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Attitudes toward Antisocial Personality Disorder Among Clinicians

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ATTITUDES TOWARD ANTISOCIAL PERSONALITY
DISORDER AMONG CLINICIANS

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Masters of Social Work

by
Theresa Matich

June 2014

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Approved by:

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ABSTRACT

The objective of this study was to explore the attitudes toward antisocial personality disorder among clinicians. The researcher created a 15 question survey to interview clinicians in hopes of eliciting information about their attitudes toward this population. The survey consisted of seven open ended questions and eight Likert scale questions. The researcher analyzed the data by transcribing the interviews and looking for common themes among the responses. Likert scale questions were tallied and compared in SPSS to determine the spread of the answers. The results of the study showed there are negative attitudes among clinicians currently in direct treatment settings; attitudes were more neutral among clinicians who are currently not involved in direct practice. In applying the theory of reasoned action it is suggested clinicians in direct practice who hold negative views display behaviors that affect the treatment process and outcome. The researcher's recommendation for future study is to explore the attitudes of other helping professionals in comparison to social work practitioners.

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DEDICATION

I dedicate this research project first and foremost to my parents, John and Margaret Matich. I would also like to thank my family and friends. Thank you for the love, support, and understanding you have given me throughout my college career. I am very lucky to have so many wonderful people in my life. Because of them I have accomplished something I never would have thought been feasible.

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CHAPTER ONE

INTRODUCTION

This chapter examines attitudes associated with antisocial personality disorder. Many mental illnesses are stigmatized, which can greatly affect clients in various ways throughout their life. It is important to learn and understand the clinicians and if they hold a negative stigma towards their clients suffering from antisocial personality disorders.

Problem Statement

A personality disorder, defined by the Diagnostic and Statistical Manual of mental disorders IV-TR (DSM-IV-TR), “is an enduring pattern of inner experience and behavior that deviates markedly from expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (2000, p.685). In the DSM-IV-TR, there are ten different personality disorders, which are categorized into three clusters based on the similarities of each personality disorder. Cluster A includes; Paranoid, Schizoid, and Schizotypal, Cluster B includes; Antisocial, Borderline, Histrionic, and Narcissistic, Cluster C includes; Avoidant, Dependent, and Obsessive-Compulsive disorders. Mental health staff members engage these clients on various levels to provide treatment (2000, p.685).

Antisocial personality disorder is currently a diagnosis in the DSM-IV-TR. The DSM-IV-TR defines Antisocial personality disorder as, “a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood” (2000, p.701). Antisocial personality disorder has also been known as “psychopathy, sociopathy, or dissocial personality disorder” (APA, 2000, p.702). This disorder is characterized by terms, such as; deceit, manipulation; disregard to others, illegal activity, impulsivity, aggression, con others, and a disregard for safety. Antisocial personality disorder is a diagnosis that is used for adults 18 and over who are diagnosed with Conduct Disorder before age 15 and exhibit the behaviors previously listed (APA, 2000, p.702).

Psychologists, psychiatrists, and clinical social workers, have been aware of the presence of personality disorders since the 19th century (Kessler, Abelson, & Zhao, 2010). The first DSM published in 1952 included personality disorders which were grouped into three different categories; “personality pattern disturbance”, “personality trait disorders”, and “sociopathic personality disorders” (Oldham, 2005, p.3). In the DSM-I personality disorders were stated as, “deficit reflecting partial developmental arrests or distortions in development secondary to inadequate or pathological early caretaking” (Oldham, 2005, p.3). These early views of personality disorder can be attributed to Sigmund Freud who observed that neurosis involved anxiety, which headed to symptom formation and the use

of defense mechanisms, where the treatment required was psychoanalysis (Oldham, 2005, p.2).

Antisocial personality disorder is a condition that is commonly misunderstood. In feature films these characters are often represented as a psychopath that is charming and holds no remorse for their actions (“Psychopathy,” 2011, p.68). Despite this widely popular characterization, it is unfair to assume that all individuals who suffer from this diagnosis are callous. Skeem argues, “psychopathy has long been assumed to be a single personality disorder. However, there is increasing evidence that is a confluence of several different personality traits” (as cited in “Psychopathy,” 2011, p.68). It has been argued that antisocial personality disorder entails “differing levels of disinhibition, boldness, and meanness” (“Psychopathy,” 2011, p.68). “Findings also suggest that a sizable subgroup of juvenile and adult offenders labeled as psychopathic are actually more emotionally disturbed than emotionally detached, showing signs of anxiety and dysphoria” (“Psychopathy,” 2011, p.68).

Personality disorders are prevalent in society, affecting 9.1% of the population, and only 39% are currently receiving treatment for their illness. Antisocial personality disorder affects 1% of the population (National Institute of Mental health [NIMH], n.d.). There is a high occurrence of personality disorders in mental health settings. Clinicians endure hard work. “Studies have shown that mental health professionals tend to have higher levels of burnout than other groups. Common stressors associated with high levels of burnout include case-

load size, job insecurity, role ambiguity, shift work, organizational change, and the demands of ‘difficult patients’ (Crawford, Adedeji, Price, & Rutter, 2010, pp.196-197). They work with individuals that are often expelled from society and casted off as ‘crazy’. Being in this setting must take a toll on workers, and draws clinicians to their own conclusions about their clients. Knowing Individuals with antisocial personality disorder are often depicted in a negative light by society, it is essential to understand the perceptions of clinicians working with this diagnosis. Individuals with antisocial personality disorder are no different from those who suffer from other mental health diagnoses and endure stigmas just as the rest.

Purpose of Study

It is important to know if the attitudes of clinicians affect the care and services given to people with antisocial personality disorder. If current workers accept the stigma the majority of society does toward this client group it can be detrimental to the care received. It would be beneficial to gain a better understanding about this population, because in school, individual personalities are skimmed over with a brief definition. But what is it really like to work with someone who has antisocial personality disorder? Do clinicians feel they are working with an “insane psychopath”, or do they see a human being who has difficulty moving through life? Learning how clinicians view people with antisocial

personality disorder is a starting point in understanding more about this population.

According to Narud, Mykletun, & Dahl, research shows clinicians have a high level of countertransference towards individuals diagnosed with a cluster B personality disorder, which include; borderline personality, antisocial, histrionic, and narcissistic. This is usually due to dramatic personality traits, such as; substance abuse, violence, acting out, and emotional outbursts towards significant persons in the patient's life. Aside from the intense traits of patients, it has been found that cluster B patients are unable to commit to a meaningful treatment plan with clinicians (Narud, Mykletun & Dahl, 2005, p.187). The diagnosis alone is not what warrants the higher rate of countertransference among clinicians but it is the behavior the patients' exhibit in and out of treatment that increases more negative attitudes clinicians have toward their patients (Rossberg, Karterud, Pederson, & Friis, 2007). It has been noted that antisocial personality disorder specifically causes the clinician a "pessimistic clinical experience" (Reid & Gacano, 2000, p. 647).

Society is made up of individuals who all have different attitudes, opinions, and beliefs of their own. These attributes contribute to an individual's character; if they were not present society would be void of individualism. Clinicians, such as; social workers, psychologists, marriage family therapists, and psychiatrists; are individuals living in our society who clearly hold their own attitudes as well. Clinicians should not pass judgment onto their clients as this would make for

unethical practice, however, attitudes hold a lot of weight in an individual and cause them to react in ways they necessarily should not. Research shows that, “attitudes have causal priority over behaviors” (Bentler & Speckart, 1981, p.235). For individuals to say, “attitudes have essentially no effects on behavior can be rejected with a high degree of confidence” (Bentler & Speckart, 1981, p.235). This study examines the attitudes clinicians have toward persons with an antisocial personality disorder.

Significance of the Project for Social Work

Learning more about antisocial personality disorder could lead social workers to improve practices, if necessary. Understanding the perceptions clinicians hold can lead to an increase in learning more about the population. It is important to examine this subject to ensure clients are receiving the best services possible. One of the National Association of Social Workers’ (NASW) values, competence, explains that, “Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession” (National Association of Social workers [NASW], 2008, p.4). Gaining insight into this subject will give the opportunity to learn why clinicians hold the views they do. For those who hold negative attitudes, exploration of these views is warranted to gain a better understanding, as there could be a number of reasons, such as; lack of knowledge on the population, lack of skills, personal bias, or

countertransference. For those who hold positive views, we should come to understand what contributes to these attitudes.

Gaining knowledge about the mental health field is essential. If practices are stagnant, it will provide the opportunity to revamp existing services. If social workers, clinicians, or therapists lack knowledge for this specific population, it will show that more education is needed. If helping professionals have shortcomings regarding skills, it could increase trainings for those working with antisocial personality disorders. Acquiring more knowledge on a specific subject is a positive thing, and improvements can come from gaining a better understanding. It is important to learn the attitudes of clinicians working with individuals who have antisocial personality disorder and discern if they are capable of viewing the disorder on a spectrum.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The purpose of this chapter is to review the literature regarding antisocial personality disorder especially in relation to negative attitudes that may be present among clinicians who treat these individuals. This chapter discusses in detail different components of antisocial personality disorder, treatment services, clinicians attitudes toward these patients, and the theory guiding the study.

Core Features

Antisocial personality disorder is a heavy diagnosis for an individual. There are many criteria an individual must meet in order to receive such a diagnosis. An individual must meet three of the following seven criteria from the DSM-IV TR to fit the diagnosis of antisocial personality disorder:

- (1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest, (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure, (3) impulsivity or failure to plan ahead, (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults, (5) reckless disregard for safety of self or others, (6) consistent irresponsibility, as indicated by repeated failure to

sustain consistent work behavior or honor financial obligations, (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.(APA, 2000, p.706)

It is important to remember these personality characteristics are displayed in different individuals at different levels, “the highest prevalence of antisocial personality disorder (greater than 70%) is among most severe samples of males with alcohol use disorder and from substance abuse clinics, prisons, or other forensic setting” (APA, 2013, p.661). There are still individuals out there who suffer from this diagnosis as a means of survival, as noted in the DSM-IV-TR:

Concerns have been raised that the diagnosis may at times be misapplied to individuals in settings in which seemingly antisocial behavior may be part of a protective survival strategy. In assessing antisocial traits, it is helpful for the clinician to consider the social and economic context in which the behaviors occur. (2000, p.704)

Persons with antisocial personality disorder are capable of showing a positive response to treatment, “Recent empirical work suggests that youth and adults with high scores on measure of psychopathy can show reduced violent and other criminal behavior after intensive treatment” (“Psychopathy,” 2011, p.68).

It is important to note the criteria for antisocial personality disorder in the DSM-IV-TR continue to be the same criteria in the DSM-5. However, before the DSM-5 was published the APA discussed using a continuum to diagnose

individuals with personality disorders, one reason being that individuals often present with multiple symptoms of different personality disorders, and the current criteria do consider the severity of the disorder. According to the APA board of trustees it aims, "...to preserve continuity with current clinical practice, while also introducing a new approach that aims to address numerous shortcomings of the current approach to personality disorders" (APA, 2013, p.761).

Those who are assessed as moderate on the scale will be determined to be severe enough to warrant a diagnosis of the disorder. "A moderate level of impairment in personality functioning is required for the diagnoses of a personality disorder" (APA, 2013, p.762). Considering the level of the disorder in diagnosing people with personality disorders is important because assigning a personality disorder diagnosis to someone with a mild case of illness still burdens the client with a label and very often the negative stigma that goes along with it. If people were not diagnosed unless their symptoms were at least at the moderate level it might be easier to determine when treatment would be needed. The alternative DSM-5 Model for Personality Disorders criterion A now includes:

Disturbances in self and interpersonal functioning constitute the core personality psychopathology and in this alternative diagnostic model they are evaluated on a continuum...The level of personality functioning scale uses each of these elements to differentiate five levels of impairment, ranging from little or no impairment (i.e., healthy, adaptive functioning;

Level 0) to some (Level 1), moderate (Level 2), Severe (Level 3), and extreme (level 4) impairment. (APA, 2013, p.762)

The diagnosis of antisocial personality disorder shows a higher prevalence in immediate family members and those who have a history of antisocial personality disorder in the family are at an increased risk for somatic symptom disorder and substance use disorder. Family members are at a higher risk for substance abuse along with antisocial personality disorder if there is a history of it in the family. This disease is known to be genetic; however, environmental factors can exacerbate the problem (APA, 2000, p.704). Children adopted into parents with antisocial personality disorder are at a “risk of developing a personality disorder and related psychopathology” (APA, 2000, p.704). Antisocial personality disorder is noted to show a significant change with age. Those who are diagnosed with antisocial personality disorder are said to improve by middle age, so in old age the disorder is uncommon. (Tyrer & Seivewright, 2008).

Individuals with antisocial personality disorder endure adverse life factors in association with their diagnosis. According to Douzenis, Tsopelas, and Tzeferakos, in general cluster B personality disorders, which include antisocial personality, have a higher rate of medical comorbidity as a diagnosis, which has a negative impact on physical health. Medical disorders of patients with a diagnosis of a personality disorder from Cluster B have reported a higher rate of cardiovascular disease and were six times more likely to have a death to coronary disease (Douzenis, Tsopelas, & Tzeferakos, 2012). This high rate of

medical comorbidity can be attributed to the character traits of anger, impulsivity, and irritability, which usually results in non-compliance, and a higher rate of risky lifestyle behavior. Especially with antisocial personality disorder diagnosis, these patients' impulsivity leads to a high rate of alcohol and substance use as well as risky sexual behavior. This behavior usually results in sexual trauma or sexually transmitted disease (Douzenis et al., 2012). The authors also note risky sexual behavior that results in a sexual trauma can lead to a diagnosis of antisocial personality disorder, causing the individual to continue at a high risk lifestyle and live a diminished satisfactory life (Douzenis et al., 2012, p. 401).

Aside from medical issues antisocial personality disorder is known to have a strong correlation with violence. The mental status of an individual is a contributing factor to physical violence; however a number of additional components are known to exacerbate physical aggression in these individuals, such as; "poverty, inability to acquire the basic necessities of life, marital disruption, single-or no- parent families, substance abuse, unemployment, and lack of education lead to social disintegration, decreased social control and violence" (Fountoulakis, Leucht, & Kaprinis, 2008, p.85). Despite the strong correlation with this diagnosis it has been shown that not all antisocial individuals are violent or lack remorse for their actions. A study of 1422 persons with antisocial personality disorder regarding remorse, reported 694 (49%) felt remorseful for their actions (Fountoulakis et al., 2008, p.88). Another study showed over a five year period nonlethal violence was reported at 12%, of that,

24% were reported having Antisocial personality disorder. The authors note that half of the subjects with antisocial personality disorder were non-violent. Mental disorder and violence have a minimal correlation, however when paired with substances increased violent behavior (Fountoulakis et al., 2008, p.85).

Antisocial individuals often have the odds stacked against them in a number of different ways. It is known that this diagnosis is associated with individuals who come from a “low socioeconomic status and urban settings” (APA, 2000, p.703).

Psychopathy is currently a subset of antisocial personality disorder, according to the DSM-IV-TR. Although these two terms are lumped together in the DSM-IV-TR, that does not necessarily mean they are the same thing. Research suggests the diagnostic criteria of the two diagnoses are debatable (Tankersley, 2011, p.350). In fact, “William Reid (1978) in his book *The Psychopath* indicates that the core psychopath lies at the end of an antisocial personality continuum, and that most people who exhibit antisocial behavior do not belong in this group” (as cited in Stevens, 1994, P.162). This is largely due to psychopathy being associated to a number of varied traits. Tankersley, states that “Levinson claims that psychopathy is a socially acquired “life philosophy”, whereas other researchers think psychopathy is mainly genetically determined” (2011, p.349). In addition psychopaths are also separated by those who show low levels of anxiety versus high levels of anxiety. Those who present with low levels of anxiety are individuals that have no remorse or empathy for others, and premeditate violent acts (Tankersley, 2011).

Tankersley, defines “acquired sociopath” as persons who experience specific types of brain trauma, which can produce similar characteristics of antisocial behavior. Both psychopath and the “acquired sociopath” can have genetic factors that cause the illness, but environmental factors can also play a large part as well. One writer suggests that, “Psychopathy is generally differentiated from other disorders involving antisocial symptoms by extreme affective deficits as well as extreme behavioral transgressions” (Tankersley, 2011, p.350). Psychopaths show an increased rate of recidivism, as opposed to the recidivism rates of individuals with antisocial personality disorder. Antisocial behavior does not always resemble the “emotional callousness and premeditated violence exhibited by the psychopath” (Tankersley, 2011, p.351).

The “acquired sociopath” portrays normal sociomoral knowledge until a brain injury happens, according to Tankersley, (2011). In the sociopath these traits differ from a psychopath as they do not have the same emotional callousness, and differ from antisocial behavior by exhibiting different traits. Sociopaths like psychopaths do have a problem showing normal emotional responses when stimulated; however, sociopaths have the ability to remember what socioemotional norms were before the brain injury. Another dominant distinction is sociopaths’ violent behavior is usually in result of a reaction to their environment, whereas psychopaths premeditate and plan goals for displaying violent behavior (Tankersley, 2011).

“Psychopathy tends to be used as a label for people we do not like, cannot understand, or construe as evil,” (“Psychopathy,” 2011, p.68). Many believe an individual with antisocial personality disorder is an individual that always commits violent acts. Even the DSM-IV-TR states antisocial personality disorder is synonymous with psychopath, sociopath, and dissocial personality disorder. These views are not very accurate; everyone who is diagnosed with antisocial personality disorder is not a violent criminal, or a morally impaired psychopath. It does not seem accurate to categorize this disorder with sociopath as well as psychopath (Tankersley, 2012).

Attitudes

According to the Merriam-Webster Dictionary, attitude is defined as, “the way you think and feel about someone or something; a feeling or way of thinking that affects a person's behavior” (2013, p.1). The literature suggests people’s attitudes are directly correlated to their behavior. In a study conducted regarding attitudes and behaviors reported, “attitude exerted a significant direct effect on behavior” (Bentler & Speckart, 1981, p.235). There was a high, “correlation between attitude and intention” (Bentler & Speckart, 1981, p.235). These findings can be related to therapists in practice. It can be concluded that clinician’s in the field hold attitudes that can directly contribute or affect a client’s treatment. This is important to note as it is hypothesized that clinicians might hold negative views

towards individuals with antisocial personality disorder in addition to viewing them as a psychopath or sociopath.

In another study regarding therapists attitudes and patient outcomes, “therapists attitudes functioned as moderators rather than as mediators” (Sandell et al., 2007, p.201). Attitudes of kindness and supportiveness have been shown to be related to creating a therapeutic alliance with the client. “Patients with therapists who value kindness as a curative factor and neutrality as a therapeutic style and who regard psychotherapy as a form of artistry show particularly positive long-term effects of psychotherapy” (Sandell et al., 2001, p.205). In the same study it was also noted kindness and artistry had a strong correlation with post treatment outcomes. Neutrality alone acted as a suppressor of post treatment outcomes (Sandell et al., 2001, p.201). This study showed examples of positive attitudes which resulted in a majority of positive outcomes. This can stem to form a hypothesis, that harmful attitudes could produce undesirable outcomes of treatment.

Clinical Treatment

Individuals present themselves to clinics to seek out professional help in determining what is “wrong” with them and to see how they can “fix” it. In the real world a clinician’s job is not that cut and dried. According to Widiger & Samuel, when assessing individuals who possibly have a personality disorder, the use of a semi-constructed interview process, would be ideal, as it ensures validity to the

assessment. However, it has been shown the preferred method is an unstructured interview. Studies have shown that a diagnosis done in an unstructured assessment tend to not consider all of the required criteria of the diagnosis. Research has also indicated that personality disorder assessments done without a standardized clinical structure tend to be unreliable (Widiger & Samuel, 2005, p.278). It is recommended that clinicians begin with administering “a self-report inventory, to avoid unnecessary interviewing and to alert clinicians to maladaptive personality functioning...followed by a semistructured interview to assess systematically the respective diagnostic criteria of the disorders that were elevated on the self-report inventory” (Widiger & Samuel, 2005, pp.284-285). The use of a standardized instrument will also provide additional information that can be pertinent to diagnosing. It has been noted that including additional factors, such as; start of illness, gender bias, inadequate use of interpersonal skills, and personality change, have been known to help increase the validity of the assessment process (Widiger & Samuel, 2005).

After the assessment is completed the clinician will develop a treatment plan for the patient. Possible treatment for individuals suffering from antisocial personality disorder, include; inpatient, correctional settings, individual therapy, group therapy, experimental programs, and medication (Reid & Gacano, 2000). Despite the long list of treatment options listed, treatment for antisocial personality disorder and psychopathy have been viewed as, “a pessimistic clinical experience” (Reid & Gacano, 2000, p.64

Clinicians' Views

It may be difficult for clinicians to limit the ways in which society affects their attitudes towards a certain group such as personality disorders. However, it is social workers that have been educated and trained to move past such bias and deliver the best possible service to the clients. The profession of social work adheres to a code of ethics and values that must be upheld, one being dignity and worth of the person. This value is defined as, "social workers treat each person in a caring and respectful fashion, mindful of individual difference and cultural and ethnic diversity...Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs" (NASW, 2008, p.4). Upholding this value should make it more difficult for clinicians to hold extremely negative views about the diagnosis of the people they are treating, especially in ways that would interfere with good treatment.

It is apparent some mental health diagnoses carry with them a very negative stigma for many people, including some of the clinicians who work with them. In fact one study suggested that, "patients with an overt diagnosis of personality disorder are believed to be harder to manage by clinicians than those with a covert diagnosis of personality disorder" (Newton-Howes, Weaver, & Tyler, 2008, p.574). The clinicians viewed those with overt personality disorders to have a higher state of aggression and chaos. However, neither overt nor covert diagnosed individual reported a higher rate of aggression toward mental health professionals, social functioning, or services. The negative attitudes reported are

indeed contributed by the stigma that diagnosed individuals endure, which in turn can have a negative impact on treatment outcomes (Newton-Howes et al., 2008).

Working with individuals diagnosed with antisocial personality disorder is a difficult task, as these individuals can often times be manipulative, charming, and deceitful. This population does not have the best record for positive treatment outcomes, which often can be attributed to the patient not staying in treatment long enough, the patient not following all the treatment recommendations, or the wrong treatment modality being utilized (Reid & Gacano, 2000, p.657). It has been stated that, “sometimes the professionals who try to treat psychopathy fall victim to it themselves” (Reid & Gacano, 2000, p.657). Clinicians who are younger and recently out of school tend to be eager to treat this population as they carry a level of optimism with them. Unfortunately, it is the clinicians who lack maturity and experience that need protecting from the client as they are easily drawn into sexual seductions, and often excited by the client’s demeanor (Reid & Gacano, 2000, pp.657-658). Among the veteran therapists, it was expressed that youthful optimism was an effort to remove away some of their pessimism about antisocial personality disorder (Reid & Gacano, 2000, p.657).

In another study the authors elaborate on some of the challenges involved in working with antisocial personality disorder. The goal of mental health is to help the individual grow and focus on attitude changes that are positive. In antisocial personality, a trait that needs attention in treatment is the ego syntonic, however these traits are so natural the client does not realize there is a problem

(Kaylor, 1999, pp.248-249). Attempting to change attitude and character traits in an individual is difficult if the person cannot fathom the need for change. A mental health relationship is based on trust that is built through therapeutic rapport, this is difficult to do with individuals who are; insincere, manipulative, unsympathetic, and look down on intimacy (Kaylor, 1999, pp.248-249). One writer suggests “these individuals never develop a sense of trust and cannot progress beyond the separation-individuation stage of development” (Kaylor, 1999, p.249). He goes on to say “the absence of an early emotional attachment leads to a detachment from all relationships and affective experiences” (Kaylor, 1999, p.249).

Countertransference is a significant issue in the therapeutic world. As it is alive and well in all clinicians, it is inevitable as they are human beings too. It may be that “countertransference relates to all the feelings the clinician experiences toward the patient, to the extreme where the therapist actually feels the intensity of suffering of the client” (as noted in Bean-Gonzalez, 2009, p.22). It is noted, “strong countertransference reactions in the therapist are common” (Narud & Mykletum, 2005, p.187). This is often due to the erratic behaviors cluster B patients exhibit, such as; “acting out, self-destructive acts, substance abuse, violence, and anger, as well as intense unstable emotional reactions toward important persons, including the therapist” (Narud & Mykletum, 2005, p.187).

Different environments produce differences in attitude. A study conducted among clinicians in a prison setting, about individuals with antisocial personality

disorder displayed both positive and negative views of the clients (Stevens, 1994). In this study clinicians were asked if they thought treatment was hopeful towards individuals with antisocial personality disorder and 72% stated treatment was not hopeless. The clinicians' who disagreed stated that when approached by the clients they would seek out something for themselves that was not of therapeutic value. Other clinicians made statements, such as; "They're not hopeless, because they're perfectly happy with their behavior. How are you going to change that?" and "You cannot treat it; what you need is a DNA splice, and we don't have this" (Stevens, 1994, pp.181-182).

Research show staff attitudes paired with a healthy working environment brought positive realistic views of clients with personality disorder (Crawford et al., 2009). The supportive staff was determined to alleviate staff burnout, as mental health professionals have shown to have the highest rate of burnout compared to other professions. Agencies that focus on collaboration among colleagues and are guided by a strong leader are shown as crucial components in providing adequate treatment to people with personality disorders as well as lessen burnout among staff (Crawford at al., 2009). Staff members who work in this environment reported that this population brought challenges; however, there were reported positives to working with them. Staff reported work was 'never-boring', a sense of satisfaction of working with individuals who have been ostracized in the past, and the clients were termed as being creative, honest, and providing insight (Crawford et al., 2009).

The literature displayed a number of different views about antisocial personality disorder, which is to be expected as there are different contributing factors to each clinician's attitude. As stated previously clinicians can unfortunately be easily drawn in during treatment with an antisocial individual as the characteristics presented can be alluring, especially to those who are younger and more naïve. Setting was a factor in affecting the clinician's attitude towards clients with antisocial personality disorder. Those in the prison setting showed hope; however individual clinicians still expressed a pessimistic view toward them. Therapists in a healthy working environment did not show negative views toward the clients as they were supported by staff and had means to alleviate burnout. Countertransference was also a predicting factor towards attitude about individuals with antisocial personality disorder that was common among clinicians.

Theory Guiding Conceptualization

Theory of Reasoned Action is the chosen theory to guide this study. It suggests:

People's evaluations of or attitudes toward an object are determined by their easily accessible beliefs about the object is defined as the subjective probability that the object has a certain attribute...Such attitudes are acquired automatically and inevitable as we form beliefs concerning the object's attributes and as the subjective values of these attributes become linked to the object. (Ajzen, 2012, p.12)

Applying The Theory of Reasoned action can be used to help understand the potential relationship between unfavorable actions clinicians might hold toward clients with antisocial personality disorder and their behaviors toward them in treatment. People, even helping professionals, cannot hide how they really feel. Individuals are very perceptive and can sense if another individual is in favor of them or judging them. In a treatment setting the client would be able to sense unwanted behaviors or feelings from the clinicians, as it is very apparent when a clinician is trying to rush through a session. A client who feels negative energy from the therapist is likely to not succeed in treatment and possibly stop attending. The researcher will study the attitudes clinicians hold for this client group, and in applying the theory infer how the attitude produces behaviors which will affect the therapeutic relationship.

Summary

This chapter reviewed literature on antisocial personality disorder, specifically, diagnostic criteria, prevalence of the disorder, risk factors, medical comorbidity, violence, and the differences between psychopath, sociopath and antisocial personality. The assessment and different forms of treatment were recognized. The term attitude was defined and determined an important component to the study. Clinicians' views were explored through different circumstances regarding individuals with antisocial personality disorder. Lastly

the chapter discussed the theory guiding conceptualization and its application to the study.

CHAPTER THREE

METHODS

Introduction

This chapter explains the research methods used to explore attitudes among clinicians towards antisocial personality disorder. Furthermore, this chapter provides detailed procedures that were used to conduct the study, including study design and sampling techniques. A depiction of the data collection and instrument used are included, along with a description regarding the process of data analysis. Additionally, this section discusses the methods taken to ensure confidentiality of the individuals who participate in the study.

Study Design

The purpose of this study is to explore attitudes towards antisocial personality disorder among clinicians. Exploring antisocial personality disorder can be achieved by learning more about the attitudes clinicians hold toward patients with antisocial personality disorder. Antisocial personality disorder is linked to terms such as; psychopath and sociopath, according to the DSM-IV-TR (APA, 2000). This diagnosis, like many others, has a spectrum, which is a variation regarding the severity of the disorder, associated to it that shows differing levels of the disorder. That is to say not all antisocial personality disorder patients are violent, not all are criminals, and not all are severely manipulative.

Literature in the field suggests clinicians are to have a non-judgmental therapeutic relationship with their clients, “your role is not to judge whether clients are to blame for their problems or to determine whether they are good or bad, evil or worthy, guilty or innocent” (Hepwoth, Rooney, Dewberry-Rooney, & Strom-Gottfried, 2013, p.58). However if clinicians are following the societal norms they very well could be imposing unfavorable attitudes onto the client. Showing a lack of insight regarding the different levels of antisocial personality disorder during treatment could be detrimental to the therapeutic relationship and the overall outcome for the client.

The research methods chosen to address the hypothesis were both qualitative and quantitative. The survey entails fifteen questions clinicians answered through an interview. This research approach was chosen to gain insight into clinicians’ perception toward patients diagnosed with antisocial personality disorder. Interviewing the clinicians helped in understanding the attitudes they hold toward this population. The approach utilized was interviewing clinicians who have experience treating patients with antisocial personality disorder. The setting was face-to-face interviews asking open-ended questions and scaling questions. The clinicians interviewed held a professional degree and based on self-report were knowledgeable in regards to antisocial personality disorder, which was determined by their area of practice.

Sampling

The sample consists of clinicians in the mental health field who have worked, or currently work with patients who are diagnosed with personality disorders, specifically antisocial personality disorder. Clinicians varied in their college background by holding different degrees. The researcher interviewed subjects who were social workers, marriage family therapists, and faculty members at The School of Social Work at California State University San Bernardino. The researcher interviewed twelve clinicians and asked each clinician the same fifteen questions. This sample was chosen to gain a better understanding of the attitudes clinicians hold towards patients with antisocial personality disorder.

The method utilized to obtain participants was a snowball sample. This method allowed participants to suggest potential colleagues who had some knowledge of antisocial personality disorder. The participants received a \$10 gift card to Starbucks or Panera to act as an incentive to partake in the study as well as an appreciation of their time.

Data Collection and Instruments

Data was gathered by utilizing an instrument the researcher created, (see appendix A). The instrument consisted of fifteen questions, seven were interview, open-ended questions and the remaining eight were Likert scale questions. The questions were designed to determine if clinicians view antisocial personality

disorder on a spectrum. The Likert scale questions measured if the clinicians recognize a spectrum of the disorder. The participants were asked if they could be audio-taped in order to obtain all pertinent information during the interview. The independent variable measured in the study was antisocial personality disorder and the dependent variable measured was the attitudes clinicians hold toward this disorder.

The instrument employed for this study contained fifteen questions created by the researcher. Each question asked was to gain more insight into the thoughts clinicians have for individuals with antisocial personality disorder. Questions one, three, and five through nine were asked to determine the attitude clinicians have towards this population in a treatment setting. Some of these questions also served the purpose of allowing the researcher to further the participants' responses by asking additional questions, such as "do you see this disorder on a continuum?" Questions four and 10 pertained to treatment for the client. These were asked to determine if clinicians were hopeful in providing this population treatment.

The remaining questions two and 11-15 involved characteristics typical of individuals with antisocial personality disorder and some that are not. This was done in an effort to elicit information regarding the clinicians' views. Were they able to view the clients on a spectrum by rating them based on characteristics that are typical of a client with the disorder, as described in the literature, as

opposed to the characteristics that are not generally viewed with antisocial personality disorder clients?

Procedures

To obtain participants the researcher approached faculty at California State University San Bernardino and available clinicians from various agencies in San Bernardino and Riverside County. The faculty members approached were from the School of Social Work who had past experience working with individuals with personality disorders. The various clinicians were picked by the researcher and were contacted by e-mail asking for their participation in the study. Once a faculty member or clinician was interviewed the researcher asked the participants if they could recommend additional individuals to be surveyed.

Protection of Human Subjects

Every clinician was given an informed consent letter (appendix B) explaining their rights as a participant which entailed taking part in the interview was voluntary along with their right to end the interview during any point of the process, in addition to an audio consent form, (appendix C), explaining the use of the audio tape. The researcher explained to participants the details of confidentiality and told them how their personal information would be kept secure. The participants choose the meeting location to safeguard their privacy and make them feel more comfortable. The interviews were taped and the tapes

were held in a secure location in the researcher's home, along with the informed consent documents. After signatures were obtained the researcher began the interview. Once the interview ended the researcher provided the participant with a debriefing statement, (appendix D).

Data Analysis

The survey consisted of fifteen questions, seven being open-ended and the remaining eight being Likert scale questions. The data analysis process began by transcribing the open-ended questions. During transcription of the open-ended questions, the researcher looked for common themes among the responses. Likert scale questions were tallied and compared in SPSS to determine the spread of the answers on the Likert scaled questions.

Summary

This chapter covered the methodology that was utilized in completing the study in order to determine the attitudes clinicians have toward individuals with antisocial personality disorder. The researcher explained the study design, sampling techniques, the data collection procedures, and the instrument employed for the interviews. An explanation of the protection of human rights was reviewed. The data analysis process was described.

CHAPTER FOUR

RESULTS

Introduction

This chapter explains the findings of the study. Qualitative and quantitative data analysis was finished with data obtained from interviews with 12 clinicians. Analysis of the data was done by transcribing the answers to the open-ended questions. During transcription of the open-ended questions, the researcher looked for common themes among the responses. Quantitative (Likert scale) were described using the Statistical Package for the Social Sciences (SPSS).

Presentation of Findings

Demographics of the study are presented in Table 1 and Table 2. 12 Clinicians were interviewed, four male and eight female. The different levels of education entailed; three LCSW's, four LMFT's, three MSW's, and two Ph.D.'s. Years in practice varied from less than five years to over 20 years. Two participants had less than five years in practice, four had five to 10 years, no participants had between 10-15 years, three had 15 to 20 years, and three participants had over 20 years of experience.

Table 1. Participant Demographics-Part 1

		MALE	FEMALE
N = 12		4	8
Level of Education			
	LCSW		3
	LMFT	1	3
	MSW	1	2
	Ph.D.	2	
Years in Practice			
	Less than 5 years		2
	5 to 10 years	2	2
	10 to 15 years		
	15 to 20 years		3
	Greater than 20 years	2	1

Table 2 displays the official title of the clinicians interviewed. There was one assistant professor, one associate professor, one BASW title IV-E Program Coordinator, one clinical therapist, one director of field education, two LCSW's, two LMFT's, one mental health stipend coordinator, one MSW, and one program manager.

Table 2. Participant Demographics-Part 2

N = 12	MALE 4	FEMALE 8
Official Title		
Assistant Professor	1	
Associate Professor	1	
BASW Title IV-E Program Coordinator	1	
Clinical Therapist	1	
Director of Field Education		1
LCSW		2
LMFT		2
Mental Health Stipend Coordinator		1
MSW		1
Program Manager		1

Question #1 asked participants: As a therapist how do you feel working with antisocial personality disorder clients affects you? Answers varied resulting in no majority among the answers. Two out of the 12 participants were wary of the diagnosis and questioned the accuracy of the diagnosis for the individual. This was displayed in responses such as, “I personally try to stay away from diagnosing” (personal communication, survey #1, January 2014). “I have an

obligation to the field and profession to challenge my colleagues on their diagnosis” (personal communication, survey #2, January 2014). Three out of the 12 participants stated antisocial personality disorder does not affect them, responses such as, “For the most part I don’t think it affects me” (personal communication, survey # 4, February 2014), were common among the three individuals. The remaining seven respondents presented it affects them in a negative way, such as; annoyed, impatient, scared, or guarded. “It does affect me it can often times be annoying” (personal communication, survey #5, February 2014). “They are difficult to work with because they can be so irrational” (personal communication, survey #6, February 2014) and “They are scary” (personal communication, survey #11, February 2014) were responses given regarding question one.

Question #2 asked clinicians: Do you think clients with antisocial personality disorder have less respect for people in general? Do they have less respect for therapists in general? Seven out of 12 participants answered with a definite “yes” to having less respect for the general population and six of them said “yes” to therapists as well. Responses such as, “I think it is a condition of their illness. I think it is they just don’t understand a lot of appropriate behaviors or respond as we would expect them to” (personal communication, survey #3, February 2014). Whereas two respondents stated “no” to respecting therapists, and one of them stated “no” to respecting the general population, a respondent stated, “yes to the general population and no to therapists. I think they value to

some extent the dialogue that is occurring among professionals, I think they have some respect for that” (personal communication, survey #10, February 2014).

The remaining four answered respectfulness depends on the situation. The following responses portray what the clinicians meant, “I think they are very selective in who they have respect for. It kind of depends on where they are in their journey in life. It’s hard for me to make a generalization like that” (personal communication, survey #6 February 2014). “It’s almost a level of lack of functioning to lack of social skills that come in and it’s not just necessarily a disregard for others” (personal communication, survey #9 February 2014).

11 out of 12 respondents answered “yes” to question #3: As a practitioner, do you feel there are any rewards treating clients with antisocial personality disorder? Respondents stated rewards were displayed through, insight gained by the client, sticking with a difficult patient, and ability to find a method that works. “I find personal satisfaction when working with clients successfully that other people have not been able to do so” (personal communication, survey #1, January 2014). Another individual answered, “I think they can have a moment of insight which can be rewarding for them, yes that is rewarding as a practitioner” (personal communication, survey #7, February 2014). The following response was offered by another clinician:

First and foremost it is that you are able to find some approach or method to work with them, where obviously from a therapeutic standpoint you believe that there is some improvement or change that is going on,

something positive happening, that is really where the reward comes from.
(personal communication, survey #3, February 2014)

Question #4 asked: Generally, how long do you feel that a client with antisocial personality disorder requires treatment? Responses varied for this question, two out of twelve stated treatment is not effective for this population, “There is really no identified successful/regular treatment” (personal communication, survey #9 February 2014). One of the twelve respondents gave a specific time treatment would take when answering, “10 months to a year” (personal communication, survey #12, February 2014). Four out of twelve stated indefinitely. The following responses of the four participants, stated; “Lifelong, lifelong consultation, lifelong check-in, lifelong support group” (personal communication, survey #10, February 2014). “Forever, if that truly is there diagnosis that is their personality and not that you can change a personality because it is what it is” (personal communication, survey #5, February 2014). The remaining five participants answered the treatment times varied depending on the situation and individual. The following responses reflect what those five said:

If someone is antisocial and then you start to see some of the symptoms or characteristics [of a sociopath], terminate services with them, because it actually makes them more savvy. What they do is they begin to learn what it is we are looking for as therapists. (personal communication, survey #2, January 2014)

Another respondent stated, “I don’t know when you really stop. I think part of the way of when someone is done is their level of motivation and their commitment to any type of change process” (personal communication, survey #3, February 2014).

Are you fearful of patients with antisocial personality disorder? This was question #5. 10 out of the 12 participants were not fearful of individuals with antisocial personality disorder. One clinician stated, “I am not. I feel like if you are fearful as a clinician, I don’t care what the diagnosis is then you are coming from your own unresolved stuff” (personal communication, survey #2 January 2014). A second participant said, “I am aware of patients with all mental disorders, fear really isn’t an issue” (personal communication, survey #3, February 2014). A third respondent stated:

No. I have worked with them enough and in a professional setting you do have certain safety protections. I feel safer inside a building then on a street and that curbs their behavior a little bit, so I feel safer. (personal communication, survey #10, February 2014)

The remaining two clinicians were fearful and stated there was some fear associated with antisocial personality disorder. One clinician responded, “Working in an institution, I would say not any more than any other mental patient. I would have to say some fears” (personal communication, survey #6, February 2014). The other clinician stated, “Sure. Yes I would be fearful in a treatment setting too. Not likely they are going to do anything because there

wouldn't be any motivation that I know of. Yeah I would be on edge" (personal communication, survey #11, February 2014).

Question #6 asked: What are your initial thoughts when you hear antisocial personality disorder? Clinicians had varied responses. One clinician stated, "My initial thought is someone that challenges authority. Somebody that is stereotyped difficult to work with" (personal communication, survey #1, January 2014). A second participant responded, "Over diagnosis. That is the first thing that comes to my head, over diagnosis" (personal communication, survey #2 January 2014). A third clinician stated, "I am just like everyone else, crazy, serial killer, ax murderer. I think that is one of the problems, I think we still, more or less are susceptible to stereotypes" (personal communication, survey #3, February 2014). A fourth practitioner stated, "I don't really have an initial reaction" (personal communication, survey #4, February 2014). "Assume they are going to think every rule or protocol is BS and doesn't apply to them," (personal communication, survey #5, February 2014). Another clinician answered, "When I hear that I think of people who have had really terrible childhoods" (personal communication, survey #6, February 2014). "My first thoughts are that client is going to take a lot of resources and a lot of energy" (personal communication, survey #7, February 2014). An eighth clinician said, "I question who is calling it that, because often times it is a reflection of the person who is labeling it" (personal communication, survey #8 February 2014). Another clinician responded, "It doesn't strike me that much as uncharted territory. For my own

personal opinion, it is being more and more acknowledged how narcissistic our entire culture is becoming. Something I see contextually not independent” (personal communication, survey #9, February 2014). “I hear conduct disorder. I hear borderline. I hear manipulation. I hear driving normal people crazy and professionals crazy” (personal communication, survey #10, February 2014). Another response, “I want to run the other way” (personal communication, survey #11, February 2014). And the last response given, “I wonder what type of behaviors/symptoms they exhibiting that might be a problem in their personal lives” (personal communication, survey #12, February 2014).

The last qualitative question, #7, was: What strengths do you see in patients with antisocial personality disorder? Seven out the 12 clinicians stated individuals with antisocial personality disorder were resilient, determined, goal-seeking, and had the ability to get their needs met. Examples of such answers are; “They are very resourceful, very resilient, they can do things that some people are unable to do” (personal communication, survey #8, February 2014). “A lot of them are intelligent; a lot of them have motivation, not necessarily for the right thing. They have the capacity to get their needs met at any costs” (personal communication, survey #7, February 2014), and “Completely and utterly determined. They are very determined people, very resilient people, they just keep bouncing back” (personal communication, survey #2, January 2014). Three out of 12 clinicians stated them coming in for treatment and trying to gain self-awareness are strengths. These respondents provided statements such as; “I

always say if someone is willing to address personality issues, that is always a strength if you are willing to work on yourself” (Participant 1, personal communication, survey #1, January 2014), “The thing that I think people overlook all the time is the number one strength the very first strength is that if someone comes for therapy, that is a huge strength” (Participant 3, personal communication, survey #3, February 2014). The remaining two clinicians stated; “I see curiosity, questioning authority, questioning traditional values, questioning boundaries. I think that can be healthy for all of us to hear” (personal communication, survey #10, February 2014). “I think they are good at reading people and figuring out their vulnerabilities are and what they want out of life so they can use that to their advantage” (personal communication, survey #11, February 2014).

Of the 12 participants eight were asked a supplemental question during the interview process: Do you view antisocial personality disorder as the same as psychopath and sociopath? Is there a continuum for this diagnosis? All eight respondents answered they do not view the disorders the same despite antisocial personality disorder being the same diagnosis in the DSM-IV-TR. Examples of answers were as such; “I think they are all viewed the same but I think in actuality they is a continuum” (personal communication, survey #2, January 2014). Another clinician provided the following response:

I would say they are different, especially those who are capable of violence and hurting other people and feeling nothing. That might be

different from an antisocial personality disorder person who doesn't care about any rules or has no regard for other's people feelings, but isn't going to hurt somebody. I think there is a difference there. (personal communication, survey #5, February 2014)

An alternative response provided:

I think it's a continuum. It's like a level of intensity; a psychopath has absolutely no empathy that is the extreme for antisocial personality disorder. I think there are a lot of people who could be categorized as antisocial personality disorder who aren't necessarily a psychopath. (personal communication, survey #6, February 2014)

Another clinician stated, "I think sociopath and psychopath are beyond. I don't think they are at the same level as antisocial personality disorder, but I very much think antisocial personality disorder can lead to that" (personal communication, survey#8, February 2014).

The next section analyzed was quantitative. Participants were asked to scale eight questions on a range from 1-5; 1=strongly disagree, 2=somewhat disagree, 3=neutral/no opinion, 4=somewhat agree, 5=strongly agree. Question #8 asked: Are you confident about working with individuals diagnosed with antisocial personality disorder? Of the twelve clinicians, one stated strongly disagree, no respondents answered somewhat disagree or neutral/no opinion, seven circled somewhat agree, and four answered strongly agree.

Respondents were asked: Do you enjoy working with people diagnosed with antisocial personality disorder, for question #9. Two strongly disagreed, one somewhat disagreed, two had a neutral/no opinion, six somewhat agreed, and one strongly agreed. Question #10 entailed: Do you think treatment is effective for patients with antisocial personality disorder? One said strongly disagree, two answered somewhat disagree, no respondents answered neutral/no opinion, seven stated somewhat agree, and two stated strongly agree.

Question #11: Do you think individuals with antisocial personality disorder are callous? No respondents circled strongly disagree, One answered somewhat disagree, four answered neutral/no opinion, three circled somewhat agree, and four answered strongly agree. Question #12 asked: Do you think an individual with antisocial personality disorder would be a good parent? One stated strongly disagree, three answered somewhat disagree, three answered neutral/no opinion, three circled somewhat agree, and two noted strongly agree. Question #13 asked: Do you think individuals with antisocial personality disorder are manipulative? No respondents answered strongly disagree, somewhat agree, or neutral/no opinion, whereas two marked somewhat agree, and 10 stated strongly agree.

Question #14 asked: Do you think individuals with antisocial personality disorder can be responsible individuals? No respondents selected strongly disagree, somewhat agree, or neutral/no opinion, seven stated they somewhat agree, and five stated they strongly agree. The last question asked: Do you think

individuals with antisocial personality disorder have a grandiose sense of self-worth? One respondent answered strongly disagree, five stated somewhat disagree, no respondents marked neutral/no opinion, three stated somewhat agree, and the remaining three marked strongly agree.

Summary

The data presented in this chapter were result of interviews with 12 clinicians who have experience treating individuals with antisocial personality disorder. All 12 volunteered to be interviewed and audio-taped. Following the interviews the researcher transcribed the interviews and analyzed the results using common themes among responses for the qualitative portion. The quantitative portion was entered into SPSS and described.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter discusses the results of the research and relates them to the literature and the theory of reasoned action. In addition this chapter will address the limitations of the study and recommendations for social work practice and future research.

Discussion

The purpose of this study was to determine how clinicians viewed individuals diagnosed with antisocial personality disorder. It was hypothesized clinicians in the mental health field would view this population negatively in general. The clinicians who took part in this study were questioned as to how the term antisocial personality disorder might relate to the terms, psychopath and sociopath which are often used in the literature to describe the same group of clients. One of the major reasons for conducting this study was to explore the relationship between negative attitudes held by clinicians towards this population and their working relationships with these clients.

The ways in which the 12 clinicians viewed clients with antisocial personality disorder varied widely. Their different views could have been caused by a number of factors including treatment settings, general treatment

effectiveness with this population, characteristics of people with antisocial personality disorder, general attitudes toward this client population, and theoretical perspectives about not only antisocial personality disorders, but personality disorders in general.

Implications of Treatment Setting

The treatment setting of the clinicians participating in the study varied from direct practice to indirect practice. 5 participants currently do not practice therapy with individual clients; however they do possess experience in working with individuals diagnosed with antisocial personality disorder. The remaining 7 are in the field and work with clients on a regular basis.

Clinicians who were not currently in a direct practice treatment setting seemed to be less negatively biased toward people with antisocial personality disorder but still acknowledged the negative stereotypes associated with people who have this diagnosis. These clinicians appeared more hopeful about positive treatment outcomes and when speaking about people with antisocial personality disorder they seemed to have more compassion.

The responses seemed to indicate that clinicians practicing in a forensic setting were not fearful of people with this diagnosis, had a better understanding of these individuals, and were sometimes wary of the validity of the diagnosis itself. These findings were similar to those in a study with clinicians in a forensic setting by Stevens (1994). In a study clinicians were asked if they felt the

diagnosis antisocial personality disorder was accurate. Stevens indicated (1994) that, "Fifty percent (n=26) of the respondents believe the diagnosis is used in the right percentage of cases, forty percent (n=21) believe it is overused, and ten percent (at n=5) believe it is underused" (Stevens, 1994, p.167).

Clinician's currently in a mental health setting appeared to experience a sense of burnout with this specific population (antisocial personality disorders), were more inclined to agree with the negative stereotypes and had a tendency to give a back handed strength. Examples of responses were, "They are good at reading people and figuring out what their vulnerabilities are and what they want out of life so they can use that to their advantage" (personal communication, survey #11, February 2014). "They can do things that some people are unable to do, they will find a way to get it or through it. They will find a way to con people out of it for their own survival" (personal communication, survey # 8, February 2014). The literature supports these findings, "patients with cluster A + B PD's evoked more negative and less positive countertransference reactions than patients with cluster C PD's" (Rossberg et al., 2007, p. 228), among clinicians.

Implications of Treatment

Questions 4 and 10 of this study pertained to the treatment of antisocial personality disorder. The attitudes of the respondents in this study toward the treatment of people with antisocial personality disorder seemed to be generally

positive and hopeful, although a majority of clinicians indicated treatment for clients with this personality disorder needed to be throughout life.

The majority of respondents agreed that the treatment of persons with antisocial personality disorder could be effective. Other studies have contrasting reviews on treatment outcomes for this population. For example Reid and Gacono (2000) state “No traditional voluntary or inpatient milieu has been shown to be effective, and there are no individual or group psychotherapy that is routinely associated with success. No medication is effective for characterologic antisocial behavior” (p. 658). Another study notes “recent empirical work suggests that youth and adults with high scores on measure of psychopathy can show reduced violent and other criminal behavior after intensive treatment” (“Psychopathy,” 2011, p.68). This incongruence in the literature regarding treatment effectiveness shows more research needs to be conducted on the general efficacy of treatment with people who have antisocial personality disorder.

Implications of Characteristics

The third general issue discussed here pertains to the core features of the diagnosis of antisocial personality disorder itself. Questions 2, 11-15, and the additional question: do you view antisocial personality disorder as the same as psychopath and sociopath, were specifically related to certain characteristics of people with the disorder. As noted in the DSM-IV-TR:

Individuals with Antisocial Personality Disorder frequently lack empathy and tend to be callous, cynical, and contemptuous of the feelings, rights, and sufferings, of others. They may have an inflated and arrogant self-appraisal and may be excessively opinionated, self-assured, or cocky. (2000, p.703)

The goal of this study was to determine the extent to which the clinicians agreed with certain stereotypical traits associated with this diagnosis in addition to traits not typically associated with this population. Question two referred to if this client group respects the general population and/or therapists. Half the respondents stated there is less respect from this client group for therapists as opposed to other individuals receiving treatment. Other statements by the respondents suggested respect for therapists is dependent on the particular situation the client is in. Since over half the respondents stated clients with antisocial personality disorder have less respect for the general population as opposed to therapists it was determined this group has less respect for the general population.

In regards to the Likert scale questions pertaining to negative traits such as callousness, manipulateness, and having a grandiose sense of self-worth, there was strong agreement between participants that these traits, are in fact, accurate descriptive words for antisocial personality disorder. However, for a grandiose sense of self-worth, participants noted clients do have this, but it is a defense mechanism they use because in reality they are not confident. For

positive traits not associated with the diagnosis, results for the term “responsible” indicated clinicians do not feel individuals with this diagnosis carry this trait.

Regarding the question related to the “ability to be a good parent,” clinicians were apparently undecided as a group. There was no majority for or against this trait in association with these individuals.

The additional question asked of eight clinicians elicited the same response for all participants. These responses addressed the second part of the hypothesis, which was related to an effort to determine if clinicians were able to view antisocial personality disorder on a spectrum in terms of traits or symptomology. The clinicians indicated a belief that the diagnosis of antisocial personality disorder is not the same as a diagnosis of psychopath or sociopath. In fact they were able to visualize the three disorders separately and on a continuum. These findings were congruent with other studies in the literature. One in particular states, “Psychopathy is generally differentiated from other disorders involving antisocial symptoms by extreme affective deficits as well as extreme behavioral transgressions” (Tankersley, 2012, p.350). Although the diagnosis of antisocial personality disorder in the DSM-I-TR includes what is often meant by the terms psychopath, and sociopath, antisocial personality disorder is at one end of spectrum which is viewed as less intense by the participants of this study than the other two types of personality

Implications of Attitude

The general issue discussed here is related to attitudes elicited from the participants' responses. Questions one, three, and five through nine were included to provoke responses related to how the clinician felt about individuals with antisocial personality disorder.

The majority of answers for question one brought negative feelings out in the clinicians, which appears to be consistent with the reputation this client group brings with them to treatment. The majority of clinicians with these feelings are currently in direct treatment settings, whereas neutral or empathetic responses were given by clinicians not in direct practice. Other studies conducted on this population had similar findings. For example one study found "patients with an overt diagnosis of personality disorder are believed to be harder to manage by clinicians than those with a covert diagnosis of personality disorder. This attitude is not a direct consequence of greater need, social functioning, or aggression" (Newton-Howes et al., 2008, p.574). The clinicians who questioned the legitimacy of the diagnosis hold the same skepticism as others in the professions, "as is common with personality disorder studies, is the debate about diagnostic validity of this label" (Newton-Howes et al., 2008, p.574).

Rewards are an intrinsic feeling clinicians sometimes have when treating clients in what they believe is an effective manner. Question three looked at what lead to rewarding work for the clinicians when treating clients with antisocial personality disorder. Almost all clinicians stated there was a reward gained when

helping this population. Apparently clinicians do see this population as receptive to treatment, which is consistent with the results to the question regarding the effectiveness of treatment.

Questions five through seven pertained to clinicians' initial thoughts of the disorder; they were asked if they were fearful of the population and if they could identify strengths in clients who have antisocial personality disorder. The majority of participants were not fearful of these individuals. The initial responses clinicians gave provided insight to how they view the population. A few clinicians questioned the validity of the diagnosis, whereas some showed concern about the clients' childhoods, and others demonstrated frustration and the abundance of resources required to help them. The strengths mentioned for this population were positive, however responses indicated a number of participants in direct practice came up with a strength that did not necessarily apply to this population, or it was a positive attribute delivered with a negative connotation. Such as, "A lot of them are intelligent, a lot of them have motivation, not necessarily for the right thing. They have the capacity to get their needs met at any cost" (personal communication, survey #7, February 2014).

Question eight and nine were Likert scale questions. The majority of clinicians stated they felt confident working with this population. Over half of respondents indicated they enjoyed working with individuals with antisocial personality disorder. It may be that clinicians are knowledgeable about the

stereotypes associated with the diagnosis, but continue to feel confident and hopeful of treatment effectiveness anyway.

The Theory of Reasoned Action

The hypothesis of this study was based on the theory of reasoned action. The purpose of the study was to evaluate the attitudes and beliefs clinicians held about antisocial personality disorder. It was hoped the researcher might be able to infer from clinician attitudes if their beliefs would affect the therapeutic relationship.

The results indicate clinicians may have a mix of emotions when working with this population, especially from those clinicians who are currently working in a treatment facility. The varying views is supported by the theory of reasoned action, which states, "People can, of course, form many different beliefs about an object, but it is assumed that they attend to only a relatively small number at any given moment" (Ajzen, 2012, p.12). The researcher believes all the clinicians held the same attitude at one point during direct practice; however those now removed from direct practice are aware of the biases about clients with antisocial personality disorder but tend to show a more neutral attitude towards this population, whereas those clinicians working in a treatment setting show signs of frustration. Literature states, "negative attitudes are part of the stigmatizing position, as outlined by Goffman, and cannot only hinder management but can also have a negative impact on outcome" (Newton-Howes et al., 2008, p. 576).

Applying the Theory of Reasoned Action to the attitudes from the participants, it is concluded the emotions clinicians hold are contingent on the treatment setting of the clinician. Clinicians who are more removed from direct practice hold a more neutral, empathetic attitude but are aware of the negative implications associated with the population. Those clinicians currently in treatment facilities appear more frustrated with this group. It may be that their biases do affect their behavior in treatment, potentially skewing a therapeutic relationship with the client.

Limitations

A limitation of the study could have been participants' answers; they could have been modest considering they felt obligated by the profession to give the "right" response, despite their anonymity guaranteed. Naturally the potential for researcher bias is always present. To limit the influence of this the researcher was aware of her bias that was geared in hopes to prove the hypotheses along with posing questions that did not elicit desired responses. Another limitation of the study was the reliability of the questions. The questions did seem to elicit some attitudes about the client group from the participants, but the questions did not provide much information about how these attitudes affected their clinical behavior and in turn affected treatment and treatment outcomes. Another limitation was this study was small sample which consisted only of 12 participants, which greatly limits any generalizability of the findings.

Recommendations for Social Work Practice, Policy, and Research

The researcher's recommendations for future research are to explore the attitudes of other helping professions in addition to the attitudes of the social work profession toward clients with antisocial personality disorder. During this study it looked as if marriage family therapists might hold a more negative view than social workers. However additional research would be needed to explore differences between the clinical professions related to these issues. It might be possible social work values and training affects the attitudes clinicians have.

Conclusion

This chapter discussed how treatment setting, treatment, characteristics, attitudes, and the theory of reasoned action were related to the findings in this study. Although this was a small sample it seemed that clinicians who were not currently involved in direct treatment had fewer negative attitudes or biases toward persons who have been diagnosed with antisocial personality disorder than clinicians who were still involved in direct treatment. People with antisocial personality disorder often have very troubled lives and often find themselves in treatment for a variety of reasons. The attitudes and biases that social workers and other mental health and human service professionals have toward people with this significant disorder could potentially affect treatment and intervention in serious ways. The relationships between people with antisocial personality disorder and the professionals who attempt to help them deserve further study.

APPENDIX A
DATA COLLECTION INSTRUMENT

Demographics:

Gender?

How many years have you been practicing therapy?

What is your official title?

What is your level of education?

Interview Questions:

1. As a therapist how do you feel working with Antisocial Personality Disorder clients affects you?

2. Do you think client with Antisocial Personality Disorder have less respect for people in general? What about therapists in general?

3. As a practitioner, do you feel that there are any rewards treating clients with Antisocial Personality Disorder?

4. Generally, how long do you feel that a client diagnosed with Antisocial Personality Disorder requires treatment?

5. Are you fearful of patients with Antisocial Personality Disorder?

6. What are your initial thoughts when you hear Antisocial Personality Disorder?

7. What strengths do you see in patients with Antisocial Personality Disorder?

Scaling Questions:

On a scale of 1-5 how would you rate the following?

1=Strongly disagree

2=Somewhat disagree

3=Neutral/No opinion

4=Somewhat agree

5=Strongly agree

8. Are you confident about working with individuals diagnosed with Antisocial Personality Disorder?

1 2 3 4 5

9. Do you enjoy working with people diagnosed with Antisocial Personality Disorder?

1 2 3 4 5

10. Do you think treatment is effective for patients with Antisocial Personality Disorder?

1 2 3 4 5

11. Do you think individuals with Antisocial Personality Disorder are callous?

1 2 3 4 5

12. Do you think an individual with Antisocial Personality Disorder would be a good parent?

1 2 3 4 5

13. Do you think individuals with Antisocial Personality Disorder are manipulative?

1 2 3 4 5

14. Do you think individuals with Antisocial Personality Disorder can be responsible individuals?

1 2 3 4 5

15. Do you think individuals with Antisocial Personality Disorder have a grandiose sense of self-worth?

1 2 3 4 5

Developed by Theresa Matich

APPENDIX B
INFORMED CONSENT

Informed Consent

The study in which you are being asked to participate is designed to investigate attitudes toward Antisocial Personality Disorder. This study is being conducted by Theresa Matich under the supervision of Dr. Ray Liles, Lecturer of Social Work, California State University, San Bernardino. This study has been approved by the School of Social Work subcommittee of Institutional Review Board, California State University, San Bernardino.

In this study you will be asked to respond to several questions regarding attitudes toward Antisocial Personality Disorder among mental health clinicians. The interview should take approximately 30 minutes to complete. All your responses will be held in the strictest of confidence by the researcher. Your name will not be reported with your responses. All the data will be reported in group form only. You may receive the group results of this study upon completion after June, 2014, through the online database at California State University, San Bernardino.

Your participation in this study is totally voluntary. You are free not to answer any questions and withdraw at any time during this study without penalty. When you have completed the interview, you will receive a debriefing statement describing the study in more detail. In order to ensure validity of the study, we ask that you not discuss this study with other participants.

There will not be any risks associated with this research, either long term or short term to the participants of this study. However, there will be benefits in terms of self-awareness and increased knowledge.

As part of this research project an audio recording device will be used. The use of the audio recordings will only be analyzed by the researcher for the sole purpose of the research project.

If you have any questions or concerns about this study, please feel free to contact me or Dr. Ray Liles, Ph D at Phone: (909) 537-5557

By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I also acknowledge that I am at least 18 years of age.

I have read, understood, and agreed to participate in this study.
Today's Date: _____

I give permission to audio tape record my interview.

909.537.5501

5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393

APPENDIX C
AUDIO CONSENT

**AUDIO USE
INFORMED CONSENT FORM
FOR NON-MEDICAL HUMAN SUBJECTS**

As part of this research project, we will be making an audiotape recording of you during your participation in the experiment. Please indicate what uses of this audiotape you are willing to consent to by initialing below. You are free to initial any number of spaces from zero to all of the spaces, and your response will in no way affect your credit for participating. We will only use the audiotape in ways that you agree to. In any use of this audiotape, your name would *not* be identified. If you do not initial any of the spaces below, the audiotape will be destroyed.

Please indicate the type of informed consent

Audiotape

- **The audiotape can be studied by the research team for use in the research project.**

Please initial: _____

- **The audiotape can be played in classrooms to students.**

Please initial: _____

I have read the above description and give my consent for the use of the as indicated above.

SIGNATURE _____ DATE _____

APPENDIX D
DEBRIEFING STATEMENT

Attitudes Toward Antisocial Personality Disorder

Mental Health Clinicians

Debriefing Statement

The study you have just completed was designed to investigate attitudes toward Antisocial Personality Disorder among mental health clinicians. The interview questions are designed to explore deeply attitudes and beliefs about the subject. The researcher is particularly interested in studying attitudes toward Antisocial Personality Disorder among mental health clinicians.

Thank you for your participation and for not discussing the contents of the survey with other participants. If you have any questions about the study, please feel free to contact **Dr. Ray Liles, Ph.D.** at **Phone (909)537-5557 or by E-mail: reliles@csusb.edu**. If you would like to obtain a copy of the group results of this study, please contact **Dr. Ray Liles, Ph.D.** at **Phone (909)537-5557 or by E-mail: reliles@csusb.edu** at the end of spring quarter of 2014.

Again, thank you for your participation.

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