ASPD.

Retention processes. Individuals must be able to retain information obtained from observing a model (Bandura, 1977). Past experiences are retained in order to guide future actions (Bandura, 1977). When individuals encounter stimuli (people or situations) similar to stimulatory experiences from the past, they form new mental models based on their past experience with the original model (Bandura, 1977). These mental models guide cognitions and subsequent emotions and behaviors (Bandura, 1977). For example, mental health professionals who have been bullied by clients with ASPD in the past may experience fear, anger, and a desire to avoid new clients when they observe symptoms of ASPD. These attitudes and emotions result from the mental models mental health professionals generate when they observe symptoms of ASPD and are based on their original experience of being bullied by clients with ASPD.

Motoric reproduction process. Motoric reproduction process involves performing behaviors driven by attention and retention processes of observational learning (Bandura, 1977). New behavior is more likely to be retained if individuals have the skills to successfully perform said behavior (Bandura, 1971). For example, mental health professionals often interact with clients through speech, body language, and therapeutic interactions (e.g., treatment interventions, homework, assessments). Mental health professionals' negative attitudes may be expressed when they are uninterested, verbally belligerent, hostile, or dismissive toward clients with ASPD.

Reinforcement and motivational processes. Even if individuals possess the ability to perform socially learned behaviors, behaviors are less likely to occur if they bring negative consequences (Bandura, 1977). Therefore, individuals must find the reinforcement of socially

learned behaviors appealing for the behaviors to be retained (Bandura, 1977). For example if mental health professionals dismiss or belittle clients with ASPD and this behavior is met with praise from co-workers and increased cooperation from the clients, the behavior is likely to persist. Furthermore, other mental health professionals who observe the praise from staff and cooperation from clients are more likely to engage in similar behaviors because of observational learning processes. Reciprocally speaking, these behaviors reinforce clients' beliefs that authority figures cannot be trusted (NICE, 2010).

Social learning theory provides insight into how attitudes toward ASPD are formed and reinforced in clinical settings. The prevalence of negative attitudes toward clients with ASPD (Salekin, 2002; Schwartz et al., 2007) may also explain why ASPD continues to receive little attention in research and treatment development (Black, 2013; 2015). Simply put, a socially learned attitude of therapeutic nihilism toward clients with ASPD in clinical settings is reflected in little research into the disorder's treatment and etiology (Black, 2015; Salekin, 2002; Wilson, 2014).

Origins of Antisocial Behavior

Behaviors that occur outside societal norms and expectations are considered antisocial (APA, 2013). Antisocial behaviors occur on a spectrum, with more extreme behaviors being less socially acceptable than minor deviations (Samenow, 2014). For example, driving over the speed limit is considered socially acceptable whereas murder is generally considered unacceptable. Acts that are perceived as intentional and cause harm to others have the greatest influence on societal attitudes (Bandura, 1977). Determining which behaviors are socially acceptable depends on legal and cultural factors that change over time (Black, 2013). In fact, approximately 70% of Americans have engaged in behaviors for which they could be imprisoned (Husak, 2008).

Antisocial behaviors have occurred throughout history and across all cultures (Samenow, 2001). The cause of antisocial behavior is a topic of fierce debate among researchers, clinicians, and the general public (Samenow, 2001). The majority of causality research examines biological and social issues associated with people who commit antisocial acts (Rothwell & Hawdon, 2008). Researchers believe that understanding what causes antisocial behaviors will lead to the development of effective prevention and intervention strategies (Samenow, 2014).

Biological Factors

Advancements in neuroscience and neurocriminology have increased research concerning the biological factors associated with antisocial behavior (Samenow, 2014). For example, Portnoy and colleagues (2014) investigated the relationship between heart rate and antisocial behaviors in a community sample of adolescent boys (N = 335). In this study, 250 boys with a history of antisocial behaviors were compared to 253 randomly selected boys on the following: (a) heart rate, (b) delinquency, (c) aggression, (d) sensation seeking, (e) psychopathy, and (f) state fear during various tasks. The tasks included resting heart rate, social stress, and a cognitive task. Findings showed that low heart rate was associated with increased aggression, violence, and delinquency. Portnoy and colleagues (2014) theorize that sensation seeking mediates the relationship between decreased heart rate and increased antisocial acts, and infer that children with low heart rates are more prone to antisocial behaviors. However, determining the cause of the children's low heart rates is difficult. Their heart rates may result from a combination of biological and social factors.

In a longitudinal study of male subjects (N = 503), Pardini, Raine, Erickson, and Loeber (2013) investigated the relationship between amygdala volume, childhood aggression, future violence, and psychopathic traits. Participants were recruited in first grade and underwent

periodic assessments (every 6 months for the first 4 years, and then annually) until they reached an average age of 25.78. Final assessments were conducted when the boys reached the average age of 29.25. Childhood aggression, psychopathic traits, and violent acts were positively associated with decreased amygdala volume. These findings suggest a relationship between biological makeup and antisocial behaviors. More specifically, individuals who commit antisocial acts are influenced by biological factors rather than social influences (Hare, 1993; Pardini et al., 2013). Studies indicate that impaired amygdala function is associated with symptoms of ASPD, however this knowledge has led to few treatment advancements (Black, 2015; Hare, 1993; NICE, 2010)

Despite research concerning the biological influences of antisocial behaviors, little progress has occurred in the development of effective biological, neuropsychological, or medical interventions (Thompson, Ramos, & Willet, 2014). Medication trials focusing on the reduction of violence and acting out behaviors of individual with ASPDs have mixed results (NICE, 2010; Thompson et al., 2014). Recent publications indicate antisocial behaviors occur due to a complex interaction between biological and social factors and a holistic intervention strategy is needed (Black, 2013; NICE, 2010).

Social Factors

Antisocial acts often begin in childhood and may include bullying, violence, harming animals, delinquency and truancy (APA, 2013; Black, 2015; NICE, 2010). Children who engage in antisocial behaviors at a young age have a greater risk of antisocial acts throughout their lifespan (Black, 2015). Furthermore, extreme antisocial behaviors are associated with ongoing criminal behavior and violence throughout adulthood (Black, 2015). Research concerning the

early onset of antisocial behaviors has led toward understanding the specific social influences linked to antisocial acts (Samenow, 2014).

To better understand the development of ASPD, Krastins and colleagues (2014) examined the relationship between childhood maltreatment, teasing, parental bonding, and anxiety that are associated with development of antisocial personality disorder. 411 participants with a mean age of 29 were selected from a university and the general public in Australia. Participants completed the *Parental Bonding Instrument* (*PBI*), the *Structured Clinical Interview of the DSM Axis II Personality Questionnaire* (*SCID-II-PQ*), the *Childhood Trauma Questionnaire* (*CTQ*), the *Teasing Questionnaire* (*TQ-R*), and the *Depression, Anxiety, and Stress Scales 21* (*DASS-21*). Results indicated a significant ($p < .05$) positive correlation between ASPD scores and childhood trauma, teasing, depression, and anxiety. Although statistically significant these results should be interpreted cautiously rather than making attributional inferences. First, the study utilized a retrospective approach when gathering information relating to childhood, which may be inaccurate especially for older adults. Also, many of the correlations, while statistically significant, fall into the small to moderate effect size. Nevertheless, this study is useful in identifying that social influences may play a role in ASPD development. However, social factors alone do not account for the disorder (Black, 2015; NICE, 2010).

Childhood maltreatment is commonly associated with development of personality disorders and ongoing antisocial behaviors (APA, 2013). However, the majority of children who experience childhood neglect or abuse do not commit chronic antisocial acts (Samenow, 2014). Furthermore, childhood maltreatment may not cause antisocial behaviors; rather it may be the result of the behaviors (Samenow, 2014). For example, a child being physically abused or neglected by his parents may result from the child's behaviors rather than poor parenting. Many

parents are not equipped to cope with children prone to intense antisocial acts, and often make decisions they would not make in normal circumstances (Black, 2013; Samenow, 2014). Often, antisocial acts from children (e.g., bullying, violence) are met with antisocial acts from parents, teachers, and mental health professionals (e.g., shaming, threats, disengaging).

Mental Health Professionals' Uncertainty

"Therapists and doctors believe it's their techniques that make the difference" however "it's much more the power of their certainty that counts" (Dass, 2000, p. 194). The lack of a definitive answer to what causes antisocial behaviors mimics the uncertainty experienced by family members, victims, and mental health professionals who encounter people with ASPD. This uncertainty can be unsettling (Black, 2013). Because mental health professionals are unclear regarding the causes of antisocial acts, they are less confident in their provision of treatment (Samenow, 2014). A direct encounter with a person who commits acts of violence, threats, bullying, or manipulation can result in feelings of confusion, fear, and bewilderment for those they encounter (Evans, 2011; NICE, 2010). These emotions are generated because of observational learning and mirror societal attitudes toward people who commit antisocial acts (Bandura, 1977). Beliefs about behaviors that are acceptable and unacceptable are socially learned and influenced by the media, peers, family members, religious institutions, and social policies (Bandura, 1971).

Attitudes Toward Antisocial Behaviors

Studies exploring the causes of antisocial behavior, such as crime, are plentiful. However, few studies have examined societal attitudes toward antisocial behaviors. According to social learning theory, behaviors, attitudes, and beliefs are learned through observation and interaction with the environment (Bandura, 1977; 1989). Therefore, attitudes toward antisocial behaviors

can be influenced by parents, media, social interactions, personal experience, and use of language. Recently, reports of mass shootings and terrorist attacks have sparked feelings of fear and insecurity in society (Black, 2013). Media coverage of predatory corporate greed, such as Ponzi schemes, has increased societal distrust and fueled motivation for retributive punishment (i.e., reprimand or getting even) (Black, 2013). These societal attitudes toward crime are reflected in therapeutic pessimism toward clients who commit antisocial acts (NICE, 2010; Salekin, 2002). Mental health professionals' negative attitudes result in a self-fulfilling prophesy of therapeutic pessimism leading to poor client treatment outcomes (Salekin, 2002). Reciprocally, poor treatment outcomes further reinforce therapeutic pessimism in the social learning process.

To better understand social attitudes toward people who commit antisocial acts, Côté-Lussier's (2016) asked 172 university students in the United Kingdom to rate their attitudes toward people who commit antisocial behaviors. The results found that participants experienced feelings of hostility and resentment toward people who commit antisocial acts. Participants were likely to demean and disassociate from people who commit antisocial acts and believed that people who commit such acts were from a lower social status. They also believed individuals who committed antisocial acts were cold, calloused, and showed little concern for others. These findings support that people hold negative attitudes toward people who commit antisocial acts. However, this study does not account for other attitudinal factors (e.g., level of contact, history of criminal victimization) that could influence participants' negative attitudes. Additionally, these results were from a university sample in the United Kingdom and may not be reflective of societal attitudes in the United States.

As previously discussed, the United States' punitive approach to crime has contributed to over 1.5 million people in prison or jail (Carson, 2015). Societal motivations for punishing people who offend vary between rehabilitation (i.e., an intervention to improve behaviors) and retribution (i.e., punishment to get even) (O'Toole & Sahar, 2014). O'Toole and Sahar (2014) gave participants (N = 150) from a liberal arts college a crime scenario, a questionnaire concerning attitudes toward various offenses, and a questionnaire addressing attitudes toward the criminal justice system. Findings indicated that when the crime is perceived as controllable (i.e.., a choice consciously made by the offender), participants were more likely to blame the person for his or her actions (r (150) = .71, p < .01). When participants attributed blame to the person who committed the act, they were more likely to experience anger toward the offender (r (150) = .41, p < .01). When the participants experienced anger, they were more likely to support punishment that was retributive or designed to make the offender suffer (r (150) = .36, p < .01). Findings also suggest that when participants attributed the offender as personally responsible and experienced anger toward the offender, they were more likely to believe in a punitive stance toward antisocial acts rather than a rehabilitative one (r (150) = .31, p < .01) (O'Toole & Sahar, 2014). Additionally, this study found that participants' experience with crime, both direct and observed, did not significantly influence their attitudes toward criminal behaviors. However, the sample for this study was limited to college students between the ages of 18 and 23 with limited exposure to crime (O'Toole & Sahar, 2014). Although these findings are not specific to mental health professionals, they provide insight into attitudes toward antisocial acts that are socially learned and perpetuated in a variety of settings. Furthermore, this study highlights how socially learned beliefs (i.e., attributing blame) influence the behaviors (i.e., support retributive punishment) of individuals who were not directly involved in the crime scenario. These learned

beliefs and subsequent behaviors occur despite the individuals in this study not being involved in the criminal scenario.

Victim Studies

As discussed, early learning theories attribute the majority of learning to direct experience (Bandura, 1977). Therefore, crime victims' subsequent behaviors and attitudes result from decisions they made while being victimized (Bandura, 1971). For example, someone who is assaulted when walking down a dark alley would likely avoid future dark alleys. Victims of antisocial acts, such as violence, have increased rates of anxiety, depression, and physical health issues (Ruback, Clark, & Warner, 2014). These aversive reactions result from direct experiential learning (Bandura, 1977). However, criminal victimization is the best predictor of future criminal victimization (Posick, 2013), which provides an important clue into the role of observational learning in criminal behaviors.

A small proportion of crime victims account for a large portion of total criminal victimization because they are repeatedly victimized (Ruback et al., 2014). This cycle of victimization parallels that of people who commit antisocial acts (i.e., a small proportion of criminals commit the majority of crimes) (Black, 2013; Hare, 1993) and illustrates the role of observational learning in victims and perpetrators of antisocial acts (Bandura, 1977). A study by Ruback and colleagues (2014) examined factors associated with criminal revictimization. Findings indicated substance use, depression, and symptoms of post-traumatic stress disorder (e.g. anxiety, hypervigilance, anger) were common factors among people who were victims of violent crimes. Furthermore, findings suggested that people who were crime victims were more likely to engage in criminal behaviors, thus increasing their exposure to subsequent victimization. Victim studies provide an intriguing link into the role social learning plays in

victimization and may provide insight into attitudes toward people who commit chronic antisocial acts.

People who commit violent crimes gain a sense of power and control through their acts (Samenow, 2014). However, their victims experience feelings of helplessness, fear, and anxiety that are tied to social learning through direct experience (Rubak et al., 2014). Observational learning also occurs during these experiences (Bandura, 1977). The perpetrator becomes the focus (i.e., model) of the victim's attention (i.e., attentional processes) (Bandura, 1971). Therefore, victims experience feelings of depression, anxiety, and helplessness as a result of their direct experience. They experience a need for retribution for being victimized (Rubak et al., 2014) that they achieve by perpetuating antisocial acts on others. Their retributive acts are motivated by their need for power and control to combat their feelings of anxiety and helplessness (Rubak et al., 2014). Simply put, victims of crime often commit crime as a result of observational learning.

The complex relationship between offending behaviors and victim behaviors (Posick, 2013) provides an important clue to how antisocial acts are perpetuated over time (Samenow, 2014). However, the relationship also provides insight into attitudes toward people who commit antisocial acts. Studies have identified that negative attitudes toward people who commit antisocial acts are pervasive and enduring (Côté-Lussier, 2015; O'Toole & Sahar, 2014). However, these studies do not adequately account for participants' histories of crime victimization that may influence their attitudes toward people who commit antisocial acts. The previously reviewed studies provide an overview of societal attitudes toward people who commit antisocial acts (Côté-Lussier, 2015; O'Toole & Sahar, 2014) and possible attitudinal motivations (Posick, 2013; Rubak et al., 2014). These studies also indicate that the motivations and effects of

criminal behaviors are complex and pervasive, which hold important clues for how criminal behaviors influence mental health professionals' attitudes. Although these studies suggest that criminal victimization influences participants' attitudes, these studies do not account for the influence of amount of contact with people who commit antisocial acts. For example, criminal victims who are often exposed to people who commit ongoing antisocial acts may have different attitudes toward perpetrators than victims who are rarely exposed to people who commit antisocial acts.

Conceptualization of Antisocial Personality Disorder

Antisocial personality disorder (ASPD) has perplexed mental health professionals throughout history and has led to uncertainty in etiology and treatment that is experienced by mental health professionals today (Black, 2013). Philippe Pinel first noticed symptoms of ASPD in the early 19th century (Horley, 2014). He was baffled by clients who entered treatment with violent behaviors without associated thought disorders (Horley, 2014). Pinel found these clients to be highly rational with clear understandings of their behaviors, yet they continued to commit violent and predatory acts (Horley, 2014). Later clinical developments built on Pinel's work leading to the ASPD diagnostic criteria proposed by Hervey Cleckly in 1941 (Black, 2013). Diagnostic criteria have evolved to the most recent *Diagnostic Statistical Manual 5 (DSM 5;* APA, 2013). However, the validity of the diagnostic criteria for ASPD is questionable (Black, 2013). The diagnostic criteria for ASPD does not account for the affective characteristics frequently associated with the disorder (Hare, 1993). The DSM 5 criteria primarily address behaviors (e.g., violence, impulsivity), which likely over diagnoses people with a history of criminality (Edens, Kelley, Lilienfield, Skeem, & Douglas, 2015). Furthermore, the ASPD diagnosis shows little predictive validly for future antisocial acts (Edens et al., 2015).

Additionally, debate persists regarding whether psychopathy is a distinct diagnosis or a variant of ASPD (Hare, 1993; Horley, 2014).

Antisocial Personality Disorder and Psychopathy

The advent of the *Psychopathy Checklist* (*PCL*) and the *Psychopathy Checklist Revised Version* (*PCL-RV*) has led to a clearer definition of a psychopathy construct and helped reinvigorate stagnant research (Hare, 1999). However, clarifying the psychopathy construct has done little to improve attitudes toward clients with ASPD (Salekin, 2002). In fact, classifying the psychopathy construct as distinct from ASPD perpetuates that the disorder is untreatable, and further increases clinical pessimism due to use of the term psychopath which is often considered a derogatory term (Salekin, 2002). Additionally, developers of the *Psychopathy Checklist* posit that treatment efficacy for psychopathy is bleak (Hare, 1993) thereby confirming pessimistic attitudes toward clients who commit chronic antisocial acts.

Antisocial behaviors occur along a continuum and additional affective characteristics such as glibness, dulled anxiety, and cruelty are necessary for a person to be deemed a psychopath (APA, 2013). Simply put, all people who meet the criteria for psychopathy also meet the criteria for ASPD, however not all people who meet the criteria for ASPD meet the criteria for psychopathy. Antisocial personality disorder and psychopathy are closely related (Black, 2015) and further differentiating the constructs is beyond the scope of this study. For the purposes of this study, psychopathy will be considered a variation of ASPD (APA, 2013; Black, 2013).

Treatment Efficacy

Debate persists among clinicians and researchers regarding diagnostic criteria, etiology, treatment efficacy, and treatment approaches for ASPD (Black, 2015; Hare, 1993; Horley, 2014;

NICE, 2009). Further uncertainty manifests in developing a name for the disorder. Sociopathy, psychopathy, dissocial personality and antisocial personality disorder have been proposed, debated, and refined (Horley, 2014). The uncertainty around the ASPD construct is mirrored in mental health professionals' attitudes toward clients who enter treatment with a history of ongoing antisocial behaviors (Salekin, 2009; Wilson, 2014). Social learning and social modeling perpetuate mental health professionals' beliefs that antisocial personality disorder is not treatable which is then reinforced when clients with ASPD have poor treatment outcomes (Salekin, 2009; Wilson, 2014; Wilson & Tamatea, 2013).

Finding outcome studies specific to ASPD is difficult (Black, 2013). Few studies are specific to ASPD and those that address ASPD have a number of limitations such as small sample size, questionable methodology, or confounding factors such as co-occurring mental health and substance use issues (Black, 2013; Salekin, 2002). As previously discussed, clients with ASPD enter treatment for a variety of reasons and there is no agreed upon holistic measurement tool from which to gauge treatment efficacy (NICE, 2010). Longitudinal studies are rare, as the transient nature of people with ASPD impairs efforts to obtain follow-up interviews (Black, 2013).

Outcome studies. Black, Baumgard, and Bell (1995) examined the long-term outcomes of men admitted to a psychiatric hospital in Iowa between 1945 and 1970. Black and colleagues (1995) compared the outcomes of men with ASPD (n = 71) to those with depression (n = 225), schizophrenia (n = 200), and a control group (n = 160) along 4 domains: marital, residential, occupational, and psychiatric. Men with ASPD showed poorer adjustment along all domains in comparison to those with depression, schizophrenia, and the control group. The men with ASPD who showed the most improvement were those who entered treatment with less severe

symptoms, which indicates that symptom severity may be a predictor of long-term outcomes. Further analysis indicated that the men with ASPD experienced symptom reduction (e.g., substance use, incarceration, violence) as they aged. These findings suggest that clients with ASPD can improve (Black, 2015).

Fletcher and Reback (2013) explored the use of contingency management designed for homeless men with ASPD and methamphetamine use disorders. Contingency management is a behavioral intervention that rewards prosocial behaviors. Rewards include vouchers, tokens, or other positive reinforcement. Of the 131 participants, 45 (34.4%) met the diagnostic criteria for ASPD. Participants were randomized into two groups, which received differing levels of contingency management for methamphetamine abstinence and health promoting prosocial behaviors. Results indicated that clients with ASPD had a 10% greater decrease in methamphetamine use than clients without ASPD, and had similar results regarding prosocial health promoting behaviors. These findings suggest that clients with ASPD use concrete, cause-and-effect styles of reasoning (Black, 2013; Thompson et al., 2014). Contingency management has clear guidelines and a structured reward system that matches the logical nature of clients with ASPD (Fletcher & Reback, 2013). Results from this study provides hope to clinicians as a modeling stimuli for new beliefs about ASPD.

Mental Health Professionals' Attitudes toward Clients with Antisocial Personality Disorder

Understanding how ASPD influences mental health professionals' attitudes is imperative because the disorder occurs in up to 70% prisoners and in substance abuse and mental health settings (APA, 2013; NICE, 2010). Therefore, mental health professionals are frequently exposed to clients with the disorder (NICE, 2010). However, few studies have examined their

attitudes toward clients with ASPD. Instead, studies have focused on mental health professionals' attitudes toward symptoms of ASPD, which provides insight into how mental health professionals' attitudes are influenced by clients with ASPD.

Childhood

Antisocial personality disorder cannot be diagnosed until a person is 18 years old (APA, 2013). During childhood, the disorder manifests as conduct disorder (APA, 2013). Children with conduct disorder display increased levels of aggression toward people and animals, destroy property, are deceitful, and consistently break rules (APA, 2013). They often display little remorse for their actions and have dulled empathy (APA, 2013). Children with conduct disorder may also show little interest in school, associate with other troubled peers, and show no interest in adhering to parental guidelines (Samenow, 2014). They are often seen in outpatient treatment agencies, by guidance counselors, or in forensic settings (e.g., juvenile detention centers) (Samenow, 2014). Much like ASPD, the construct of conduct disorder is debated with some researchers distinguishing between conduct disorder and childhood psychopathy and other researchers favoring less stigmatizing language (Rockett, Murrie, & Boccaccini, 2007). An additional similarity of ASPD and conduct disorder is the uncertainty in treatment efficacy (Rockett et al., 2007). However, treatment in childhood is more effective than later in life (Black, 2013; Hare, 1993; NICE, 2010).

Attitudes toward conduct disorder. The belief that children with conduct disorder are resigned to poor treatment response, unstable relationships, and development of a personality disorder, is socially taught (Woolley & Muncey, 2004). Mental health professionals often find children who enter treatment with symptoms of conduct disorder troublesome and their symptomatic antics burdensome (Samenow, 2014). Mental health professionals who believe

children with conduct disorder cannot be helped, may avoid or neglect these clients, thereby, intensifying negative treatment outcomes. When mental health professionals observe poor treatment outcomes (e.g., crime in adulthood, ongoing substance use and mental health issues) their negative attitudes about children with conduct disorder are reinforced (Black, 2013; Bandura, 1971). Mental health professionals who interact with children with conduct disorder are often manipulated, threatened, or demeaned (APA, 2013). They also may find the children are being abused, and/or are harming other people or animals (APA, 2013).

Animal abuse is a common symptom of conduct disorder that many mental health professionals find disturbing (NICE, 2010). For example, Schaefer, Hays, and Steiner (2007) surveyed the opinions of psychologists (N = 174) who treated clients with a history conduct disorder. Twenty eight percent of respondents reported having clients with a history of animal abuse. The majority (89%) of psychologists recognized the animal abuse as a mental health issue. However, 49% believed that laws concerning confidentiality should be changed so that cases of animal abuse could be reported to authorities. These findings highlight the mental health professionals' conflicting socially learned atttidues (Bandura, 1971). Simply put, mental health professionals acknowledge that animal abuse is a mental health issue, however they believe it is a legal issue that is not being properly addressed. Symptoms of conduct disorder strongly affect mental health professionals' attitudes and their optimism for clinical outcomes (Rockett et al., 2007).

Rockett et al., (2007) asked 109 juvenile justice mental health professionals (i.e., psychologists, case workers, social workers, program administrators, and interns) to respond to a case vignette involving a juvenile offender. The vignette included a diagnosis of conduct disorder or psychopathy and questionnaires addressed mental health professionals' beliefs

concerning client treatability and risk for future offenses. Findings indicated that participants believed that children with a diagnosis of psychopathy or conduct disorder are at high risk for chronic antisocial behaviors throughout their lifespan. Interestingly, most children with conduct disorder do not develop ASPD (Black, 2013; Samenow, 2014). This discrepancy further highlights the role of socially perpetuated attitudes in clinical settings.

Violence

Clients with ASPD display little affective expression (APA, 2013; NICE, 2010). However, they often experience intense feelings of anger associated with their need for power and control (APA, 2013; NICE, 2010). They are egocentric and frequently belittle others as a means of defending against their own inner emotional experience (Perry, Presniak, & Olson, 2013). They may mimic the emotions of others to appear normal and avoid drawing attention to themselves or use charm and evasion to manipulate others (Black, 2013; Hare, 1993; NICE, 2010). However, when these initial coping strategies fail, clients with ASPD may use violence as a means of meeting their need for power and control (APA, 2013). They have increased rates of domestic violence, child abuse, and assaults (APA, 2013).

Attitudes toward violent clients. The potential for violence among clients with ASPD is intimidating to mental health professionals (Evans, 2011). Mental health professionals are vulnerable to verbal and physical attacks because clients with ASPD are frequently treated in public agencies that are underfunded and understaffed (Jussab & Murphy, 2015; NICE, 2010). 40% of psychologists report being at risk of a client attack at some point during their career (American Psychological Association, 2002). Furthermore, mental health professionals report having little knowledge of how to handle client violence, which indicates a gap in knowledge and practice (Jussab & Murphy, 2015). Verbal or physical attacks from clients creates feelings of

inadequacy, fear, anxiety, and anger in mental health professionals which negatively influences their attitudes toward clients with violent tendencies (Jussab & Murphy, 2015).

Mental health professionals' attitudes are often profoundly affected by client violence (Evans, 2011; Jussab & Murphy, 2015). They may prefer to avoid working with violent clients and often develop negative attitudes towards clients who have histories of violence (Eren & Sahin, 2016). Bandura's (1977) work on aggression posits that attitudes and behaviors regarding aggression are learned through experiencing aggression from others and observing the effects of aggression on others. For example, if a mental health professional is assaulted by a client, other staff members within the same work environment may feel frightened or angry when working with clients with histories of violence. For mental health professionals, these attitudes and reactions are reinforced when clients with ASPD threaten, bully, or assault others.

The majority of studies on violence examine precipitating factors, predictors, or management issues. Kurtz and Turner (2007) met with members of a multidisciplinary team (N = 13) to explore how they were affected by clients prone to violence. Clients with a potential for violence require increased monitoring by mental health professionals and this can strain agency resources and negatively influence staff attitudes (Kurtz & Turner, 2007). Findings indicated that even when mental health professionals felt physically safe, they experienced emotional vulnerability, anxiety, and feelings of being isolated from coworkers. They also reported feelings of frustration due to the distrusting nature of their clients (Kurtz & Turner 2007). Interestingly, mental health professionals reported decreased levels of trust in their employing agency which may provide an important link to the role of social learning in clinical interactions with ASPD. Simply put, mental health professionals form attitudes similar to those of clients with ASPD, which highlights the attentional process of observational learning. For example, lack of trust in

their employing agency mirrors clients with ASPD's lack of trust in authority. Kurtz and Turner's (2007) study identifies major themes mental health professionals experience when treating violent offenders. However, the small sample size and qualitative design limit its generalizability. Not all clients with ASPD are violent and other symptoms such as manipulation, egocentrism, and blaming others, can affect therapeutic interactions (Black, 2013).

Countertransference

Mental health professionals experience strong emotional reactions when working with clients with ASPD resulting from countertransference (Evans, 2011; Schwartz et al., 2007). Countertransference is the cognitive and emotional reaction experienced by mental health professionals resulting from client-counselor interactions (Schwartz et al., 2007). According to Ellis (2001) "countertransference in therapy stems from biological tendencies and social learning influences that involve mild or heavy prejudiced thinking, feeling, and behaving" (p. 999). Countertransference occurs when clients remind mental health professionals of persons from their past that triggers an emotional reaction, or when clients behave in ways that mental health professionals find objectionable (Schwartz et al., 2007). In other words, countertransference reactions result from mental health professionals' beliefs, experiences, and behaviors and are triggered by client interactions. Countertransference can cause mental health professionals to lose objectivity and form negative attitudes regarding clients with ASPD (Schwartz et al., 2007).

To clients with ASPD "the world is a chessboard, with other people serving as pawns" (Samenow, 2014 p. 111). They are experts at manipulating others for personal gain and use their manipulative skills in all social interactions (Samenow, 2014; Bowers, 2003). Clients with ASPD use rationalization, denial, and blaming others as methods of defending against the disturbance in their inner worlds and to portray themselves in a positive light (Evans, 2011; Samenow, 2014).

Despite their normal appearances, they often experience inner feelings of rage, anxiety, and an overwhelming need to come out on top (Black, 2013; Evans, 2011). To cope with these thoughts and emotions they portray themselves as victims of circumstance or as powerful and important figures with vast knowledge on various topics (Black, 2013; Thompson et al., 2014). Their plausible arguments and charming demeanor make distinguishing fact from fiction difficult for mental health professionals (Black, 2013; Evans, 2011). Furthermore, their concrete reasoning and intolerance for authority make establishing a therapeutic relationship challenging (Evans, 2011; NICE, 2010).

Lack of a trusting therapeutic relationship is discouraging for mental health professionals (Evans, 2011; Thompson et al., 2014). Social learning, through education and experience, has instilled mental health professionals' belief that trust and rapport in the therapeutic alliance are necessary for therapeutic change (Koekkoek et al., 2011). However, clients with ASPD do not trust others and form bonds slowly (Martens, 2004). They often spend their therapy sessions justifying why they do not need therapy and blaming their troublesome situation on others (Black, 2013; NICE, 2010). Their lack of cooperation, concrete reasoning, and brash interpersonal communication, is off-putting to most mental health professionals (Salekin, 2002).

A study by Schwartz and colleagues (2007) provides a glimpse into how professional counselors' attitudes are influenced by clients with ASPD. Researchers examined the reactions of master's and doctoral counselors-in-training (N = 73) who watched a video of a clinical interview with a client with ASPD (Schwartz et al., 2007). They subsequently completed questionnaires regarding thoughts and emotions experienced during the video. Findings indicated that participants felt dominated when watching the client with ASPD. They also reported worrying about being controlled, belittled, or harassed by the client (Schwartz et al., 2007).

These findings underscore how observational learning and direct experience with clients with ASPD can influence counselors. After observing a client with ASPD, the counselors-in-training experienced reactions similar to those reported by mental health professionals who frequently encounter clients with ASPD. Further, because this study was with counselors-in-training, these findings suggest that socially learned beliefs and attitudes about clients with ASPD are entrenched and reinforced in education programs. These socially learned beliefs and attitudes continue to be reinforced as counselors enter professional settings.

As this review has established, societal views toward antisocial behaviors are mirrored in clinical settings toward clients with ASPD. Mental health professionals express dislike, hatred, and resentment toward clients with ASPD thereby sabotaging the therapeutic process (Schwartz et al., 2007). Furthermore, clients with ASPD distrust authority figures (APA, 2013; Black, 2013; 2015; Martens, 2004) which is reinforced when mental health professionals appear disinterested, overly use confrontation, or engage in client belittling. This mutual reinforcement of direct and observed experiences between the client and the helping professional may offer a better understanding of how mental health professionals' education and training programs can prepare professionals to treat clients with ASPD. Attitude studies (Black et al., 2011; Bowers, et al., 2005; Bowers et al., 2006) provide a glimpse into how high risk clients influence mental health professionals' attitudes, however no studies speak specifically to ASPD, and underlying social learning factors such as level of clinical contact and a history of criminal victimization. Prison studies provide the nearest representation of how clients with ASPD influence mental health professionals' attitudes.

Prison

A common outcome for people with ASPD is prison because they engage in a variety of criminal behaviors motivated by their need for excitement and their disregard for societal norms (APA, 2013; Black, 2013; Black 2015; NICE, 2010). As previously discussed, up to 70% of prisoners meet the diagnostic criteria for ASPD (APA, 2013). Antisocial personality disorder manifests differently for each individual therefore, crimes range from petty theft to terrorist acts including mass murder (Black, 2013; Samenow, 2014). The chronic nature of ASPD often leads to intermittent sanctions (e.g., citations, probation, short-term incarceration) before obtaining a long-term sentence (NICE, 2010). Resultantly, individuals with ASPD are seen in a variety of forensic settings including prisons, jails, and forensic psychiatric settings (APA, 2013). Their behaviors stemming from ASPD continue while they are in forensic settings which provides a new venue to practice their maladaptive patterns (Samenow, 2014). Clients with ASPD may con and threaten others, attempt to outwit prison officials, and engage in fights or other acts of violence (Samenow, 2014). When released, people with ASPD often reoffend (NICE, 2010; Samenow, 2014).

Dangerous and Severe Personality Disorder Unit. In response to high recidivism rates, the United Kingdom sponsored the development of a Dangerous and Severe Personality Disorder (DSPD) unit which is housed within a prison (NICE, 2010). The purpose of the unit is to provide services for prisoners with severe personality disorders within a secure setting (NICE, 2010). The unit was developed due to the failure of mental health and forensic services to effectively treat dangerous offenders (i.e., reducing recidivism) (Carr-Walker et al., 2004). Treatment in the DSPD unit is provided by a multidisciplinary treatment team including psychiatrists, psychologists, nurses, prison officers, and probation officers (Carr-Walker et al., 2004).

Treatment providers are trained to work with prisoners with severe personality disorders (Carr-Walker et al., 2004).

Prisoners admitted to the DSPD unit are considered dangerous to themselves or others, and require intensive safety monitoring and therapeutic services that they cannot receive in a lower level of care such outpatient therapy or community support (Bowers et al., 2005). Upon admission, prisoners are screened using DSM 5 criteria as well as the Psychopathy Checklist-Revised (PCL-R) to ensure they meet the criteria for ASPD and possibly additional personality disorders (Bowers et al., 2005). Dangerous and Severe Personality Disorder unit studies show how direct and observed experiences with clients with ASPD influence mental health professionals' attitudes (Bowers et al., 2005).

Prison Staff Attitudes. To understand the prolonged effects of contact with offenders diagnosed with ASPD, Bowers et al. (2005) conducted interviews with prison officers working in the DSPD unit. Officers reported feelings of frustration and disinterest associated with interacting with the prisoners. They also reported feeling annoyed after being manipulated or when prisoners displayed overt acting out behaviors (e.g., fighting, self-harm, threats). From a social learning perspective, the officers' negative attitudes have multiple effects on their colleagues and the prisoners (Bandura, 1977). For instance, negative discussions about the inmates among prison officers further perpetuate the negative attitudes among officers through observational learning. Furthermore, prisoners who notice the negative attitudes of officers may disengage from, demean, or become aggressive toward prison officers. This behavior by prisoners further reinforces the negative attitude of prison officers, and further entrenches and perpetuates the socially learned attitudes of officers and prisoners.

In an additional longitudinal study, Bowers et al. (2006) examined the relationship between job performance, burnout, personal well-being, and prison officers' attitudes toward clients with personality disorders treated in the DSPD unit. Officers were given the *Attitude to Personality Disorder Questionnaire* (APDQ) at three fixed points: baseline, eight months, and sixteen months after entering the DSPD. Findings indicated 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. Furthermore, the findings suggested that during the first eight months of the study officers' attitudes remain stable, however after eight months on the job, officers' attitudes declined. These findings provide a direct link between social learning (i.e., amount of contact) and attitudes toward ASPD. Over a span of 8 months officer attitudes did not change, however after 8 months of direct and observed experience with clients with ASPD their attitudes declined. The officers' attitudinal decline was reinforced when clients acted out, bullied, or manipulated them. These findings suggest that being immersed in an environment where ASPD is common may influence attitudes. However, a time variable (i.e., length of employment) does not account for the level of contact officers have with clients with ASPD. This study does not examine whether contact with clients with ASPD negatively influenced officers' attitudes or other environmental issues negatively influenced officers' attitudes. This study also does not account for historical social learning experiences such as the officers' histories of being crime victims.

Chapter Summary

In the previous review, social learning theory helped explain the circular interaction between mental health professionals and clients diagnosed with ASPD. That is, difficult exchanges with clients, perpetuate negative attitudes among mental health professionals which

increases the likelihood of more difficult exchanges. Although the rates of clients with ASPD are high in substance abuse and mental health settings (APA, 2013), few studies examine how clients with ASPD influence the mental health professionals with whom they interact. Instead, the majority of ASPD studies focus on causes, treatment, and prevention efforts (NICE, 2010). Despite these studies, clinical interventions for ASPD remain unclear (Black, 2015; NICE, 2010; Samenow, 2014). Mental health professionals' uncertainty further confounds the treatment of the mysterious and largely ignored disorder (Black, 2013; NICE, 2010).

Despite the lack of progress in ASPD treatment, awareness of how clients with personality disorders affect mental health professionals abounds (Black et al., 2011; Bowers et al., 2005; Bowers et al., 2006; Evans, 2011; NICE, 2010; Schwartz et al., 2007). In response to this awareness, Bowers and Allan (2006) developed the *Attitudes toward Personality Disorders Questionnaire* (*APDQ)* in order to quantify the influence of clients with personality disorders on mental health professionals' attitudes. The *APDQ* has been used in prison settings to better understand how high risk clients influence the attitudes of those with whom they interact. The *APDQ* may be a useful instrument for understanding mental health professionals' attitudes toward clients with ASPD

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

Introduction

The following chapter describes the research design and methodology used to examine mental health professionals' attitudes toward clients with antisocial personality disorder (ASPD). The chapter contains a review of the research questions, research design, population of interest, sampling procedure, instrumentation, variables of interest, statistical analysis, ethical considerations, and research limitations.

Research Questions

This study examined mental health professionals' attitudes toward clients with antisocial personality disorder (ASPD). This study included two independent variables: level of clinical contact and criminal victimization. The *Adapted-Attitudes toward Personality Disorders Questionnaire* (*A-APDQ*) subscales measured the dependent variables, which were: *Security, Enjoyment, Acceptance, Purpose, and Enthusiasm* (Bowers & Allan 2006). The following research questions examined how social learning influences mental health professionals' attitudes toward clients with ASPD:

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*?

Research question one examined whether mental health professionals' attitudes were influenced by the level of clinical contact they had with clients with ASPD. As previously discussed, social learning includes direct experiential learning and observational learning (Bandura, 1977; 1989), both of which occur within therapeutic relationships. Bowers and colleagues (2005) examined the influence of prolonged exposure to prisoners with severe personality disorders on prison officers' attitudes. Findings indicated that amount of time (i.e., length of time employed in a prison setting) was negatively correlated with prison officers' attitudes (Bowers et al., 2005). These findings suggest that being immersed in an environment where ASPD is prevalent negatively influenced prison guards' attitudes (Bowers et al., 2005). To protect against confounding environmental factors, research question one builds upon these findings by examining the influence of the level (i.e., no contact, low contact, and high contact) of clinical contact with clients with ASPD on mental health professionals' attitudes rather than the time construct examined by Bowers and colleagues (2005). Examining mental health professionals' levels of clinical contact determines whether interactions with clients with ASPD influences their attitudes, rather than environmental factors (i.e., time) as identified by Bowers and colleagues (2005). Therefore, research question one examined whether the level of clinical contact with clients with ASPD influenced mental health professionals' attitudes.

Research question two examined whether criminal victimization influenced mental health professionals' attitudes toward clients with ASPD. Victims of violent crimes often experience

depression, anxiety, and substance use issues, which suggests that violent crimes have long-term effects on crime victims (Ruback et al., 2014). Reciprocally, clients with ASPD have high rates of committing crimes that harm other people (APA, 2013). Therefore, research question two compared mental health professionals who were crime victims to those who were not crime victims regarding their attitudes toward clients with ASPD.

Research question three examined the interaction effect of the independent variables (i.e., clinical contact and criminal victimization) on the dependent variables (i.e., *A-APDQ* subscales). Interaction effects examine whether changes in the dependent variables associated with one independent variable are contingent upon the other independent variables (Manley, 2004). Simply put, research question three examined if changes in *A-APDQ* subscale scores associated with the level of clinical contact with clients with ASPD were contingent upon whether participants were crime victims.

Research Design

The current study built upon previous research, which examined mental health professionals' (e.g., nursing, psychology, prison officers) attitudes toward personality disorders (Bowers et al., 2005; Eren & Sahin, 2016). This study used an exploratory online survey design to examine whether social learning factors (i.e., clinical contact and criminal victimization) influenced mental health professionals' attitudes toward clients with ASPD. This study was exploratory because it examined a previously identified construct (i.e., attitudes) from a new theoretical angle (i.e., social learning) specific toward an unexplored population (i.e., clients with ASPD) (Trochim, 2006).

To examine the attitudes of mental health professionals toward clients with ASPD, Medicaid approved mental health professionals (N = 98) in North Carolina were surveyed.

Medicaid approved mental health professionals meet national and state standards for providing mental health services to clients.

To determine minimum acceptable sample size, a power analysis was conducted using G*Power version 3.1.9.2. G*Power indicated a minimum sample size of 67 was appropriate for a MANOVA with two independent variables (i.e., amount of clinical contact and history of criminal victimization) and five dependent variables (i.e., *A-APDQ* scales). To compensate for an expected low response rates inherent to online survey research, (Heppner, Wampold, & Kivlighan 2008) all Medicaid-approved mental health providers (N = 5679) in North Carolina were invited to participate. Medicaid approved mental health providers in North Carolina were emailed an invitation to participate in a study examining mental health professionals' attitudes toward clients with ASPD. The emailed invitation included a link to a computer administered self-report survey. The survey was administered through Qualtrics, a browser-based survey administration instrument that collects and organizes data from online surveys. Prior to participating in the study, participants completed an online informed consent form. After participants completed the informed consent process, they were directed to the online survey. Participants who did not agree to the informed consent process were not able to participate in the survey. Incomplete survey responses (n = 58) were discarded from this study.

Due to the lack of psychometrically validated instruments specific to mental health professionals' attitudes toward clients with ASPD, this study used an adapted version of an established psychometrically valid instrument, the *Attitudes to Personality Disorder Questionnaire* (*APDQ*) (Bowers & Allan, 2006). Specific instrument adaptations are discussed later in this chapter. The online survey included the *Adapted-Attitudes to Personality Disorder Questionnaire* (*A-APDQ*) and an author-developed demographic questionnaire containing the

independent variables. Participants (N = 98) completed the demographic questionnaire followed by the *A-APDQ*. Data was analyzed with a computerized statistical analysis program, SPSS 24. Initial descriptive statistics and graphical displays were analyzed to determine the appropriate statistical approaches and applicable statistical models. Statistical processes are specified for each research question later in this chapter.

Study participants were treated in accordance with the ACA code of ethics. The following steps were taken to protect participants' confidentiality: (a) Participants were required to complete an informed consent document. (b) Data was analyzed at the group level rather than the individual level. (c) No identifying information, other than demographic data (i.e., age, gender, race, years of experience, licensure, work setting, level of clinical contact with clients with ASPD, and exposure to crime) was gathered. (d) Participants were informed that they could withdraw from the study at any time.

Population and Sample

The population of interest for this study was Medicaid-approved mental health professionals in the United States. This exploratory study examined Medicaid approved mental health professionals in North Carolina to represent Medicaid-approved mental health professionals in the United States. Mental health professionals include professional counselors, addictions specialists, nurses, social workers, psychiatrists, psychologists, and marriage and family therapists. Mental health professionals must hold advanced degrees, undergo training and supervision, and meet state licensure requirements in their respective disciplines to provide mental health services to clients with Medicaid benefits in North Carolina (North Carolina Department of Health and Human Services [NCDHHS], 2016). Specifically, licensed professional counselors, licensed clinical social workers, licensed clinical addictions specialists,

and licensed marriage and family therapists must have a master's degree and one to two years of supervised clinical experience to earn Medicaid approved provider status. Psychologists must have a doctorate, and psychiatrists must have a medical degree in addition to being fully licensed. Nurses must complete an advanced degree and obtain two years of supervised practice (NCDHHS, 2016).

The current study's demographic questionnaire included items addressing professional licensure, professional discipline, years of experience, and work setting to describe the study's sample. External validity refers to this study's ability to generalize its results to the population, in this case Medicaid approved mental health professionals (Heppner et al., 2008).

Sampling Design

This study used a purposive sampling procedure to obtain a sample of Medicaid-approved mental health providers. Purposive sampling means that participants must meet a specified criteria to take part in the study (Heppner et al., 2008). To participate in this study, participants must meet the following criteria: (a) Participants must be fully licensed to practice mental health and/or substance abuse treatment in North Carolina. (b) Participants must be approved by the North Carolina Department of Health and Human Services as a treatment provider for consumers with Medicaid benefits. (c) Participants must have at least a Master's Degree.

Because study participants chose whether or not they wished to participate, sampling for this study is considered self-selecting (Heppner et al., 2008). Self-selection minimizes the time necessary to obtain a sample and provides adequate external validity (Heppner et al., 2008). Self-selection is commonly used in survey research (Heppner et al., 2008). This study used online recruitment and data collection methodology. Email addresses of 6750 Medicaid approved

mental health professionals in North Carolina were obtained from the North Carolina Department of Health and Human Services' online provider directory (NCDHHS, 2016).

As previously discussed, the required sample size for this study was calculated using G*Power and parameters were based on Cohen's (1992) suggestions for power and effect size. Cohen (1992) suggests that a power of .8 and an effect size of .2 will detect moderate to large differences among the groups as defined by the independent variables. Based on Cohen's (1992) specifications, G*Power recommends a minimum sample size of 46 for a 3 X 2 factorial MANOVA. Effect size measures changes in the dependent variables associated with the different levels of the independent variables (Heppner et al., 2008). Power measures the probability that the analysis will correctly reject the null hypothesis if the null hypothesis is actually false (Heppner et al., 2008). Although 46 is the required sample size, Garson (2015) suggests that MANOVAS are appropriate when every cell has more cases than dependent variables. Therefore, each cell must have at least 5 cases to meet the requirements for a MANOVA for this study. To ensure sampling adequacy and compensate for invalid and unused email addresses, and low response rates, the survey invitation was emailed to every Medicaid approved mental health helping professional on the list obtained through NCDHHS.

Sampling Procedures

Email surveys were sent to 6750 Medicaid approved providers in North Carolina. The online survey remained available from October 27, 2016 to November 10, 2016. Of the 6750 available email addresses, 1750 were invalid or blocked. Of the remaining 5679 email addresses, 156 participants (3%) started the survey. Ninety-eight (N = 98; 2%) participants completed the survey and were used in this study. Incomplete survey responses (n = 58) were discarded.

The survey was administered through the online survey administration and data collection tool, Qualtrics. The survey contained an informed consent, *the Demographic Questionnaire* which ascertained descriptive data (i.e., age, race, licensure, years of experience, professional discipline, and work setting) and the independent variables (i.e., level of clinical contact and criminal victimization), and the *Adapted-Attitudes toward Personality Disorders Questionnaire* (*A-APDQ*) (Bowers & Allan, 2006).

Additionally, an optional qualitative question, "Is there is a particular observation or experience that has shaped your opinion about clients with antisocial personality disorder? If so, please describe briefly in the space provided." was included to gather information for future research and was not used in this analysis.

Instrumentation

Research specific to mental health professionals' attitudes toward clients with antisocial personality disorder (ASPD) is limited and has not included underling social learning factors (i.e., clinical contact and criminal victimization). Additionally, instrumentation specific to mental health professionals' attitudes toward ASPD is lacking (Bowers et al.,, 2005). The *Attitudes to Personality Disorder Questionnaire* (*APDQ*) measures attitudes toward personality disorders (Bowers & Allan 2006). However, the *APDQ* lacks specificity to clients with ASPD. For the current study, Bowers and Allan's (2006) *APDQ* was adapted to increase specificity toward clients with ASPD. Specific adaptations are discussed later in the chapter.

Demographic Questionnaire

The author-developed demographic questionnaire provides descriptive data including participants' age, gender, race, licensure, professional discipline, years of experience, and work setting. The demographic questionnaire also included questions ascertaining participants' level

of clinical contact with clients with ASPD and their history of criminal victimization which were the independent variables examined in this study.

To ascertain participants' level of clinical contact with clients with ASPD the following question was included on the demographic survey: "During an average 5 day workweek, how many clients with ASPD do you treat?"

This study operationalized level of clinical contact by placing participants in one of three groups based on a tertiary split. Tertiary splits convert quantitative variables into categorical variables by separating the data into three groups (MacCallum, Zhang, Preacher, & Rucker, 2002). Although a tertiary split doesn't account for all of the data's variability, it aids in interpretability in comparison to a regression formula (Macallum et al., 2002). The tertiary split for this study was conducted by analyzing the data and dividing the participants into three groups based on the data distribution (i.e., No Contact group, Low Contact group [seeing one or two clients a week with ASPD] and High Contact group [seeing ≥ 3 clients with ASPD a week]). A tertiary split was used reduce the likelihood of data polarization by accounting for participants' varied levels of clinical contact with clients with ASPD (i.e. No Contact, Low Contact, High Contact).

The criminal victimization construct is operationalized with the following question: "Have you, a family member, or a significant other, ever been a victim of a violent crime?" Participants who reported being crime victims comprise the "Yes Victimization group", and participants who did not report being crime victims comprise the "No Victimization group".

The final question on the demographic questionnaire, "Is there is a particular observation or experience that has shaped your opinion about clients with antisocial personality disorder? If so, describe briefly in the space below", was an optional qualitative question that will be used to

guide future research. This question was included to determine if historical and social factors that have not been considered by this researcher influence counselors' attitudes toward clients with ASPD. Because this study examines counselors' subjective perceptions of clients with ASPD, diagnostic criteria for the disorder are not specified. Rather, a short descriptive paragraph is included prior to the *A-APDQ* items which briefly describes the disorder and provides instructions for completing the questionnaire (Appendix C.).

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). The Likert responses include: 1 = "never", 2 = "seldom", 3 = "occasionally", 4 = "often", 5 = "very often, 6 = "always". Participants select one response for each item. The *ADPQ* 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 question whereas item 12 "I feel pessimistic about PD patients" is a negative feeling question (Bowers & Allan, 2006, p. 23). For the purpose of this study, the instrument was adapted to specify clients with ASPD.

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, Qualtrics. 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.

As previously discussed, the *APDQ* was developed to measure mental health professionals' attitudes toward all personality disorders rather than ASPD (Bowers & Allan,

2006). Mental health professionals' attitudes toward clients with ASPD may contribute to their attitudes toward clients with personality disorders, however the original *APDQ* does not measure ASPD's influence on mental health professionals' attitudes specifically. For example, mental health professionals who treat clients with narcissistic personality disorder may respond differently to the *APDQ* than someone who is primarily exposed to clients with ASPD (Bowers & Allan, 2006). Therefore, "AS" (i.e., antisocial) was added before each "PD" abbreviation to provide specificity toward clients with ASPD. For example, item 14 which originally read "I admire PD people" was modified to read "I admire ASPD people".

An additional item specifying observational learning was added at the end of the *A-APDQ*; "I have observed co-workers being intolerant of ASPD peoples' behaviors" describes observationally learned behaviors regarding mental health professionals' attitudes toward clients with ASPD. For example, mental health professionals working in an environment where other staff members are intolerant of clients with ASPD may have different attitudes than those in a tolerant and supportive environment. This item did not contribute to the *A-APDQ* scale scores, rather this item's data was descriptive.

Dependent variables. This study included five continuous dependent variables. The dependent variables were the five factor (i.e., scales) scores from the *Adapted-APDQ*. The scale scores can be summed to yield a total score for each participant. Each item is scored according to the Likert responses (i.e., never = 1, to 6 = always), and scores are summed to yield scale scores. Negative feeling questions are reverse scored to ensure that higher scores reflect positive attitudes (Bowers & Allan, 2005). Reverse scoring of negative feeling questions improves the instruments' interpretability (Bowers & Allan, 2005). Four of the five *A-APDQ* scales are reverse scored, a summary of which, is included in Table 3.1.

The five scales on the APDQ were derived from principal components analysis (PCA) (Bowers & Allan, 2005). The instruments' five scales include the term "versus" to emphasize the spectrum of thoughts and emotions measured by each scale (Bowers & Allan, 2006). The instruments' scales titles are shortened for the analysis by dropping the "versus" term (e.g., "enjoyment versus loathing" is titled "enjoyment"). Additionally, because each scale contains a different number of items, each scale was standardized by dividing participants' scores on each scale by the number of scale items. Standardization yielded scale scores for each participant from 1 to 6 which aids in comparisons across scales. High scale scores indicate positive attitudes, whereas low scale scores indicate negative attitudes. Scale scores near scale medians indicate feelings of neutrality. For example, a score of 1 on the enjoyment/loathing scale indicates negative attitudes, whereas a score of 3 indicates neutral feelings, and a score of 6 indicates positive feelings. The number of items in each scale is included in table 3.1.

Bowers and Allan (2006) previous research indicated that the question "I feel provoked by ASPD people" and the question "I feel cautious and careful in the presence of ASPD people" do not significantly contribute to the established *A-APDQ* scales and these items were subsequently discarded. However, these items were included in the current study to promote consistency with previous instrument administrations. More specifically, the original 35 Likert-style questions were used to maintain consistence with previous research (Bowers & Allan, 2006). These questions comprise the five scales of the A-APDQ: enjoyment/loathing, security/vulnerability, acceptance/rejection, purpose/futility, and enthusiasm/exhaustion. Cronbach's alpha scores were calculated for each scale on the *A-APDQ* to measure internal reliability and are included in the following sections.

***Enjoyment versus loathing*.** The enjoyment/loathing scale is a standard scale consisting of 15-items that express feelings of warmth and positive regard toward clients with ASPD (Bowers & Allan, 2006). For example, item 1, "I like ASPD patients" and item 4, "I respect ASPD patients", examine participants' experiences of positive emotions toward clients with ASPD. Therefore, a "6 = always" on these items indicates feelings of warmth and positive regard toward clients with ASPD, whereas a "1 = never" indicates feelings of dislike and disregard toward clients with ASPD. The principal components analysis (PCA) indicated this scale had an eigenvalue of 7.87 and explained 21.3% of total variance of the *APDQ* (Bowers & Allan, 2006). Cronbach's alpha for *Enjoyment* scale items on the *A-APDQ* was .92 (Table 4.13).

***Security versus vulnerability*.** The security/vulnerability scale is a reversed scale consisting of 10 items that measure negative feelings toward clients with ASPD as well as how physically and emotionally safe mental health professionals feel when interacting with clients with ASPD (Bowers & Allan, 2006). 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. A score of "6 = always" on these items indicates feelings of emotional and physical vulnerability toward clients with ASPD and a "1 = never" indicates feelings of physical and emotional safety and security toward clients with ASPD. The PCA indicated that this scale had an eigenvalue of 6.27 and explained 16.9% of total variance of the *APDQ*. Cronbach's alpha for *Security* scale items on the *A-APDQ* was .92 (Table 4.13).

***Acceptance versus rejection*.** The acceptance/rejection scale is a reversed scale consisting of 5 items that measure negative feeling such as anger and rejection toward clients with ASPD (Bowers & Allan, 2006). 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. A score of "6 = always" indicates feelings of rejection and dismissal toward clients with ASPD whereas a score of "1 = never" indicates feelings of acceptance and tolerance toward clients with ASPD. The PCA results indicated that the acceptance/rejection scale has an eigenvalue of 2.99 and explains 8.1% of the total variance (Bowers & Allan, 2006). Cronbach's alpha for *Acceptance* scale items on the *A-APDQ* was .85 (Table 4.13).

Purpose versus futility. The purpose/futility scale is a reversed scale consisting of 3 items that measure feelings of hopelessness and pessimism toward clients with ASPD. 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. A score of "6 = always" on these items indicates feelings of apathy toward clients with ASPD, whereas a score of "1 = never" indicates feelings of meaning and purpose toward clients with ASPD. The PCA results indicated that this scale has an eigenvalue of 2.31 and explains 6.2% of the total variance of the *APDQ* (Bowers & Allan, 2006). Cronbach's alpha for *Purpose* scale items on the *A-APDQ* was .86 (Table 4.13).

Enthusiasm versus exhaustion. The enthusiasm/exhaustion scale is a reversed scale consisting of 2 items that measure feelings of dissatisfaction when working with clients with ASPD. Item 2, "I feel frustrated by ASPD patients" and item 3, "I feel drained by ASPD patients" examine participants' negative emotions toward clients with ASPD. A score of "6 = always" on these items indicates feelings of malaise toward clients with ASPD whereas, as score of "1 = never" indicates feelings of zeal and eagerness toward clients with ASPD. The PCA indicated that this scale has an eigenvalue of 1.42 and explains 3.8% of the instruments' total variance (Bowers & Allan, 2006). Cronbach's alpha for the *Enthusiasm* scale items on the *A-APDQ* was .75 (Table 4.13).

Table 3.1
Attitudes toward Personality Disorders Questionnaire Scoring Properties

Scale	Scoring	No. of Items	Reliability
Enjoyment/Loathing	Standard	15	.79
Security/Vulnerability	Reverse	10	.85
Acceptance/Rejection	Reverse	5	.72
Purpose/Futility	Reverse	3	.74
Enthusiasm/Exhaustion	Reverse	2	.77

Independent variables. This study had 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 *A-APDQ*.

Psychometric properties. Few psychometrically validated instruments have been developed for measuring clinicians' attitudes toward clients with personality disorders (Bowers & Allan, 2006). The *APDQ*'s psychometric properties, accessibility in public domain, and ease of administration make it suitable for better understanding how clients with ASPD influence mental health professionals' attitudes.

Reliability. Reliability or score consistency for the *APDQ* were calculated through test-retest procedures (Bowers & Allan, 2006). Test-retest reliability was calculated by having a multidisciplinary group (n = 23) take the *ADPQ* twice over a 10 day period. Test-retest reliability scores were calculated for the five scales: Enjoyment (.79); Security (.85); Enthusiasm (.77);

Acceptance (.72); and purpose (.74). The total score reliability was .84 and participants' scores had a Pearson's *r* of .71 (Bowers & Allan, 2006). These reliability scores indicated that the APDQ produces acceptably consistent results when measuring attitudes toward personality disorders (Carr-Walker et al., 2004). The Cronbach Alpha of .94 indicated excellent internal consistency (Bowers & Allan, 2006), and a Cronbach Alpha was calculated for this study to ensure adequate reliability. Further validation was derived through a PCA (Bowers & Allan, 2006).

Validity. The face validity of the APDQ is high because each question is specific to how personality disorder symptoms influence clinicians' attitudes. The APDQ was validated through PCA and a follow-up confirmatory factor analysis (Bowers & Allan, 2006). The PCA data was taken from a sample (N = 651) of professional and student nurses working in high security psychiatric hospitals with clients with personality disorders (Bowers & Allan, 2006).

A Keiser-Mayer Olkin (0.949) and Bartlette's Test of Sphericity ($p < .0005$) support the use of PCA and confirmatory factor analysis to measure the instrument's validity (Bowers & Allan, 2006). Initially, PCA indicated six factors with eigenvalues >1, however one factor consisted of only one item and was therefore eliminated. The remaining five factors comprise the finalized *APDQ* (Bowers & Allan, 2006). A confirmatory factor analysis supported the use of five factors in the original *APDQ* however; a PCA was not conducted for this study. (Bowers & Allan, 2006). Additionally, the *APDQ* was normed on nurses and prison officers, therefore this study will expand the instruments' scope by examining mental health professionals' (i.e. professional counselors, social workers, psychologists, psychiatrists) attitudes specific to ASPD. Although the present study included minor instrumental modifications, the psychometric properties of the APDQ support its use for examining attitudes toward clients with ASPD.

Normalization. Normative data for developing the APDQ was obtained from prison officers (n = 73), nurses (n = 651), and multidisciplinary psychiatric staff (n = 51) working in high security psychiatric settings (Bowers & Allan, 2006). Normative concerns are discussed further in the limitations section in this chapter.

Statistical Analysis

This study used a 3 X 2 factorial multivariate analysis of variance (MANOVA) to examine how mental health professionals' attitudes toward clients with ASPD, as measured by the *A-APDQ*, are influenced by two independent variables: clinical contact and criminal victimization. A MANOVA is appropriate for examining how multiple categorical independent variables influence multiple continuous dependent variables (Manly, 2005). A MANOVA provides main effects and interaction effects (Manly, 2005). Additionally, a MANOVA is more appropriate than multiple ANOVAS for multivariate analysis because a MANOVA reduces the chance of a type 1 error (rejecting the null hypothesis when it is actually true) (Manly, 2005). The data must meet statistical assumptions to be analyzed using a MANOVA (Weinfurt, 1995).

Data analyzed by a MANOVA is assumed to be from a multivariate normal distribution (Weinfurt, 1995). The underlying matrix algebra, upon which a MANOVA is founded, is based on a multivariate normal distribution; therefore, extreme deviations from normality may negatively influence the precision of the analysis (Manly, 2005). However, MANOVAs are robust against mild to moderate deviations from normality (Weinfurt, 1995). Therefore, a MANOVA design was appropriate for this study. A Kolmogorov-Smirnov test was used to verify that the data meets the assumption of multivariate normality. A MANOVA also assumes that the data has equal variance and covariance matrices (Weinfurt, 1995). This assumption requires that the data have equal variances along all levels of the independent variables

(Weinfurt, 1995). Equal variance was verified with a Box's M Test. Finally, MANOVAs assume that each observation is independent (Weinfurt, 1995). This assumption was met by having each participant measured only one time. The significance level for this study was $\alpha = .05$.

Research Question One.

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*?

Research Question Two.

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*?

Research Question Three.

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*?

Limitations

This study has limitations that should be considered when interpreting results. First, online survey research is prone to sampling issues (Wright, 2005). This researcher assumed participants' provided honest answers and accurate demographic information, however there was no way of verifying participants' information. Therefore, the computer based survey design creates difficulty in determining how well the sample represents the population (Heppner et al., 2008).

Another issue of online survey research is the generation of unused or invalid email addresses (Wright, 2005). That is, unused or invalid email addresses negatively affect the response rate. Furthermore, some participants did not receive the invitation email due to unused or invalid email addresses, this negates the possibility of comparing participants to nonparticipants. This study compensated for the low response rates inherent to online surveys (Heppner et al., 2008) by increasing the number of invited participants. Additionally, the online survey design increased participants' accessibility to the study, which enhanced the study's external validity.

A second limitation in survey research is self-selection bias (Wright, 2005). Some participants chose to participate in the study while others chose to ignore the invitation to participate. As previously discussed, online survey designs prohibit research into participants' versus nonparticipants' differences. This study's use of a survey design increases the risk of participants providing answers they deem socially desirable and may not be a valid measurement of their attitude (Heppner et al., 2008).

The third limitation is the instrumentation. The *APDQ* normative data was gathered primarily from nurses and probation officers (Bowers & Allan, 2006) rather than mental health professionals. The instrument's psychometric properties may not be accurate with a sample of mental health professionals which could influence the external validity of this study.

Furthermore, Bowers and Allan (2006) developed the *APDQ* to measure attitudes toward personality disorders and adapting the instrument to measure ASPD may affect the psychometric properties. The adaptations made (i.e., adding "AS" to survey questions) were to add specificity to ASPD. In fact, Bowers and Allan (2006) recommend further studies on how specific personality disorders, such as ASPD, influence mental health professionals' attitudes. However,

the addition of "AS" is an alteration of the original instrument. To compensate for this modification a Cronbach's alpha was calculated to verify the modified instruments' reliability (Table 4.13).

Ethical Considerations

Survey designs are effective and efficient for collecting data to describe a populations' characteristics (Heppner et al., 2008), however ethical concerns exist. The most common issue in online survey research is maintaining participants' confidentiality (Buchanan & Hvizdak, 2009). To promote confidentiality, this study's surveys were completed through a secure website and data was coded to protect participants' identifying information. As previously discussed, all data was analyzed and reported at the group level to ensure the highest level of participant confidentiality. Additionally, this study minimizes ethical concerns by having participants complete an online informed consent process that reminded participants that they were free to withdraw from the survey at any time. The use of an online informed consent procedure ensures that the informed consent delivery was uniform for all participants (Buchanan & Hvizdak, 2009). However, the online informed consent procedure prohibited interaction with participants, therefore any participant questions or concerns were not addressed by the researcher (Buchanan & Hvizdak, 2009).

Chapter Summary

The purpose of this study was to examine mental health professionals' attitudes toward clients with antisocial personality disorder (ASPD). The population examined was Medicaid approved mental health professionals. This study used purposive self-selected sample of participants from the North Carolina Department of Health and Human Services' list of mental health providers approved for Medicaid reimbursement. Participants completed an online survey

that included a demographic questionnaire and the *Adapted-Attitudes to Personality Disorders Questionnaire* (*APDQ*). The *APDQ* was adapted specifically for clients with ASPD and distributed through an online survey. A two- way factorial MANOVA was used to examine the relationship between independent variables (i.e., clinical contact and criminal victimization) on mental health professionals' attitudes toward clients with ASPD. Ethical concerns included protection of participants' confidentiality and lack of interactive informed consent procedure.

CHAPTER FOUR: RESULTS

Introduction to the Chapter

The purpose of this study was to examine the influence of social learning factors (i.e., level of clinical contact and criminal victimization) on mental health professionals' attitudes toward clients with antisocial personality disorder (ASPD). This chapter reviews results from the study including: sampling procedure, descriptive statistics, and statistical analysis and results relative to the research questions. The chapter concludes with a summary.

Data Cleaning

As previously discussed, participants' (N = 98) data was gathered through an online survey. Data was prepared by removing participants' internet protocol (IP) addresses, global positioning coordinates, email addresses, and survey start and end times because this data was not relevant to the study. This researcher removed this data, which was provided by Qualtrics, to protect participants' confidentiality. The survey tool, Qualtrics, was programmed to require survey completion to promote internal validity and protect against threats to statistical conclusion validity (Heppner et al., 2008). After data cleaning, 98 surveys were used in this study to comprise the self-selected sample.

Descriptive Data Results

Study participants were classified in terms of their demographic characteristics and professional characteristics. Measures of central tendency, including means and standard deviations were used to describe participants' along the following domains: (a) age (in years), (b) race, (c) gender, (d) professional discipline, (e) years worked as a mental health professional, (f) licenses held, (g) work setting, (h) and coworker observation. Demographic variables were not used to explore this study's research questions. Rather, demographic variables were analyzed to

protect against covariance through Pearson correlations for continuous variables and effect size (i.e. eta squared) for categorical variables. Appropriate tables and graphs were used to describe the distribution of categorical variables (i.e., race, gender, licenses held, work setting) and continuous variables (i.e., age, years worked as a mental health professional, coworker observation) for the sample as a whole and the demographic distribution among the six groups defined by the independent variables: (a) No Contact Non Victims, (b) Low Contact Non Victims, (c) High Contact Non Victims, (d) No Contact Crime Victims, (e) Low Contact Crime Victims, and (f) High Contact Crime Victims.

Age, Gender, and Race

The mean age for this sample was 53 years (M = 53.03, SD = 10.54). Participants 60 to 69 years old comprised the largest age group (n = 29; 29.6%). Participants age 20 to 29 comprised for the lowest percentage of respondents (n = 1) at 1.0 %. Female participants (n = 67) represented 68.4% of the sample, and male participants (n = 31) represented 31.6%. The majority of participants were White/Caucasian (n = 78; 79.6%). Table 4.1 provides a summary of participants' age, and Table 4.2 provides a summary of participants' race.

Table 4.1
Participant Age

Age Category (Years)	Frequency	%
20 – 29	1	1.0
30 – 39	10	10.2
40 – 49	27	27.6
50 – 59	27	27.6
60 – 69	29	29.6
70 – 79	4	4.1
Total	98	100.0

Table 4.2
Participant Race

Race	Frequency	%
White/Caucasian	78	79.6
African American/Black	15	15.3
Hispanic/Latino	2	2.0
Native American/American Indian	1	1.0
Other	2	2.0
Total	98	100.0

Professional Characteristics

Participants (N = 98) were classified according to their years of experience, professional discipline and licensure, and work setting.

Years of experience. Participants' years of professional experience ranged from 4 to 50 with a mean of 23.1 (*M* = 23.1, *SD* = 10.8) years. The majority of participants (n = 65) reported between 11 and 30 years of experience and account for 66.2% of the sample. Table 4.3 illustrates participants' years of professional experience.

Table 4.3
Years of Experience

Experience (Years)	Frequency	%
1 – 5	1	1.0
6 – 10	10	10.2
11 – 15	17	17.3
16 – 20	17	17.3
21 – 25	17	17.3
26 – 30	14	14.3
31 – 35	7	7.1
36 – 40	7	7.1
>40	8	8.2
Total	98	100.0

Professional discipline and licensure. 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%). Of the four participants who identified as "other", one participant identified as an addictions specialist, one as both a registered nurse and a social worker, one as a perinatal substance abuse professional, and one as a psychiatric nurse. All participants held licenses from their respective fields. Additionally, 38 (38.8%) participants held more than one license. The most commonly held additional licenses were Licensed Clinical Addictions Specialist (LCAS) (n = 15; 15.3%) and National Certified Counselor (NCC) (n = 17; 17.3%). Table 4.4 summarizes participants' professional disciplines.

Work setting. 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%). Of the participants who selected "other", one reported working for a managed care organization, another reported working in a social services setting, two reported working in crisis centers, and two reported working in both public and private outpatient settings.

Table 4.4
Professional Discipline

Discipline	Frequency	%
Professional Counseling	48	49.0
Social Work	26	26.5
Psychology	17	17.3
Psychiatry	3	3.1

Other	4	4.1
Total	98	100.0

Level of clinical contact with clients with antisocial personality disorder. The "No Contact" group was comprised of participants (n = 45; 45.9%) who reported not having contact with clients with 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. As previously discussed, a tertiary split was used to account for participants' varied levels of clinical contact with clients with ASPD and protect against data polarization, which is more likely with a median split (Macallum et al., 2002).

History of criminal victimization. Sixty-five participants (n = 65; 66.3%) denied having been victimized by violent crimes (direct [i.e., self] or observational [i.e., family member or significant other]) and comprised the "No Victimization" group. Thirty-three participants (n = 33; 33.7%) reported that they, a family member, or a significant other had been victimized by violent crime and comprise the "Yes Victimization" group. Table 4.5 illustrates the 3 X 2 relationship between the independent variables and Table 4.6 illustrates the correlation between the descriptive variables and the dependent variables.

Table 4.5
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

Demographic Correlations

A correlation matrix (Table 4.6) illustrates the demographic variables' relationships to the dependent variables: *Security, Enjoyment, Acceptance, Purpose,* and *Enthusiasm.* Pearson's *r* quantifies the strength of the variables' relationships. Correlational findings indicate that age was significantly negatively correlated with *A-APDQ Purpose* subscale scores (r (96) = -.24, $p < .05$). Race, gender, professional discipline, and work setting were categorical variables therefore, eta squared ($\eta^{2)}$ was used to determine these variables' associations to the dependent variables and determine whether further testing was indicated.

Eta squared measured effect sizes or percentage of variance in the dependent variables accounted for by changes in the following categorical demographic variables (Cohen, 1992): Race, Gender, Professional Discipline, and Work Setting. Effect sizes were categorized based on the following Cohen (1992) parameters: .02 to .12 = small effect size; .13 to .25 = medium effect size; ≥ .26 = large effect size. Medium to large effect sizes warrant further analysis such as ANOVA (Cohen, 1992). However, the effect sizes for Race, Gender, Professional Discipline, and Work Setting fall in the small effect size range (see Table 4.6), therefore, no further analysis

is indicated. Small effect sizes suggest that Race, Gender, Professional Discipline, and Work Setting do not significantly influence participants' attitudes as measured by the *A-APDQ*.

Table 4.6
Demographic Variables' Attitude Correlations

Variable	Age	Exp	C.O	1	2	3	4	5
Age	-							
Expr.	.70**	-						
C.O	.05	-.11	-					
Security	-.13	.01	.08	-				
Enjoy.	-.05	.05	.01	.48**	-			
Accept.	-.12	.00	.05	.81**	.58**	-		
Purpose	-.24*	-.15	.14	.73**	.66**	.75**	-	
Enthus.	-.08	-.02	.00	.74**	.49**	.73**	.68**	-

(Note. ** Correlation is significant at the .01 level (2 tailed). * Correlation is significant at the .05 level (2 tailed) C.O. = Coworker Observation. 1 = Security; 2 = Enjoyment; 3 = Acceptance; 4 = Purpose; 5 = Enthusiasm)

Research Question One

The first research question was: Is there a main effect for the level of clinical contact (i.e., No Contact versus Low Contact versus High Contact) on mental health professionals' attitudes toward antisocial personality disorder as measured by the *Adapted-Attitudes toward Personality Disorders Questionnaire*? A one-way factorial MANOVA was conducted to determine whether the contact groups (i.e., No Contact, Low Contact, High Contact) differed in terms of their *A-APDQ* subscale scores. Assumptions of multivariate normality, homogeneity of variance and covariance, and independence of observations were verified prior to statistical analysis. Prior to

conducting the MANOVA, a Kolmogorov-Smirnov test was conducted to verify the assumption of multivariate normality. Results indicated that the *Security* and *Enjoyment* subscale scores on the *A-APDQ* were normally distributed. However, the *Acceptance*, *Purpose*, and *Enthusiasm* subscales scores did not meet the assumption of multivariate normality. Kolmogorov-Smirnov results, coupled with the highly correlated subscale scores, suggest that the *APDQ* subscales identified by Bowers and Allan (2006) may be best interpreted as a total score rather than subscales. The *A-APDQ* total score Kolmogorov-Smirnov statistic of .082 and *p* value of .10 supports using this instrument's total score rather than subscale scores. However, because MANOVAs are robust against deviations from multivariate normality, the subscale analysis was conducted (Manly, 2005). Additionally, a series of Pearson correlations were performed to test the assumption that the dependent variables (*A-APDQ* subscale scores) were correlated. Results from this analysis indicated that the scales are highly correlated and suggest that the MANOVA assumption of dependent variable correlation was well met. (See Table 4.8 for results.) Additionally, the Box's M value of 67.3 was associated with a *p* value of .579 indicating a non-significant result. Thus, the covariance matrices between groups were assumed to be equal for the purposes of the MANOVA. The sample size (N = 98) and the data's distribution among the groups met the required specifications for this analysis (Cohen, 1992).

Table 4.7

Kolmogorov-Smirnov Tests for Multivariate Normality

Variable	Statistic	Df	Sig.
Security	.080	98	.14
Enjoyment	.061	98	.20*
Acceptance	.097	98	.02
Purpose	.103	98	.01
Enthusiasm	.180	98	.00

(*Note.** This is a lower bound of the true significance. Acceptance, Purpose, and Enthusiasm scales reject the null hypothesis $p < .05$ that the data is normally distributed.)

Table 4.8

Pearson Correlation for A-APDQ Scales

Variables	Security	Enjoyment	Acceptance	Purpose	Enthusiasm
Security	-				
Enjoyment	.48**	-			
Acceptance	.81**	.58**	-		
Purpose	.73**	.66**	.75**	-	
Enthusiasm	.74**	.49**	.73**	.68**	-

(*Note.* **p < .01 [two tailed].)

Means and standard deviations of subscale scores are displayed in Table 4.9. 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, which indicated 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 *A-APDQ* scores, the

univariate main effects were examined with follow-up univariate ANOVAs. Univariate ANOVAs were used to determine which of the five *A-APDQ* subscale scores had significant differences between 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. More specifically, among the three groups (i.e., No Contact, Low Contact, High Contact) participants (N = 98) were significantly different in terms of their *Enjoyment*, *Acceptance*, and *Purpose* subscale scores. 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* subscales scores ($\eta^2 = .08$). 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 4.9 to indicate directionality.

Table 4.9
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 *A-APDQ* subscales, and results are displayed in table 4.10. Only scales containing statistically significant ($p < .05$) were included in this table. Therefore, the *Security* and *Enthusiasm* subscale were dropped, meaning no pairwise comparisons were conducted along these factors, because these factors were non-significant.

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*)* and 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 as were the differences between Low Contact group (*M* = 4.87) and High Contact group (*M* = 4.92).

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) were non-significant as were the differences between the Low Contact group (*M* = 3.53) and High Contact group (*M* = 4.32).

Research Question Two

Research question two was: 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*? A factorial MANOVA was used to examine how the two groups (i.e., Yes Victimization versus No Victimization) differ along the five scales of the *A-APDQ*. The multivariate assumptions of normality, homogeneity of variance and independence of observations were verified in research question one and hold true for all levels of this multivariate analysis (Manly, 2005). 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 λ = .97 F (5, 88) = .47 $p > .05$, partial η^2 = .03. Mean scores for history of criminal victimization (Yes Victimization versus No Victimization) are shown in table 4.11.

Research Question Three

Research question three was: 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*? A two-way factorial MANOVA was used to determine whether the influence of level clinical contact on participants' attitudes, as measured by the *A-APDQ*, was contingent upon their being crime victims. The multivariate assumptions were verified prior to conducing the omnibus analysis for the three research questions. 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 λ = .91 F (10, 176) = .85 $p > .05$, partial η^2 = .05). To illustrate directionality, the mean scores for interaction effect are displayed in table 4.12.

Table 4.10
Pairwise comparisons for levels of clinical contact

Dependent Variable	(I) Contact Group	(J) Contact Group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Enjoyment	No Contact	Low Contact	-.22	.14	.38	-.57	.13
		High Contact	-.75*	.17	.00	-1.17	-.32
	Low Contact	No Contact	.22	.14	.38	-.13	.57
		High Contact	-.53*	.18	.01	-.97	-.08
	High Contact	No Contact	.75*	.17	.00	.32	1.17
		Low Contact	.53*	.18	.02	.08	.97
Acceptance	No Contact	Low Contact	-.44	.18	.05	-.89	.00
		High Contact	-.56*	.22	.02	-1.12	-.05
	Low Contact	No Contact	.44	.18	.05	-.00	.89
		High Contact	-.14	.23	1.00	-.70	.42
	High Contact	No Contact	.59*	.23	.03	.05	1.12
		Low Contact	.14	.23	1.00	-.42	.70
Purpose	No Contact	Low Contact	-.55	.26	.11	-1.18	.08
		High Contact	-.79*	.32	.05	-1.57	-.01
	Low Contact	No Contact	.55	.26	.11	-.08	1.18
		High Contact	-.24	.34	1.00	-1.07	.60
	High Contact	No Contact	.79*	.32	.05	.01	1.57
		Low Contact	.24	.34	1.00	-.60	1.07

(Note. Bonferroni adjusted. Security and Enthusiasm scales were not included because no main effect was found to be significant for these scales. Based on observed means. * The mean difference is significant at the .05 level.)

Table 4.11
Mean A-APDQ scores for history of criminal victimization

Dependent Variable	History of criminal victimization	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Security	No	4.63	.10	4.44	4.83
	Yes	4.72	.15	4.42	5.01
Enjoyment	No	2.94	.08	2.77	3.10
	Yes	2.90	.13	2.64	3.15
Acceptance	No	4.70	.10	4.49	4.90
	Yes	4.71	.16	4.39	5.03
Purpose	No	3.92	.14	3.65	4.20
	Yes	4.03	.21	3.61	4.45
Enthusiasm	No	3.70	.12	3.45	3.95
	Yes	3.59	.19	3.21	3.97

(*Note*. No = No Victimization group, Yes = Yes Victimization group)

Reliability

As discussed in Chapter 3, reliability, or internal consistency, of the *A-APDQ* is described with a Cronbach's alpha statistic. Cronbach's alpha is a commonly used test statistic to describe instruments' internal consistency (Heppner et al., 2008). This statistic is used in this study to determine the influence of instrumental adaptations on the *A-APDQ*. Scores above .7 are commonly considered acceptable for human sciences studies (Heppner et al., 2008). Cronbach's alpha scores are displayed in table 4.13.

Table 4.12
Mean Interaction for Clinical Contact and Criminal Victimization

Dependent Variable	Contact Group	Criminal Victimization	Mean	Std. Error	95% Confidence Interval	
					Lower Bound	Upper Bound
Security	No	No	4.41	.15	4.12	4.71
		Yes	4.48	.18	4.12	4.84
	Low	No	4.61	.16	4.30	4.92
		Yes	4.83	.24	4.35	5.31
	High	No	4.88	.21	4.47	5.29
		Yes	4.86	.34	4.18	5.54
Enjoyment	No	No	2.65	.12	2.41	2.90
		Yes	2.51	.15	2.21	2.81
	Low	No	2.81	.13	2.56	3.07
		Yes	2.83	.20	2.43	3.23
	High	No	3.34	.17	3.01	3.68
		Yes	3.35	.28	2.78	3.91
Acceptance	No	No	4.44	.15	4.14	4.75
		Yes	4.21	.19	3.84	4.59
	Low	No	4.69	.16	4.37	5.02
		Yes	5.04	.25	4.54	5.54
	High	No	4.96	.21	4.53	5.38
		Yes	4.88	.36	4.17	5.59
Purpose	No	No	3.51	.20	3.10	3.91
		Yes	3.56	.25	3.06	4.05
	Low	No	4.03	.22	3.60	4.46
		Yes	4.13	.34	3.46	4.80
	High	No	4.24	.28	3.67	4.80

		Yes	4.40	.48	3.45	5.35
Enthusiasm	No	No	3.33	.19	2.96	3.70
		Yes	3.42	.23	2.97	3.87
	Low	No	3.77	.20	3.38	4.16
		Yes	3.65	.30	3.04	4.26
	High	No	4.00	.26	3.49	4.51
		Yes	3.70	.43	2.84	4.56

Table 4.13
Adapted- Attitudes toward Personality Disorders Questionnaire Scoring Properties

Scale	Scoring	No. of Items	Cronbach's α
Enjoyment/Loathing	Standard	15	.92
Security/Vulnerability	Reverse	10	.92
Acceptance/Rejection	Reverse	5	.85
Purpose/Futility	Reverse	3	.86
Enthusiasm/Exhaustion	Reverse	2	.75

Chapter Review

This chapter provides a review of this study's sampling procedure, participants' descriptive statistics, and a review of statistical analyses used to answer the research questions. A 3 X 2 factorial MANOVA was used as an omnibus analysis to answer three research questions examining whether level of clinical contact (i.e., No Contact, Low Contact, High Contact) and history of criminal victimization (i.e., Yes Victimization versus No Victimization) influenced mental health professionals' attitudes toward clients with ASPD. Findings indicated that level of

clinical contact significantly influences mental health professionals' attitudes toward clients with ASPD. Resultantly follow-up analyses were conducted for this factor. Findings revealed no significant effect for history of criminal victimization nor an interaction effect. Chapter five contains a review and discussion of the results as well as discussion of limitations, implications, and recommendations for future research.

CHAPTER 5: DISCUSSION

Introduction to the Chapter

This chapter provides a study review, a discussion of the results, a review of the study's limitations, and a discussion of this study's implications, contributions, and recommendations for future research.

Study Review

This study examined the influence of social learning factors (i.e., level of clinical contact and criminal victimization) on mental health professionals' attitudes toward clients with antisocial personality disorder (ASPD). Chapter two established that despite studies suggesting that mental health professionals' attitudes are negatively influenced by clients with personality disorders (PDs) (Bowers et al., 2006; Eren & Sahin, 2016; Schwartz et al., 2007), few studies have been specific to ASPD, and no studies have examined the underlying social learning influences of level of clinical contact and history of criminal victimization. The current study examined the influence of social learning factors (i.e., level of clinical contact and criminal victimization) on mental health professionals' attitudes toward clients with ASPD by administering an adapted version of the *Attitudes toward Personality Disorders Questionnaire* (*APDQ*) (Bowers & Allan, 2006) to a purposive sample of Medicaid-approved mental health providers in North Carolina.

This study examined mental health professionals' attitudes through the theoretical lens of Bandura's (1977; 1989) social learning theory. Bandura (1977; 1989) posits that learning occurs in a social context through direct experience, observational learning, and reinforcement. Because ASPD is associated with behaviors that deviate from social norms and expectations (APA,

2013), social learning theory (Bandura, 1977; 1989) provides a lens from which to understand how mental health professionals' attitudes are influenced by people with ASPD.

Instrumentation for this study included the adapted version of *The Attitudes toward Personality Disorders Questionnaire* (*APDQ*) and an author-developed *Demographic Questionnaire*. The *Demographic Questionnaire* included items addressing the independent variables: (a) level of clinical contact and (b) history of criminal victimization.

An a priori power analyses was conducted using G*Power to determine appropriate sample size. Power parameters were based on Cohen's (1992) criteria and indicated that a minimum sample of 46 was needed to detect moderate to large effects with a power of .80. To represent the population of Medicaid-approved mental health providers, this study examined a purposive sample of Medicaid-approved mental health providers in North Carolina. A list of Medicaid-approved mental health providers' email addresses was used to recruit participants. Participants were emailed an invitation to participate in a study examining helping professionals' attitudes toward clients with ASPD. Of the 5679 emails sent, 98 (2%) self-selected participants completed the survey from October 27, 2016 to November 10, 2016. Data was collected through an online survey administration and data collection instrument, Qualtrics, and analyzed with statistical software, SPSS 24.

Prior to examining the influence of social learning factors (i.e., level of clinical contact and criminal victimization) on mental health professionals' attitudes toward clients with ASPD, descriptive statistics were analyzed to describe the sample. Descriptive data included age, race, gender, years of experience, professional discipline, licensure, work setting, and coworker observation. After analyzing descriptive data, tests were performed to ensure that the data adequately met MANOVA assumptions of multivariate normality, homogeneity of

variance/covariance, and independence of observations (Manly, 2005). Following MANOVA assumption verification, a 3 X 2 factorial MANOVA was conducted to answer three research questions established in Chapter One and Chapter Three. Follow-up analyses were conducted for factors determined to be statistically significant. An alpha level of .05 was used to determine statistical significance per standard social science research protocol (Heppner et al., 2008).

Discussion

The following sections contain a review of the results of this study's examination of the influence of social learning factors (i.e., level of clinical contact and criminal victimization) on mental health professionals' attitudes toward clients with ASPD. Descriptive data are reviewed to conceptualize the study sample. Results are reviewed through the lens of Bandura's (1977) social learning theory and past research.

Sample Description

Participants (N = 98) were described in terms of their personal and professional characteristics. Personal characteristics included: age, race, and gender. Professional characteristics included professional discipline and licensure, years of experience, work setting and coworker observation.

Personal Characteristics

Gender and age. Of the 98 participants in the current study, 67 (68.4%) identified as female and 31 (31.6%) identified as male. Gender did not significantly influence participants' attitudes as measured by the *A-APDQ* subscales. More specially, the small effect size (Cohen, 1992) of gender on *A-APDQ* subscale scores suggests that men and women have similar attitudes toward clients with ASPD. The current finding differ from that of Jussab and Murphy's (2015) qualitative study where a largely female sample (n = 5; 72%) reported feeling fearful and unsafe

because they had been verbally or physically attacked by clients in the past. From a social learning perspective, these results suggest that gender attitudinal influences may be influenced by mental health professionals' levels of clinical contact with clients with ASPD. However, Jussab and Murphy's (2015) study examined mental health professionals' experiences of client violence rather than ASPD. Although violence is common in clients with ASPD (APA, 2013), many clients with the disorder are not violent (Black, 2013). Further studies could determine whether gender influences mental health professionals' attitudes toward clients with ASPD.

The mean age for the current sample was 53.03 (*SD* = 10.54) years, with 29.6 % (n = 29) of participants being between 60 and 69 years old. The current study found that age was significantly negatively correlated (r (96) = -.24, $p < .05$) with decreased scores on the *Purpose* subscale of the *APDQ*.

A prior study by Schwartz and colleagues (2007) examined mental health professionals-in-training's cognitive and emotional responses to symptoms of ASPD. Schwartz and colleagues' (2007) study included participants (N = 73) from graduate level mental health programs with a mean age of 33.03 (SD = 10.23) years. Fifty-five (75%) participants identified as female and 18 (25%) identified as male. Although gender distributions from Schwartz and colleagues (2007) are similar to the current study, age distribution is highly disparate; with the sample from Schwartz and colleagues (2007) having a mean age 20 years younger than the current study. Schwartz and colleagues (2007) findings that mental health professionals-in-training have negative cognitive and emotional reactions when exposed to symptoms of ASPD parallel findings from the current study which included older adults. As previously reported, the current study found that age was significantly correlated with decreased scores on the *Purpose* subscales of the *APDQ*. Because *Purpose* subscale scores reflect self-efficacy (Bowers et al., 2006), older

mental health professionals' decreased scores suggest that they have less confidence in their abilities to treat clients with ASPD. Self-efficacy results from successful past experiences (Bandura & Adams, 1977). Therefore, older mental health professionals' decreased *Purpose* subscale scores may reflect negative treatment experiences (e.g. outcomes) common with clients with ASPD. From a social learning perspective, older mental health professionals may have experienced more negative attitudinal reinforcement than younger mental health professionals because they have been exposed to more social learning influences including negative experiences with clients with ASPD, media, peer groups, professional organizations, educational systems, and political organizations than younger professionals (Bandura & Adams, 1977). Because increased age is associated with increased experience (r (96) = .7, $p < .05$) and lack of causal modeling data, attribution for decreased *Purpose* scores cannot be inferred (Heppner et al., 2008). Future studies are needed to determine the role of age, experience, and self-efficacy in mental health professionals' attitudes toward clients with ASPD. The *APDQ* subscales *Security, Enjoyment, Acceptance* and *Enthusiasm* were not significantly correlated with participant age.

Years of counseling experience. Participants' years of experience did not significantly influence their *A-APDQ* subscale scores (Table 4.6, p. 73). These findings are in keeping with those of Black and colleagues (2011) who found that experienced professionals' attitudes toward clients with personality disorders were not contingent upon their years of professional experience. From a social learning perspective and based on the results of research question one of the current study (p. 93), this lack of effect suggests that mental health professionals' levels of clinical contact with clients with ASPD, rather than years of clinical experience may influence relationships between attitudes and professional experiences. For example, mental health professionals with more experience specific to clients with ASPD may view negative behaviors

of clients with ASPD as symptomatic rather than experience feelings of domination and intimidation common to mental health professionals with little experience with clients with ASPD (Schwartz et al., 2007). However, because of the cross-sectional and correlational design of both studies, age and experience causal attributions cannot be made (Heppner et al., 2008). Further studies, such as a longitudinal experimental design, could tease apart the roles of age, experience, and clinical contact in attitudes toward clients with ASPD.

Race. Racial minorities were underrepresented in the current sample. Seventy-eight (n = 78; 79.6%) participants identified as Caucasian/White, 15 participants (n = 15; 15.3%) identified as African American/Black, two participants (n = 2; 2%) identified as Hispanic/Latino, one participant (n = 1; 1%) identified as Native American/American Indian, and two participants (n = 2; 2%) identified as other. This sample illustrates racial disparities between clients with ASPD and mental health professionals.

Although ASPD occurs equally among all races and ethnicities, it is overly diagnosed in minority populations because of social and cultural dissonance (Black, 2013; NICE, 2010 Samenow, 2014). That is, people with ASPD are often incarcerated (APA, 2013), and minorities, specifically Black and Hispanic populations, are overrepresented in the criminal justice system (Carson, 2015). Further, minorities are often diagnosed with ASPD based on their criminal histories rather than exhaustive diagnostic processes (Black, 2013; NICE, 2010), and ASPD is common in urban, low-income areas, which are frequently associated with minority populations (APA, 2013).

The majority of participants (n = 78; 79.6%) in this study were White/Caucasian, which reflects the importance of multicultural competence in treating clients with ASPD. Because ASPD is commonly associated with minority populations, poor therapeutic relationships may

linked to cultural and racial issues rather than symptoms of ASPD. For example, White counselors may interpret Black males' distrust as symptomatic of ASPD rather than a multicultural issue. Symptoms of ASPD such as distrust for authority, irritability, and aggression, may reflect racial tensions rather than pathology. Although findings indicated that race was did not significantly influences participants' attitudes as measured by the *A-APDQ*, the attitudinal influence of racial disparities between mental health professionals and clients with ASPD warrants further research. The underrepresentation of minority participants in this study may mirror the underrepresentation of minority mental health professionals working with clients with ASPD.

Professional Characteristics

Professional discipline and licensure. Participants (N = 98) met licensure requirements for their specific disciplines. Attitudinal differences among professional disciplines (professional counseling, social work, psychology, psychiatry, nursing) were not significantly different based on their derived small effect sizes (Cohen, 1992). A study by Black and colleagues (2011) found that professional disciplines differed in their attitudes toward clients with personality disorders. However, further analysis indicated that attitudinal differences were associated with different levels clinical contact with clients with personality disorders, such as nurses, who frequently interact with clients with personality disorders compared to psychiatrists who interact less (Black et al., 2011). Findings from the current study support that professional discipline differences may be influenced by participants' levels of clinical contact with clients with ASPD. Research among professional disciplines shows mixed results (Black et al., 2011; Bowers et al., 2006) and warrants further research.

From a social learning perspective, differences among disciplines may result from different educational experiences. For example, psychiatrists and nurses likely treat clients from a medical model, whereas professional counselors, psychologists, and social workers likely conceptualize clients from a biopsychosocial perspective. Additionally, discipline specific observational learning occurs when mental health professionals enter fieldwork training such as internships and residency programs because they are exposed to trainers (i.e., models) in the attentional processes function of social learning (Bandura, 1977).

Years of experience. Participants (N = 98) mean years of experience was 23.18 (*SD* = 10.80) which indicates that this study reflects attitudes of highly experienced mental health professionals rather than professionals who are new to the mental health field. Eren and Sahin (2016) found that in a sample of 332 mental health professionals with a mean years of experience of 9.88 (*SD* = 7.82) that mental health workers years of experience were significantly positively ($p < .05$) correlated with positive attitudes. However, as previously identified, Kurtz and Turner (2007) found that in a sample of mental health professionals-in-training, participants experienced negative cognitive and emotional reactions and prefer not to encounter clients with ASPD. Findings from the current study suggest that participants' years of experience do not significantly influence their attitudes toward clients with ASPD (table 4.6, p. 73). From a social learning perspective (Bandura, 1977) these findings suggest that mental health professionals' attitudes toward ASPD do not change with more experience, rather the type of experience (i.e. level of clinical contact with ASPD) is what influences their attitudes.

However, because this study utilizes a cross-sectional design, drawing these conclusions may be spurious (Heppner et al., 2008). These results may reflect a polarization effect associated with mental health professionals' attitudes toward ASPD (Heppner et al., 2008). For example,

mental health professionals with negative attitudes toward clients with ASPD may avoid working with people with the disorder, change professions, or choose not to participate in studies about clients with ASPD; whereas mental health professionals with positive attitudes toward people with ASPD may choose to work in settings where ASPD is common, seek education and training specific to ASPD, and opt to participate in studies regarding clients with ASPD. A longitudinal design could determine how mental health professionals' attitudes change throughout their professional development.

Work setting. The majority (n = 64; 65.3%) of participants worked in private outpatient settings. The small effect size of work setting on mental health professionals' attitudes toward clients with ASPD indicate that work setting does not significantly influence professionals' attitudes toward clients with ASPD. However, Lent and Schwartz (2012) found that mental health professionals who work in private outpatient settings experienced less burnout, or mental/physical exhaustion resulting from job stress, than mental health therapists who work in public outpatient, or inpatient settings. Clients with ASPD usually lack insurance and can rarely afford to pay for mental health services (NICE, 2010). They seldom see the need to voluntarily engage in insight oriented therapies such as counseling (Black, 2015). Instead, clients with ASPD seek short-term, goal specific treatment such as detoxification, crisis stabilization, or medication management services which are most commonly offered in public agencies (NICE, 2010).

From a social learning perspective, mental health professionals in private outpatient settings have less clinical contact (i.e., direct and observed) to clients with ASPD than mental health professionals in public agencies. Additionally, findings from Lent and Schwartz (2012) suggest that agencies where clients with ASPD are often treated (i.e., public settings) are

operated by professionals who experience increased job stress. This increased job stress may exacerbate socially learned attitudes toward ASPD. However, the study design by Lent and Schwartz (2012) included survey research which does not account for time within a work setting. Often, mental health professionals begin their careers in public agencies to fulfill licensure requirements and then move to private agencies or private practice. Because of these mixed results, future research is needed to determine the relationship between work settings, clinical contact with clients with ASPD, and attitudes toward clients with ASPD.

Prior studies (Black et al., 2011; Eren & Sahin, 2016; Kurtz & Turner, 2007; Lent & Schwartz, 2012) suggest a relationship between years of experience, work setting, and attitudes toward clients with ASPD. The current study suggests that the influence of these variables may be influenced by level of clinical contact with clients with ASPD. According to social learning theory (Bandura, 1977), mental health professionals' behaviors and attitudes result from environmental reinforcement. Therefore, mental health professionals likely seek out work settings that are congruent with their attitudes and belief systems. More specifically, they choose different work settings as their beliefs and attitudes change with increased professional experience. Future longitudinal studies may examine mental health professionals' career decision making relating to work settings where ASPD is common.

Coworker observation. Participants mean score of 3.11 (*SD* = 1.15) on the coworker observation item suggested that mental health professionals were exposed to coworkers' intolerance of ASPD symptomatic behaviors. However, coworker observation was not significantly correlated with *A-APDQ* scale scores (Table 4.6, p. 72). These findings suggest that participants (N = 98) were not susceptible to observational learning of negative attitudes, which further suggests that clinicians' levels of clinical contact with clients with ASPD may build

resilience toward negative attitudes and behaviors socially modeled by coworkers (Bandura, 1977; 1989).

Sample Summary

Personal (i.e., age, gender, race) and professional (i.e., professional, discipline, licensure, years of experience, work setting, and coworker observation) demographic information was obtained from 98 Medicaid-approved mental health professionals in North Carolina. Descriptive data, data correlations, and measures of effect sizes based on Cohen (1992) parameters were used describe participants and link the current study findings with prior research. The current finding suggest that personal characteristics, specifically race and gender, do not influence mental health professionals' attitudes. Age was significantly associated with decreased *Purpose* scores, however further research is necessary to differentiate the influence of age versus level of clinical contact with clients with ASPD on mental health professionals' attitudes toward clients with ASPD. Professional characteristics including professional discipline, work setting, years of experience, and coworker observation did not significantly influence participants' attitudes as measured by the *A-APDQ*

Research Question One

Research question one was: Is there a main effect for the level of clinical contact (i.e., No Contact, Low Contact, or High Contact) on mental health professionals' attitudes toward antisocial personality disorder as measured by the *Adapted-Attitudes toward Personality Disorders Questionnaire*? The purpose of this research question was to examine whether participants' attitudes toward clients with ASPD were significantly different based on three levels of clinical contact (i.e., No Contact, Low Contact, High Contact). Participants (N = 98) were assigned to three groups based on their level of weekly clinical contact with clients with

ASPD: No Contact Group = 0 clients with ASPD per week; Low Contact Group = 1 to 2 clients with ASPD per week; High Contact Group ≥ 3 clients with ASPD per week. The groups were compared in terms of their scores along the five scales of the *A-APDQ* with a 3 X 2 factorial MANOVA.

Results indicated that level of clinical contact significantly influences participants' attitudes as measured by the *A-APDQ (*Wilkes $\lambda = .785$, F (10.0, 176.0) = 2.27, $p < .05$). Follow-up univariate ANOVAS revealed that the statistical significance was accounted for by participants' *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. Furthermore, mean scores along all five *A-APDQ* scales increased with increased levels of clinical contact.

Findings suggest that mental health professionals who frequently interact with clients with ASPD have more positive attitudes in terms of *Enjoyment, Acceptance, and Purpose,* toward clients with ASPD than mental health professionals who never or rarely interact with clients with ASPD. As discussed in Chapter 3, Bowers and colleagues (2006) define *Enjoyment* as feelings of warmth and caring; *Acceptance* as feelings of tolerance; and *Purpose* as feelings of meaning. These findings are consistent with findings from Black and colleagues (2011), who found that mental health professionals' attitudes toward clients with personality disorders were higher (increased score indicated positive attitudes) among mental health professionals with high levels of clinical contact with clients with personality disorders. Findings from the current study, coupled with findings from Black and colleagues (2011), suggest that level of clinical contact influences mental health professionals' attitudes toward clients with personality disorders, specifically ASPD. Through a social learning lens, these findings suggest that direct and

observed experience with clients with ASPD improves mental health professionals' attitudes. Increased clinical contact helps mental health professionals to normalize behaviors of clients with ASPD and decrease emotional and behavioral reactivity toward them. These findings indicate that the initial shock mental health professionals-in-training experience toward symptoms of ASPD (Schwartz et al., 2007) decreases or become adaptive rather than maladaptive as mental health professionals have increased clinical contact with clients with ASPD. Additionally, the experience of positive emotions as measured by *Enjoyment*, *Acceptance*, and *Purpose A-APDQ* scales can become self-reinforcing (Bandura, 1977) because they occur when mental health professionals' have contact with clients with ASPD.

Reciprocally, clients with ASPD often use behaviors such as violence, manipulation, and bullying because these behaviors have been reinforced in the past (APA, 2013; Black, 2015; NICE, 2010). Through the social learning cycle, mental health professional decrease reactivity may extinguish negative behaviors of clients with ASPD (e.g., violence, bullying). However, the cross-sectional design of these studies limits their generalizability and causal inferences may be inaccurate (Heppner et al., 2008).

As previously discussed, these findings may reflect polarization effects rather than causative effects of levels of clinical contact. Longitudinal findings by Bowers and colleagues (2005) suggest that attitudes of prison officers decline with increased levels of contact with clients with ASPD. These findings add validity to polarization effects and suggest that mental health professionals with better attitudes toward clients with ASPD choose work in settings where ASPD is common and mental health professionals with poor attitudes toward clients with ASPD may avoid clients with ASPD or change professions, and are unlikely to be represented in survey research regarding clients with ASPD. However, Bowers and colleagues (2005) suggest

that social factors such as education, supervision, and environmental factors moderate attitudinal development. Findings from the current study coupled with Bowers and colleagues (2005) suggests that observational learning (e.g., education, supervision) may override negative direct experiences with clients with ASPD (e.g., bullying, violence). Future studies are needed to determine the influence of social learning factors such as education, supervision, and environment. However, the current study findings suggest that level of clinical contact with clients with ASPD influences mental health professionals' attitudes toward clients with ASPD.

Research Question Two

Research question two was: 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*? The purpose of this research question was to understand whether criminal victims' attitudes differed from non-victims toward clients with ASPD. A 3 X 2 factorial MANOVA found that differences between the two groups (i.e., Yes Victimization versus No Victimization) were non-significant (Wilkes $\lambda = .97$ F (5, 88) = .47 $p > .05$, partial $\eta^2 = .03$). Findings from this research question suggest that criminal victimization does not significantly influence mental health professionals' attitudes toward clients with ASPD.

Findings from Posick (2013) indicate that criminal victimization is associated with future engagement in criminal activities. Posick's (2013) findings suggest that criminal victimization negatively influences the future behaviors of those who are victimized. However, findings from the current study are contradictory. This discrepancy is likely accounted for by differing populations, environmental factors, and mental health professionals' motivations.

First, Posick (2013) used a sample of adolescents to determine how history of criminal victimization influences future criminal acts such as violence. The current study examines adults and does not account for participants' histories of criminal offenses during adolescence nor adulthood. Similarly, Posick's (2013) findings are correlational and do not account for causative or longitudinal effects. Adolescents may engage in crime for a variety of reasons including family influences, peer influences, exposure to crime, abuse and neglect (United States Office of the Surgeon General, 2001). Adolescents who commit crimes during adolescence often do not engage in criminal activities later in life (Samenow, 2014).

Posick (2013) suggests that environmental factors mediate the relationship between criminal victimization and future criminal acts. The current study found that history of criminal victimization was not significantly correlated with participant work setting, coworker observation, or level of clinical contact. These findings suggest that mental health professionals may have unique responses to criminal acts. Mental health professionals often help others create meaning from their past experiences (Corey & Corey, 2011). Mental health professionals who are crime victims may enter helping professions to better cope with their past victimization. Therefore, mental health professionals who are crime victims may be empathetic toward criminal perpetrators, rather than punitive such as was found in a study of mock jurors by O'Toole and Sahir (2014). Social learning factors such parental bonding (Posick, 2013), socioeconomic status, belief systems, media, religion, and culture may also influence how criminal victims' attitudes and behaviors are influenced by criminal acts (Bandura, 1977; 1989).

Research Question Three

Research question three was: Is there an interaction between level of clinical contact and histories of criminal victimization on mental health professionals' attitudes toward antisocial

personality disorder as measured by the *Adapted-Attitudes toward Personality Disorders Questionnaire*? The purpose of this question was to examine whether level of clinical contact influenced mental health professionals' attitudes toward clients with ASPD differently for crime victims versus non-crime victims (i.e., Yes Victimization versus No Victimization). A factorial MANOVA indicated 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 $\eta^2 = .05$). Findings indicated that participants' *A-APDQ* scores increased with increased levels of clinical contact (i.e., No Contact, Low Contact, High Contact) similarly for crime victims and non-crime victims (i.e., Yes Victimization versus No Victimization).

No significant differences were found between the Yes Victimization and No Victimization groups along levels of clinical contact as measured by the *A-APDQ*. . These findings support that clinical contact with clients with ASPD may moderate the influence of past criminal victimization on mental health professionals' attitudes. Social learning theory (Bandura, 1977; 1989; Bandura & Adams, 1977) explains how increased levels of clinical contact may reduce affective symptoms of past criminal victimization such as anger, anxiety, and fear by decreasing emotional reactivity.

According to Bandura and Adams (1977) "Those who persist in subjectively threatening activities will eventually eliminate their inhibitions through corrective experience, whereas those who avoid what they fear, or who cease their coping efforts prematurely, will retain their self-debilitating expectations and defensive behavior" (p. 288). Therefore, clinical contact with clients with ASPD may constitute a curative effect for mental health professionals who are crime victims. As previously discussed, clients with ASPD often trigger feelings of anger, anxiety, and

fear in mental health professionals (Evans, 2011; Kurtz & Turner, 2007; Schwartz et al., 2011). From a social learning perspective, these aversive reactions are symptomatic of past socially learned beliefs and attitudes (Bandura & Adams, 1977). Mental health professionals' attitudes improve with increased levels of clinical contact because they are exposed to stimuli (i.e., clients with ASPD) that trigger aversive reactions, therefore, over time they become desensitized to these aversive reactions (Bandura & Adams, 1977). For example, mental health professionals who are crime victims may initially experience feelings of anger, hatred, and anxiety when they are exposed to clients with ASPD. However, as they continue to work with clients with this disorder these reactions decrease, thereby improving their attitudes toward clients with ASPD. Bandura and Adams (1977) posit that factors such as self-efficacy mediate this desensitization, which holds important implications for mental health professionals' supervision and training in treating clients with ASPD. Implications are discussed later in the chapter.

Limitations

Study limitations were briefly identified in Chapter Three and consist of limitations in research design, sampling, and instrumentation. Research design and sampling limitations are discussed in terms of threats to internal validity and threats to external validity. Internal validity refers to causative inferences and external validity refers to how well the study's results can be generalized to a specific population (Heppner et al., 2008) such as Medicaid-approved mental health professionals in the United States. Instrumentation limitations are discussed in terms of construct validity, or how accurately this study measures mental health professionals' attitudes toward clients with ASPD (Heppner et al., 2008).

Research Design Limitations

This study used an online survey to examine mental health professionals' attitudes toward clients with ASPD. Online surveys have gained popularity because they enhance researchers' geographical scope without adding cost and produce timely results (Heppner et al., 2008). Survey research examines the strength of association between variables (May, 2001), such as those between independent variables (i.e., level of clinical contact and history of criminal victimization) and dependent variables (i.e., *A-APDQ* scores). However, survey designs limit researchers' abilities to show causal relationships in cross-sectional studies (May, 2001).

Threats to internal validity. This study's cross-sectional design limits causative inferences (Heppner et al., 2008). Cross-sectional studies are inexpensive and provide prompt results when compared to experimental or longitudinal studies (Hulley, Cummings, Browner, Grady, & Newman, 2007). However, cross-sectional study designs limit researchers' abilities to infer causation because they do not account for time effects (Hulley, 2007). For this study, the cross-sectional design does not account for mental health professionals' attitude changes over time, how these attitudes shape participants' decision making (e.g., career decision making), nor how participants' attitudes affect therapeutic relationships. As previously discussed, mental health professionals' attitudes toward clients with ASPD are likely contingent upon how much time they spend with clients with ASPD. This study's cross-sectional design omits valuable longitudinal information which may illustrate the role of socially learned beliefs and behaviors in therapeutic relationships. Although the theoretical framework of social learning theory helps conceptualize mental health professionals' attitudinal processes (May, 2001), causal attributions for this study are speculative and based on variable associations. Further studies are necessary to determine causal factors for mental health professionals' attitudes toward clients with ASPD.

Additionally, future studies may determine the amount of clinical contact necessary to influence mental health professionals' attitudes toward clients with ASPD. Nevertheless, cross-sectional designs often serve as foundations for future studies such as longitudinal designs (e.g., cohort studies) and/or experimental designs (Hulley, 2007).

Threats to external validity. This online survey took place between October 27, 2016 and November 10, 2016 and overlapped with local, state, and national elections including the presidential election. Mental health, substance abuse, and criminality are topics of debate and social division, which often arouse emotional reactions from the general population (Slife, 2012). From a social learning perspective, this emotional reactivity is exacerbated by media, religious, family, and other social influences (Bandura, 1977). Because mental health, substance abuse, and crime are common with ASPD (APA, 2013), the political climate during which data was collected may have influenced participants' responses. For example, participants favoring increasing criminal punishment may have responded differently during this period because they were exposed to the media addressing crime or were engaging in political discussions regarding crime as a result of the elections.

Sampling Limitations

This study used a purposive sampling design to examine Medicaid-approved mental health professionals' attitudes toward clients with ASPD. Purposive sampling is a non-probability sampling technique used to gather data from a predefined group (Trochim, 2006), in this case Medicaid-approved mental health professionals in North Carolina. As discussed in Chapter Three, participation criteria ensures participants adequately represent Medicaid-approved mental health providers in the United States. Purposive sampling adds rigor in

comparison to convenience sampling, however it also limits researchers' causal inferences (Trochim, 2006).

Threats to internal validity. Ninety-eight (N = 98), of the 156 participants who started the survey, completed it. Fifty-eight (n = 58) participants dropped out of the study prior to completing the survey and constitute a mortality threat (Trochim, 2006). The final sample (N = 98) may not accurately represent the 156 participants who started the survey. Comparing incomplete surveys to completed surveys could protect against mortality threats (Trochim, 2006), however incomplete responses were discarded. Similarly, comparing completed survey demographics to incomplete responses may identify contributing factors to survey drop out.

A history threat may also have influenced this study's internal validity in relation to sampling and study participation (Trochim, 2006). As previously discussed, this study took place during presidential elections amidst an upsurge of media coverage on social issues such as mental health, substance abuse, and criminality. According to social learning theory, media coverage influences attitudes and behaviors (Bandura, 1977) and may have affected study participation.

Threats to external validity. This study uses a purposive sample to examine Medicaid-approved mental health professionals' attitudes toward clients with ASPD. Although study participants are Medicaid-approved mental health professionals in North Carolina, determining the extent to which they represent the population of Medicaid-approved mental health professionals in the United States is speculative. Participants from North Carolina may not accurately represent mental health professionals in other areas of the United States. Social learning influences such as religious institutions, media, politics, social norms, and parenting styles differ throughout the United States (Bandura, 1977; 1989). Subsequently, beliefs and

attitudes about clients with ASPD likely differ between mental health professionals from different geographic regions. Based on proximal similarities (Trochim, 2006), this study likely reflect attitudes of mental health professionals in the southeastern region of the United States. Further study is needed to determine if geographical differences influence mental health professionals' attitudes toward clients with ASPD.

Purposive sampling also threatens this study's external validity through unequal group representation (Trochim, 2006). 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). Nevertheless, purposive sampling is an effective method of obtaining timely results from a target population and is often followed by more rigorous studies using probability sampling (Trochim, 2006).

Instrumentation Limitations

This study used an author-developed demographic questionnaire and an adapted version of the *Attitudes toward Personality Disorders Questionnaire* (Bowers & Allan, 2006) to examine mental health professionals' attitudes' toward clients with ASPD. There are several limitations to instrument modifications which may be have influenced this study's results.

Threats to construct validity. Because attitudes toward clients with ASPD receive little attention (Black, 2015), instrumentation for this construct is rudimentary. Therefore, further studies are needed to determine how to best measure mental health professionals attitudes toward

clients with ASPD. For this study, construct validity is discussed in terms of face validity and content validity.

Face validity. Face validity is the extent to which test items appear to measure an identified construct (Trochim, 2006), in this case attitudes toward clients with ASPD. Face validity for this study is high because each *A-APDQ* item was taken from a psychometrically validated instrument (i.e., *APDQ*) and each item measures participants' thoughts or feelings toward clients with ASPD (Trochim, 2006). However, face validity is a poor measure of construct validity (Trochim, 2006) and associations based on face validity alone may be spurious.

Content validity. Content validity refers to how well measurements represent a construct (Heppner et al., 2008). Although Bowers and Allan (2006) identified the five *APDQ* scales of *Enjoyment, Security, Acceptance, Purpose,* and *Enthusiasm*, further studies are needed to determine how well these subscales represent attitudes. The subscales correlation scores (Table 4.8) suggest that the instruments' subscales may be measuring a single construct (i.e., attitudes) rather than distinct attitudinal factors (i.e., *Enjoyment, Security, Acceptance, Purpose,* and *Enthusiasm*). These correlations may result from instrumental modifications and further analysis such as principal components analysis could determine factor loadings.

Similarly, the *APDQ* (Bowers & Allan, 2006) was developed to measure attitudes toward all personality disorders, whereas the *A-APDQ* was adapted to specify for antisocial personality disorder. Concurrent validity measures how well instruments distinguish between groups (Trochim, 2006), such as personality disorders collectively and antisocial personality disorder specifically. Instrument modifications may have negatively influenced the concurrent validity of

the instrument by adding specificity for ASPD. Further studies could determine the concurrent validity of the *A-APDQ* by comparing it to the *APDQ* (Bowers & Allan, 2006).

Implications and Contributions

Despite the identified limitations, this study's finding have several implications for mental health professionals, supervisors, educators and researchers.

Mental Health Professionals

Clients with antisocial personality disorder (ASPD) are often overlooked, ignored, or regarded as untreatable by mental health professionals (Black, 2013; 2015). Mental health professionals who are unequipped or unwilling to work with clients with ASPD and may interact with these clients from a punitive, hostile stance, or refer them to other providers to avoid interacting with them (Black, 2013; NICE, 2010). From a social learning perspective, these referrals and punitive interactions reinforce clients' distrust and may increase treatment drop-out. However, findings from the current study indicate that mental health professionals' attitudes toward clients with ASPD may improve with increased clinical contact for crime victims and non-crime victims. Therefore, mental health professionals' negative attitudes toward clients with ASPD in early clinical experiences may be part of a developmental process in the social learning cycle.

As discussed, clients with ASPD engage in behaviors (e.g., violence, theft) that are aversive to society (APA, 2013; NICE, 2010). These aversive reactions result in mental health professionals' feelings of bewilderment, frustration, and anger toward clients with ASPD (Evans, 2011), specifically mental health professionals with little clinical experience (Schwartz et al., 2007). Reported findings suggest that mental health professionals who frequently interact with clients with ASPD are less prone to aversive reactions toward ASPD symptomatology than

health professionals who interact less. The current study findings serve to increase mental health professionals' awareness that attitudes toward clients with ASPD may improve with experience, thereby normalizing their early negative attitudinal experiences and improving optimism toward clients with this disorder.

Criminal victimization did not significantly influence participants *A-APDQ* scores, which indicated that mental health professionals who are crime victims may have increased resilience or experience a curative effect by treating clients with ASPD. Mental health professionals who are crime victims may develop empathy toward criminal perpetrators as a means of making meaning from their own past experiences.

Treatment outcomes are influenced by the strength of therapeutic alliances between clients and mental health professionals (Lambert & Barley, 2001). Although clients with ASPD are prone to aggression, distrust, and deceit (APA, 2013; NICE, 2010), findings from this study suggest that mental health professionals' attitudes, as measured by the *A-APDQ,* are higher for mental health professionals in the High Contact group. Mental health professionals' with greater levels of clinical contact with clients with ASPD had higher *A-APDQ* scores, which suggests that contact with this population may help mental health professionals normalize rather than personalize symptoms of ASPD such as deceit, bullying, and manipulation. Mental health professionals' positive attitudes toward clients with ASPD may strengthen therapeutic alliances with clients with the disorder and improve treatment retention and outcomes.

Participants who were White/Caucasian (n = 79; 79.6%) and/or female (n = 67; 68.4%) were overrepresented in this study which underscores the importance of the influences of race and gender differences on therapeutic relationships with clients with ASPD. Despite attitudinal similarities between women and men and among racial groups, mental health professionals

working with clients with ASPD may benefit from ongoing multiculturalism training that includes how to discuss gender and racial differences with clients and the role of privilege, social class, and stereotypes in therapeutic relationships.

Mental Health Supervisors

Mental health disciplines require professionals-in-training to practice under experienced professionals' supervision (Bernard & Goodyear, 2014). The current study serves to increase mental health supervisors' awareness of the developmental processes of mental health professionals-in-training/supervisees, in terms of their attitudes toward clients with ASPD. The current study also accentuates the role of self-efficacy in mental health professionals' socially learned attitudinal development (Bandura & Adams, 1977).

Most developmental models of supervision identify that inexperienced supervisees undergo feelings of anxiety and uncertainty when they begin practicing mental health counseling (Bernard & Goodyear, 2014). As they gain experience, these feelings of anxiety decrease as a result of the social learning cycle (Bandura, 1977; Bernard & Goodyear, 2014). 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 with ASPD, had more positive attitudes than mental health professionals with no contact. Although mental health professional's levels of clinical contact may result from various factors such as work setting, scope of practice, and 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 with this disorder, whereas mental health professionals who believe they are less effective at treating clients with this disorder may choose to avoid them. These

choices influence their levels of clinical contact with clients with ASPD, and thus influence their attitudinal development toward clients with ASPD.

Supervisors supervising mental health professionals-in-training can help increase supervisees' self-efficacy regarding clients with ASPD by tailoring their supervisory interventions to common issues in treating clients with ASPD. For example, Evans (2011) posits that mental health professionals treating clients with ASPD experience negative thoughts and emotions toward clients with ASPD during clinical interactions. Evans (2011) suggests that supervisors help supervisees process these thoughts and emotions in order to better understand and treat clients with ASPD. Furthermore, Dunbar and Sias (2015) suggest that because clients with ASPD experience dulled emotional responses, supervisors can use supervisees' emotional responses to help them better understand clients with ASPD.

Supervisors can enhance supervisees' perceived self-efficacy through a strengths based approach that includes education on ASPD, discussion of realistic therapeutic expectations of clients with ASPD, normalization of struggles treating clients with ASPD, and processing of supervisees emotional and cognitive reactions to clients with ASPD (Bernard & Goodyear, 2014; Dunbar & Sias, 2015; Evans, 2011).

Mental Health Educators

Findings from the current study coupled with findings from previous research (Black et al., 2011; Schwartz et al., 2007) suggest that mental health counselor educators may influence mental health professionals' attitudes toward ASPD. Mental health counselor educators may assist mental health professionals-in-training conceptualize symptoms of ASPD, identify how attitudes influence treatment, and understand the role of language in socially learned beliefs and behaviors (Bandura, 1977).

Although clients with ASPD are treated in the majority of clinical settings, treatment development for these clients is stagnant (Black, 2013). Most mental health counselor education programs provide little specific guidance on treating clients with ASPD (Black, 2013; Samenow, 2014). Mental health counselor educators may help improve mental health professionals-in-trainings' attitudes toward clients with ASPD by providing treatment strategies specific to clients with ASPD and educating mental-health-professionals in training on the social learning influences associated with treating the disorder such as race, gender, and social class.

Mental health counselor educators may also play a pivotal role in 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) and the current study suggests that increased clinical contact with clients with ASPD may improve 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 treatment success when treating clients with ASPD (Martens, 2004; NICE, 2010). Mental health counselor educators can promote mental health professionals' treatment optimism toward clients with ASPD through a strengths-based approach that emphasizes person-centered treatment and avoids stigma (NICE, 2010). Mental health counselor educators can educate mental health professionals-in-training on identification of strengths of clients with ASPD such as creativity, persuasiveness, and resilience (Black, 2013). Additionally, mental health counselor educators can avoid stigmatizing language that may

influence mental-health-professionals in trainings' attitudes (Catthoor et al., 2015). For example, stigmatizing language specific to clients with ASPD might include "difficult", "resistant", and "unmotivated".

Mental Health Researchers

Research and treatment development on ASPD is sparse despite the societal costs people with the disorder pose such as crime, incarceration, and public assistance scams (Black, 2013). Researchers interested in ASPD often research alternative topics because funding for ASPD research is limited (Black, 2013). Researching clients with ASPD is expensive and time consuming because of their transient lifestyles and distrustful nature (Black, 2013). The current study provides an alternative lens from which to research clients with ASPD by examining their influence on mental health professionals' attitudes.

Although research on clients with ASPD can be challenging (Black, 2013), mental health professionals' attitudes toward clients with the disorder can be readily examined. Researchers may better understand people with the disorder by examining how they affect those with whom they interact. Findings from the current study suggest that increased levels of clinical contact with the disorder are associated with more positive attitudes. Researchers may gain insights into the disorder by examining other populations' attitudes such as families, employers, and corrections officers. By better understanding how attitudes toward clients with ASPD develop, researchers may be able to improve treatment recommendations and interventions. Future research may improve mental health professionals' treatment provision to clients with ASPD.

Future Research

As previously discussed, research on mental health professionals' attitudes toward ASPD is scarce. The current study contributes to the study of mental health professionals' attitudes

toward clients with ASPD by including the social learning factors; level of clinical contact and history of criminal victimization. To date, few attitudinal studies have been specific to ASPD and no studies have included these social learning factors. Findings from this study suggest that level of clinical contact influences mental health professionals' attitudes similarly for crime victims and non-crime victims. Future research can build upon these findings through alternative study designs, developing interventions, and 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 suggests that increased levels of clinical contact are associated with positive attitudes toward clients with ASPD, future research may include less experienced professionals such as professionals-in-training and newly licensed professionals to provide a developmental perspective. Similarly, the current study includes mental health professionals from North Carolina which may not accurately represent mental health professionals' attitudes in other geographical regions. A nationwide sample may allow researchers to account for geographical and developmental influences which the current study omits.

Future studies can address multicultural issues by examining the racial and gender influences in therapeutic relationships with clients with ASPD. The current study includes mostly White female mental health professionals, whereas many clients with ASPD minority males. Future research can determine how racial and gender differences influence therapeutic relationships by examining the relationships between mental health professionals and clients with ASPD in terms of race, gender, consumer satisfaction, and outcome measurements.

The current study suggests that increased levels of clinical contact with clients with ASPD influence mental health professionals' attitudes however, this study does not account for

other influences such as supervision and training. For example, participants with higher attitude scores may have had adequate supervision, whereas participants with lower attitude scores may have had poor supervision. Future studies may explore supervisory and training interventions with experimental designs to determine their influences on mental health professionals' attitudes toward clients with ASPD.

Although the *APDQ* (Bowers & Allan, 2005) has been 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

The current study examined the influence of social learning factors (i.e., level of clinical contact and history of criminal victimization) on mental health professionals' attitudes toward clients with ASPD through an online survey of Medicaid-approved mental health professionals in North Carolina. The study uses an author developed *Demographic Questionnaire* and the *A-APDQ*. The study conceptualizes mental health professionals' attitudes through Bandura's (1977) social learning theory. This study found that increased levels of clinical contact were associated with significantly elevated *A-APDQ* scores. The study failed to detect significant main effects for history of criminal victimization and interaction effects on mental health professionals' attitudes as measured by the *A-APDQ*.

Study limitations include: (a) research design, specifically limitations of a cross-sectional survey design; (b) sampling bias, as the sample included only highly experienced mental health professionals; and (c) instrumentation, specifically use of an adapted version of an established instrument.

Study findings hold implications for mental health professionals, supervisors, educators, and researchers regarding mental health professionals' attitudinal development. For mental health professionals, results imply that increased clinical contact with clients with ASPD may improve attitudes toward clients with ASPD, and that negative attitudes may improve with clinical contact and experience. Mental health counseling supervisors may aid in this process by understanding attitudinal development and supporting mental health professionals' self-efficacy when treating clients with ASPD. Mental health counseling educators may influence attitudinal development through language usage and normalization of ASPD symptoms. Researchers may explore attitudinal development and attitudinal interventions for mental health professionals.

Study findings support future research regarding mental health professionals' attitudes toward clients with ASPD. Specifically, ongoing research into the effects of social learning factors such as media, geographical, and political influences may help researchers understand attitudinal development. Intervention research may include education and supervisory factors. Findings from this study support examining mental health professionals' attitudes toward clients with ASPD through Bandura's (1977) social learning theory and indicate a need to better understand how additional social learning factors influence these attitudes.

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APPENDIX A – COVER LETTER AND INTRODUCTION TO THE STUDY EXAMINING MENTAL HEALTH PROFESSIONALS ATTITUDES TOWARD CLIENTS WITH ANTISOCIAL PERSONALITY DISORDER

Consent to Participate in Research

Dear Participant,

I am a doctoral candidate at East Carolina University (ECU) in the Department of Addictions and Rehabilitation Studies. I am conducting research under the direction of Dr. Shari M. Sias, as a requirement of my doctoral degree in Rehabilitation Counseling Administration. I am asking you to take part in my research entitled "Mental Health Professionals' Attitudes toward Clients with Antisocial Personality Disorder". The purpose of this research is to examine helping professionals' attitudes toward clients with antisocial personality disorder to better understand how social learning factors influence attitudes. Your participation is voluntary.

You are being invited to take part in this research because you are a Medicaid-approved mental health professional in North Carolina. The amount of time it will take you to complete this survey is 15 minutes.

If you agree to take part in this survey, you will be asked questions that relate to your attitude and beliefs about people with antisocial personality disorder, how often you interact with clients with antisocial personality disorder, and your history and family members' history of being a victim(s) of violent crime.

This research is overseen by the ECU Institutional Review Board. Therefore, Institutional Review Board members and their staff may need to review my research data. However, the information you provide will not be linked to you. Therefore, your responses cannot be traced back to you by anyone, including me.

If you have questions about your rights when taking part in this research, please call Dr. Shari M. Sias at (252) 744-6304; siass@ecu.edu or the ECU Office of Research Integrity & Compliance (ORIC) at phone number 252-744-2914 (8:00 am-5:00 pm). If you would like to report a complaint or concern about this research study, call the Director of ORIC, at 252-744-1971.

You do not have to take part in this research, and you can stop at any time. If you decide you are willing to take part in this study, check the AGREE box below and the research questions will appear.

Thank you for taking the time to participate in my research.

Sincerely,

Edward T. Dunbar Jr.

Principal Investigator

APPENDIX B – DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

1. What is your age in years? _____
2. What is your race? (Please circle)
    - White/Causation
    - Hispanic/Latino
    - Black/African American
    - Native American/American Indian
    - Asian/Pacific Islander
    - Other
3. Gender: (Please circle)
    - Female
    - Male
    - Other
4. How many years have you worked as a helping professional? _____
5. Which of the following best describes your professional discipline?
    - Nursing
    - Psychology
    - Psychiatry
    - Professional Counseling
    - Social Work
    - Marriage and Family Counseling
    - Other (please Specify) _____

6. Which of the following licenses do you hold? (Please select all that apply)
    - Licensed Professional Counselor (LPC)
    - Licensed Professional Counselor Supervisor (LPCS)
    - Licensed Professional Counselor Associate (LPCA)
    - Licensed Clinical Mental Health Counselor (LCMHC)
    - National Certified Counselor (NCC)
    - Licensed Clinical Social Worker (LCSW)
    - Licensed Psychiatrist
    - Licensed Psychologist
    - Licensed Marriage and Family Therapist (LMFT)
    - Other (please list)_____
7. What best describes your work setting? (Please circle)

    Private inpatient

    Private outpatient

    Public Inpatient

    Public Outpatient

    Forensic Setting

    Other: _____
8. During an average 5 day workweek, how many clients with antisocial personality disorder (ASPD) do you treat? _____
9. Have you, a significant other/family member, or close friend ever been the victim of a violent crime? Yes No

10. If Yes who? (Mark all that apply)
    - Self
    - Significant Other/Family Member
    - Close friend
11. If there is a particular observation or experience that has shaped your opinion about clients with antisocial personality disorder? If so please, describe briefly in the space below.

APPENDIX C – ADAPTED ATTITUDES TOWARD PERSONALITY DISORDERS QUESTIONNAIRE

Now please take a moment to reflect upon your experience of working with clients with antisocial personality disorder (ASPD).

By ASPD we mean antisocial personality disorder as defined by the Diagnostic Statistical Manual 5 (DSM 5) or any commonly used diagnostic system. This includes ASPD combined with other conditions, (e.g., learning disability, substance abuse, depression, etc). We recognize that ASPD clients vary, however typical behaviours of clients with ASPD often include impulsivity, violence, dishonesty, manipulation, and blaming others.

For the purposes of this questionnaire we would like you to think about your feelings towards ASPD clients overall. We realize that you may have different feelings toward different clients with ASPD. However, for this questionnaire we would like to you average those feelings toward clients with ASPD as a whole.

For each response listed below please indicate the frequency of your feelings toward people with antisocial personality disorder. Please select your choice quickly, rather than spending a long time considering it. We want to know your honest, gut feelings.

	Never	Seldom	Occasionally	Often	Very Often	Always
1. I like ASPD people. *(Enjoyment)*						
2. I feel frustrated with ASPD people. (*Enthusiasm)*						
3. I feel drained by ASPD people. (*Enthusiasm)*						
4. I respect ASPD people. (*Enjoyment)*						
5. I feel fondness and affection for ASPD people. (*Enjoyment)*						

6. I feel vulnerable in ASPD people company. (*Security)*						
7. I have a feeling of closeness with ASPD people. (*Enjoyment)*						
8. I feel manipulated or used by ASPD people. (*Security)*						
9. I feel uncomfortable or uneasy with ASPD people. (*Security)*						
10. I feel I am wasting my time with ASPD people. (*Purpose)*						
11. I am excited to work with ASPD people. (*Enjoyment)*						
12. I feel pessimistic about ASPD people. (*Purpose)*						
13. I feel resigned about ASPD people. (*Purpose)*						
14. I admire ASPD people. (*Enjoyment)*						
15. I feel helpless in relation to ASPD people. (*Security)*						
16. I feel frightened of ASPD people. (*Security)*						
17. I feel angry toward ASPD people. (*Acceptance)*						
18. I feel provoked by ASPD people. (*Not Scored*)						
19. I enjoy spending time with ASPD people. (*Enjoyment*)						
20. Interacting with ASPD people makes me shudder. (*Acceptance*)						
21. ASPD people make me feel irritated. (*Acceptance*)						
22. I feel warm and caring towards ASPD people. (*Enjoyment*)						

23. I feel protective towards ASPD people. (*Enjoyment*)						
24. I feel oppressed or dominated by ASPD people. (*Security*)						
25. I feel that ASPD people are alien, or strange. (*Acceptance*)						
26. I feel understanding towards ASPD people. (*Enjoyment*)						
27. I feel powerless in the presence of ASPD people. (*Security*)						
28. I feel happy and content in ASPD people company. (*Enjoyment*)						
29. I feel cautious and careful in the presence of ASPD people. (*Not Scored*)						
30. I feel out manoeuvred by ASPD people. (*Security*)						
31. Caring for ASPD people makes me feel satisfied and fulfilled. (*Enjoyment*)						
32. I feel exploited by ASPD people. (*Security)*						
33. I feel patient when caring for ASPD people. (*Enjoyment*)						
34. I feel able to help ASPD people. (*Enjoyment*)						
35. I feel interested in ASPD people. (*Enjoyment*)						
36. I feel unable to gain control of the situation with ASPD people. (*Security*)						
37. I feel intolerant. I have difficulty tolerating ASPD people behaviour. (*Acceptance*)						
38. I have observed co-workers be intolerant of ASPD people behaviour. (*Co-worker observation*)						

Thank you for taking the time to complete our survey

APPENDIX D – EAST CAROLINA UNIVERISTY INSTITUTIONAL REVIEW BOARD APPROVAL

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board Office
4N-70 Brody Medical Sciences Building· Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** · **www.ecu.edu/irb**

Notification of Exempt Certification

From: Social/Behavioral IRB

To: Edward Dunbar

CC: Shari Sias

Date: 10/17/2016

Re: UMCIRB 16-001696

Counselors' Attitudes Toward ASPD

I am pleased to inform you that your research submission has been certified as exempt on 10/17/2016. This study is eligible for Exempt Certification under category # 2.

It is your responsibility to ensure that this research is conducted in the manner reported in your application and/or protocol, as well as being consistent with the ethical principles of the Belmont Report and your profession.

This research study does not require any additional interaction with the UMCIRB unless there are proposed changes to this study. Any change, prior to implementing that change, must be submitted to the UMCIRB for review and approval. The UMCIRB will determine if the change impacts the eligibility of the research for exempt status. If more substantive review is required, you will be notified within five business days.

The UMCIRB office will hold your exemption application for a period of five years from the date of this letter. If you wish to continue this protocol beyond this period, you will need to submit an Exemption Certification request at least 30 days before the end of the five year period. The Chairperson (or designee) does not have a potential for conflict of interest on this study.

APPENDIX E – CURRICULUM VITAE

Edward Timothy Dunbar Jr.

1536 Somerset Drive, Greenville, NC. 27834 252-495-2420 • dunbaret@gmail.com

Professional Objective

To obtain the position of Assistant Professor of Counselor Education where I can combine my passion for teaching, diverse clinical supervisory experiences, and established research interests to help counselors-in-training develop their craft.

Education

East Carolina University, Greenville NC
Doctor of Philosophy in Rehabilitation Counseling and Administration. ABD Status *Expected Completion:* May 2017

East Carolina University, Greenville NC
MS Substance Abuse and Clinical Counseling
MS Rehabilitation Counseling May 2012

East Carolina University, Greenville NC
BS Rehabilitation Studies with minor in Alcohol and Drug Studies May 2010

Licenses and Certifications

Licensed Professional Counselor Associate September 2013 – June 2017
License number: A10394
(*Full licensure pending board verification)*

Certified Clinical Supervisor March 2015 – March 2018
Certificate number: 20069

Licensed Clinical Addictions Specialist August 2013 – December 2017
License number: 2403

Teaching Experience

Co-Instructor
Substance Abuse and Clinical Counseling Practicum September 2015 - December 2015

- Taught clinical counseling skills to 10 master's level practicum students during their fieldwork experience
- Assessed students' clinical skills through use of tape review, self-report, role play, and experiential teaching modalities
- Evaluated students' fieldwork experience in community based mental health and substance abuse treatment agencies

- Supervised students through individual and group formats to develop their knowledge and skills in mental health and substance abuse counseling including: screening, assessment, diagnosis, treatment, multicultural competence, referral, prevention, record keeping, and systems navigations
- Collaborated with community agencies to evaluate students' clinical counseling knowledge and skills
- Connected students' learning to counseling theories and techniques by using experiential modalities such as role playing, interpersonal process recall, and empty chair exercises

Teaching Assistant

Ethical and Legal Aspects of Substance Abuse and Rehabilitation Counseling July - August 2015

- Conducted bimonthly online ethics lectures for Master's level students in substance abuse counseling program using Blackboard, SabaMeeting, and Tegrity
- Created weekly learning goals relative to ethical issues in substance abuse and mental health counselors
- Facilitated experiential learning activities for students to practice using ethical decision making models and skills
- Developed ethics scenarios to allow students to apply newly acquired knowledge to real world ethical dilemmas
- Evaluated students' learning through test development, online assessments in Blackboard, and classroom discussion

Instructor

Interviewing Techniques for Health and Rehabilitation Settings January - May 2015

- Conducted weekly class sessions for 5 bachelor's level students entering healthcare professions
- Taught basic clinical interviewing skills including empathy, reflective listening, effective questioning, and structuring therapy sessions
- Evaluated student learning and skill level by facilitating student role play demonstrations, and reviewing taped interview sessions
- Conducted experiential activities for students to practice using newly acquired knowledge
- Developed learning goals, syllabi, and weekly lesson plans to facilitate student learning
- Created case scenarios for students to apply newly learned clinical skills

Teaching Assistant

Alcohol and Drug Abuse: Health and Social Problem August - December 2014

- Lead online weekly discussions for bachelor's level students entering the substance abuse treatment field by using Blackboard
- Evaluated student learning of criteria for substance use disorders, social issues influencing substance abuse, treatment of substance use disorders, and physiological effects of substance use

Publications

Journal Articles

Dunbar, E. (2016) Program considerations for clients with antisocial personality disorder. *In ideas and research you can use: VISTAS 2016.* Retrieved from http://www.counseling.org /knowledge-center/vistas

Dunbar, E., & Sias, S. (2015). Antisocial personality disorder and clinical supervision. *In ideas and research you can use: VISTAS 2015.* Retrieved from http://www.counseling.org /knowledge-center/vistas

Dunbar, E., & Goodwin L. (2016) The silent treatment: Meditative interventions for antisocial personality disorder. Under review

Atherton W., **Dunbar E**., & Baker S (2016) Mindfulness and Animal Assisted Therapy. *In ideas and research you can use: VISTAS 2016.* Retrieved from http://www.counseling.org /knowledge-center/vistas. In press

Book Chapters

Dunbar, E. Sias, S., Atherton, W. (in press) My arms are tired: The effects of substance use disorders on family systems. In D. Viers (2nd Ed.), *The group therapists notebook. Homework, handouts and activities for use in psychotherapy.*

Dunbar, E., Atherton, W., Sias, S. (in press) My family support group. In D. Viers (2ndEd.), *The group therapists notebook. Homework, handouts and activities for use in psychotherapy.*

Presentations

Dunbar, E. & Dewald K. (2017, March). *Fighting the fear factor: Improving helping professionals' attitudes toward clients with personality disorders.* Training presentation scheduled for Eastern Area Health Education Center. Greenville, NC.

Dunbar, E. (2016, November). *From psychopath to psychotherapist: The role of clinical supervision in treating antisocial personality disorders.* The 32nd Annual Substance Abuse Services State of the Art Conference -Through the Looking Glass: Hello from the Other Side. State conference presentation. Greenville, NC.

Dunbar, E. (2016, September). *Eight tips for interviewing clients with antisocial personality disorder.* National conference presentation for the Vocational Evaluation and Career Assessments Professionals Association. Greenville, NC.

Crawford, C., **Dunbar, E.,** & Dewald, K. (2016, September). *Integrative treatment for substance use disorders.* Radio interview for the British Broadcasting Corporation.

Dunbar, E. (2016, June). *Using meditation to manage school stress.* Presentation for East Carolina University Department of Physical Therapy. Greenville, NC.

Dunbar, E. (2016, March). *Assessing for substance use disorders in families.* Experiential activity for East Carolina University Department of Marriage and Family Therapy. Greenville, NC.

Dunbar, E. (2016, January). *The silent treatment: Mindfulness and antisocial personality disorder.* Training presentation for Eastern Area Health Education Center. Greenville, NC.

Dunbar, E. (2015, November). *The silent treatment: Mindfulness and antisocial personality disorder.* Training presented for Eastern Area Health Education Center at Cherry Point Marine Corp Air Station. Havelock, NC.

Dunbar, E. (2015, November). *The silent treatment: Mindfulness and antisocial personality disorder.* The 31st Annual Substance Abuse Services State of the Art Conference – Holistic Pathways to Recovery and Change. Conference presentation for state conference. Greenville NC.

Dunbar, E. (2015, October). *Eight tips for interviewing clients with antisocial personality disorder.* National conference presentation for the Vocational Evaluation and Career Assessment Professionals National Issues Forum. Atlantic Beach, NC.

Crozier, M. & **Dunbar, E.** (2015, October). *Treating behavioral addictions.* Training presentation for Eastern Area Health Education Center. Greenville, NC.

Dunbar, E. (2015, May). *Myths and facts of the marijuana movement.* Conference presentation for Eastern Region Adult Services Conference. Greenville, NC.

Dunbar, E. (2015, May). *The silent treatment: Meditative interventions for antisocial personality disorder.* Paper presented for The East Carolina University Department of Addictions and Rehabilitation Studies. Greenville, NC.

Dunbar, E. (2015, April). *Implementing seeking safety model for treating posttraumatic stress disorder and substance use disorders in clinical settings.* Presentation for master's interns in The East Carolina University Department of Addictions and Rehabilitation Studies. Greenville, NC.

Dunbar, E. (2015, April). *Program considerations for clients with antisocial personality disorder.* Paper presentation for The East Carolina University Department of Addictions and Rehabilitation Studies. Greenville, NC.

Dunbar, E. (2015, March). *Meditation and antisocial personality disorder.* Poster presentation for the Professional Association of Rehabilitation Counselors Regional Conference. Atlantic Beach, NC.

Dunbar, E. (2015, February). *Myths and facts of the marijuana movement.* Presentation for students in The East Carolina Department of Criminal Justice. Greenville NC.

Dunbar, E. (2014, November). *Introduction to problem gambling.* The 30th Annual Substance Abuse Services State of the Art Conference – Against all Odds: Take a Look at Me Now. Presentation for state conference. Greenville, NC.

Clinical and Related Experience

Program Director of Substance Abuse Services September 2014 - Present
East Carolina University Navigate Counseling Clinic Greenville, NC

- Supervise master's level practicum students in clinical skill development
- Manage daily clinic operations and delegate staff work tasks
- Instruct master's level practicum students in providing mental health and substance use counseling
- Conduct case reviews with practicum students to help them link theory with practice and improve their case conceptualization
- Develop and implement a weekly meditation group for clients with mental health and substance use issues
- Develop research protocol for criminal justice clients as part of the N.C. Governor's Crime Commission Grant through The Pitt County Reentry Program
- Develop outpatient treatment program for clients in the criminal justice system with addiction disorders
- Design outpatient treatment programs for clients with mental health and substance use issues
- Screen, assess, and counsel clients with mental health and substance use disorders
- Collect and analyze data for ongoing research and program design by using SPSS and Excel

Independent Practice June 2011 - Present
Private Practitioner Wilson, NC/Greenville, NC

- Develop protocol for providing outpatient counseling services to individuals and families with mental health and substance use issues
- Supervise associate level addictions counselors
- Screen, assess, and counsel individuals and families with mental health and substance use issues
- Collaborate with community agencies to provide services to individuals and families with mental health and substance use issues
- Provide community outreach sponsored by the North Carolina Department of Health and Human Services Problem Gambling Program

Clinical Substance Abuse Counselor May 2010 - September 2014
Walter B. Jones Alcohol and Drug Abuse Treatment Center Greenville, NC

- Counseled individuals in an inpatient crisis stabilization and substance abuse treatment center
- Screened, assessed, and treated clients for co-occurring substance use and mental health disorders
- Developed and implemented a meditation and stress reduction program for clients with comorbid substance use and anxiety and/or chronic pain issues

- Supervised master's level students during their practicum and internship
- Supervised bachelor's level students completing their internship in rehabilitation studies
- Conducted daily individual, family, and group therapy services in a 65 bed inpatient substance abuse treatment center
- Collaborated within an interdisciplinary treatment team to provide integrative treatment services
- Developed core curriculum for all clients entering treatment

Research

Counselors' Attitudes toward Antisocial Personality Disorder January 2015 – March, 2017

- Design and implement dissertation study

Clinical Outcome Studies

East Carolina University Department of Addictions and Rehabilitation Studies September 2014 – Present

- Collect data for ongoing studies in on-site department clinic

Mindfulness and Animal Assisted Therapy

East Carolina University Department of Addictions and Rehabilitation Studies September 2015 – September 2017

- Design research and collect data for collaborative study

North Carolina Governor's Crime Commission Study January 2016 – January 2018

- Collect data for interdepartmental study
- Design substance use treatment interventions for clients within the criminal justice system

Professional Memberships

Pitt County Reentry Council	September 2014 - Present
American Counseling Association	September 2014 - Present
Professional Association of Rehabilitation Counselors	January 2010 - Present