

RESEARCH ARTICLE

Explaining the willingness of clinicians to work with patients with antisocial personality disorder using the theory of planned behaviour and emotional reactions

Arno van Dam^{1,2}  | Madeleine Rijckmans^{1,3,4} | Louisa van den Bosch^{5,6}

¹Tranzo Scientific Center for Care and Welfare, Tilburg School of Social and Behavioral Sciences, Tilburg University, Tilburg, Netherlands

²Research and Innovation, GGZ WNB Mental Health Institute, Halsteren, Netherlands

³Mental Health Institute, Innovation and Quality, GGZ Breburg, Tilburg, Netherlands

⁴Forensic Psychiatric Institute, Fivoor, Tilburg, Netherlands

⁵Institute for DBT Training and Treatment, Dialexis, Nijmegen, Netherlands

⁶Consulting in Mental Health, Synthis, Deventer, Netherlands

Correspondence

Arno van Dam, Tranzo Scientific Center for Care and Welfare, Tilburg School of Social and Behavioral Sciences, Tilburg University, Tilburg, Netherlands.

Email: a.vandam@ggzwnb.nl

Abstract

Many clinicians seem to experience negative emotions towards patients with antisocial personality disorder (ASPD), resulting in the exclusion of patients in many treatment programmes. The behaviour of individuals with ASPD has a significant impact on society, which affects ASPD patients and their environment, and therefore, the exclusion from programmes is a serious concern. Relatively, little is known about why some clinicians are willing to work with ASPD patients and others are not and what factors contribute to an increase in the motivation to do so. In this study, clinicians ($n = 130$) working in a regular and forensic mental health service in the Netherlands completed a questionnaire based on the theory of planned behaviour (TPB) and the Feeling Word Checklist and questions about the relevant experience gained and education received. The current study confirms the limited willingness to work with ASPD patients, especially in regular mental health care. Experience working with ASPD patients, education on cluster B personality disorders and having experienced verbal and/or physical violence in clinical practice did not fully explain whether or not clinicians were motivated to provide treatment to ASPD patients. TPB appeared to predict the intention to provide psychological therapy to ASPD patients adequately. The impact of positive emotions towards ASPD patients on providing treatment appeared to be stronger than negative emotions. This study provides more insight into why so few clinicians are willing to work with ASPD patients and what may increase motivation to include this group in treatment programmes.

KEYWORDS

antisocial personality disorder, attitude, clinicians, emotions, motivation, theory of planned behaviour

1 | INTRODUCTION

Antisocial personality disorder (ASPD) is characterized by a pervasive pattern of disregard for the feelings of others, often accompanied by

violation of the rights of others through negligence or overt action. People with ASPD have great difficulty conforming to social norms and rules, making it very difficult for them to maintain employment and function within a family (APA, 2013; L.M.C. Van den Bosch

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2021 The Authors. *Clinical Psychology & Psychotherapy* published by John Wiley & Sons Ltd.

et al., 2018). For an individual to meet the criteria for the DSM-V Antisocial Personality Disorder, they must experience the following: (A) The pattern of disregarding others' rights is present since age 15 by fulfilling at least three of the following seven behaviours: (1) failure to conform to social norms concerning lawful behaviours, 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 the safety of self or others; (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or fulfil financial obligations, and (7) lack of remorse, as indicated by being indifferent or rationalizing. In addition, (B) the individual is 18 years or older, (C) shows evidence of conduct disorder before age 15 and (D) antisocial behaviour that is not directly related to schizophrenia or bipolar disorder (APA, 2013).

Because of these maladaptive behaviours, individuals with ASPD evoke strong aversive emotions in others. They are often expelled by their social environment, like family, friends and work, resulting in high rates of unemployment and divorce rates (Bahlmann et al., 2002; Black & Larson, 1999; Holzer & Vaughn, 2017; Raine, 2013). Also, in mental health care, these patients evoke strong emotions that often lead to exclusion from treatment programmes (R.C. Schwartz et al., 2007; Sheehan et al., 2016; L.M.C. Van den Bosch et al., 2018). Being diagnosed with ASPD often is an exclusion criterion for admission to mental healthcare. Even if patients with ASPD seek help for comorbid disorders, like post-traumatic stress disorder, major depression, anxiety disorders or primary for ASPD, they do not get access to treatment (Djadoenath & Decoene, 2015; L.M.C. Van den Bosch et al., 2018). The exclusion of ASPD patients in many treatment programmes is also a serious problem. ASPD significantly impacts society and affects patients and their environment regarding interpersonal, financial and emotional consequences (Goldstein et al., 2012; Quinsey et al., 1998; Rijckmans et al., 2020).

Countertransference describes how various feelings are elicited in clinicians, which is a common phenomenon when working with individuals with personality disorders and can be of diagnostic and therapeutic value (Betan et al., 2005). However, countertransference is problematic when it leads to stigma and refraining patients from care (Chartonas et al., 2017).

Concerning ASPD patients, clinicians report feelings of being rejected, on guard, bored, overwhelmed (B. Thylstrup & Hesse, 2008), dominated (i.e., exploited, manipulated and talked down to; Colli et al., 2014; Meloy & Yakeley, 2014; R.C. Schwartz et al., 2007) but also feelings of shock, hostility, moralistic outrage and hatred (Meloy & Yakeley, 2014; R.C. Schwartz et al., 2007). At times, professionals may also experience fear and dread due to feeling threatened and helpless (Colli et al., 2014; Meloy & Yakeley, 2014). Lion (1978) was the first one who described that these reactions might eventually result in therapeutic nihilism, which is the clinician's rejection of all patients with an antisocial history as being completely untreatable (Meloy & Yakeley, 2014).

Key Practitioner Message

- Providing treatment to ASPD patients is essential because ASPD significantly impacts society and affects patients with ASPD and their environment regarding interpersonal, financial and emotional consequences.
- Experience working with ASPD patients and education on cluster B personality disorders do not automatically lead to enhanced motivation to provide treatment to ASPD patients.
- The most critical factor in our study contributing to providing psychological treatment to ASPD patients is perceived behavioural control. Therefore, training and supervision aimed at feelings of control and competence of the clinician could enhance perceived behavioural control.
- Having experienced verbal and/or physical violence in clinical practice does not automatically lead to reduced motivation to provide treatment to ASPD patients.

An international Delphi study (L.M.C. Van den Bosch et al., 2018) involving 61 experts on ASPD revealed that clinicians working with ASPD patients might also experience professional, positive feelings towards them. These feelings usually stem from a thorough knowledge of theories that explain ASPD and the therapies based upon it. A non-judgmental attitude towards the patient's behaviour is regarded as necessary by these experts on ASPD because the behaviour is part of the disorder and highlights important treatment targets (e.g., therapy interfering behaviour; L.M.C. Van den Bosch et al., 2018).

Although there are clinicians that have a positive attitude towards ASPD patients, the majority of clinicians report negative emotions towards them, and this results in the exclusion of ASPD patients from many treatment programmes (A. Bateman et al., 2013; L.M.C. Van den Bosch et al., 2018; Crawford et al., 2009; Reid & Gacono, 2000; van Dam & Rijckmans, 2020). Exclusion from treatment is a serious problem because ASPD patients suffer from psychiatric disorders like post-traumatic stress disorder, major depression, anxiety disorders and addiction, and the number of suicides and suicide attempts is relatively high (Blackburn et al., 2003; Frances et al., 1986; Galbraith et al., 2014; Goodwin & Hamilton, 2003; Lenzenweger et al., 2007; Sareen et al., 2004).

A recent Cochrane systematic review showed that research on treatment programmes targeting antisocial behaviour is scarce and that there is not yet an evidence-based treatment for ASPD available (Gibbon et al., 2020). Although there is no treatment available with substantial empirical evidence for effectiveness, some studies reveal promising results and deserve to be further developed and researched in clinical practice (L.M.C. Van den Bosch et al., 2018). The findings

contradict pessimistic views on the treatability of violent offenders with PD's and support the effectiveness of long-term psychotherapy on rehabilitation and PD symptoms. Furthermore, some evidence-based treatment protocols for borderline personality disorder (BPD) have been adapted for ASPD or the combination of ASPD and BPD and show favourable outcomes, for example, Dialectical Behavioural Therapy (DBT; L.M.C. Van den Bosch et al., 2012; Wetterborg et al., 2020), Mentalisation Based Treatment (MBT; A. Bateman et al., 2016; McGauley et al., 2011) and Schema Focused Treatment (SFT; D.P. Bernstein et al., 2021; D.P. Bernstein et al., 2012; Doyle et al., 2016). Furthermore, ASPD patients who receive cognitive behavioural therapy aimed at ASPD appear to benefit from it, resulting in reduced levels of substance abuse and psychiatric complaints (Crawford et al., 2009; B. Thylstrup et al., 2017; B. Thylstrup & Hesse, 2016).

Little is known about why some clinicians are willing to work with ASPD patients and others are not. Insight into the factors that contribute to the motivation of psychotherapists to treat patients with ASPD could provide insight into what measures increase that motivation.

The theory of planned behaviour (TPB) is a motivation theory that has proven to be effective in predicting behaviour in a wide variety of domains like health behaviour, education, ecological behaviour and psychotherapy and therapist behaviour (I. Ajzen, 2011; Clough et al., 2017; Cooke et al., 2016; Rebergen et al., 2006; van Dijk et al., 2012). The TPB states (A) that if people's attitude towards the suggested behaviour is more positive, (B) they think that significant others want them to adopt the behaviour and (C) they believe they can adopt the behaviour, this results in a stronger intention to adopt that behaviour, which makes it more likely that they will behave in that way. I. Ajzen (1991) defines intention as a person's motivation, willingness to exert effort and willingness to try hard to enact the behaviour.

We also measured the nature and intensity of emotions experienced by clinicians and determined whether they influenced the willingness to provide psychological treatment. The Feeling Word Checklist (FWC-30; Whyte et al., 1982) was developed as a more general list to measure the feelings of mental health professionals towards their patients. In addition, the FWC measured the feelings of clinicians towards forensic patients and found a significant relationship to their assessed risk as measured by the Historical Clinical Risk management-20 (HCR-20; Webster et al., 1997), a widely used tool for violence risk assessment (V. de Vogel & de Ruiter, 2004; Dernevik et al., 2001). Therefore, it is plausible that these feelings are also related to the willingness to provide treatment for ASPD patients.

2 | METHODS

2.1 | Participants

Participants in this study were 130 clinicians (psychiatrists [10], psychologists [74], social workers [14] and psychiatric nurses [32]),

working in regular (66) and forensic mental health services (64) in the mental health institutions GGZ WNB (Mental health institute Western North Brabant [forensic and regular outpatient and inpatient mental health care]), GGZ Breburg (Mental health institute Breburg (forensic and regular outpatient mental healthcare), Scelta (standard outpatient mental healthcare) and forensic mental health institution Fivoor (four outpatient departments and inpatient forensic psychiatric clinic De Kijvelanden), all in the Netherlands. Details of the participants are provided in Table 1.

2.2 | Measures

Theory of planned behaviour questionnaire for ASPD treatment (TPBaspdT): According to the manual for constructing a theory of planned behaviour questionnaire (I. Ajzen, 2013; Fishbein & Ajzen, 2010), we created a questionnaire to measure the intention to provide psychological treatment to ASPD patients, attitude towards providing psychological treatment to ASPD patients, the perceived social norm to do so and the belief of being capable in providing the treatment. After selection of items that contributed to acceptable internal reliability of a subscale, we constructed a questionnaire with three items for attitude (A), perceived social norm (PSN) and perceived behavioural control (PBC), and two items for intentions (I) (see Appendix A). The items were scored on a 7-point Likert scale. We applied principal component analysis (PCA), using varimax rotation forcing three factors, to check whether the items in our questionnaire adequately represented the factors derived from theory. This analysis was applied to the scores of nine items, which according to TPB theory, predict intention to provide psychological treatment to ASPD patients. The Kaiser-Meyer-Olkin (KMO) measure showed good sampling adequacy (KMO = .78 exceeded the recommended value of .6, which is considered good). The three-factor solution explained a total of 77.7% of the variance. Factor 1 (internal consistency reliability is high, Cronbach's alpha is .88) contributing 47.7% to the explained variance, Factor 2 (internal consistency reliability is high, Cronbach's alpha is .84) contributing 20.8% to the explained variance, and 9.1% was explained by Factor 3 (internal consistency reliability is high, Cronbach's alpha is .78). The items loading on the factors revealed that Factor 1 comprised the three PSN items, Factor 2 the three PBC items and Factor 3 the three A items. Reliability of I was also high; Cronbach's alpha is .86.

The Feeling Word Checklist (FWC-30; Whyte et al., 1982) is a short self-report questionnaire containing 30 emotions. Overall, the psychometric properties of the FWC have been found to be acceptable for the different versions of 12, 24, 30 and 58 items (Breivik et al., 2020; Dahl et al., 2012; Lindqvist et al., 2017; Ulberg et al., 2013). The factor structure appeared to be different for the different versions, however. Therefore, we performed a factor analysis on the original 30-item version used in this study, as this version was already available in Dutch (V. de Vogel & Louppen, 2016). Table 2 shows 30 items that relate to feelings. Staff member rates each item on a four-point scale according to the extent to which the staff member experiences each

TABLE 1 Demographic variables, work setting (regular/forensic) and experience of clinicians

Characteristic	Psychiatrist (n = 10)	Psychologist (n = 74)	Social worker (n = 14)	Psychiatric nurse (n = 32)
Age in years (SD) range	42.0 (9.6) 28–58	37.4 (11.1) 23–64	51.1 (7.8) 39–64	40.8 (13.5) 19–62
Gender (M/F)	6/4 (60/40)%	18/56 (24/76)%	5/9 (36/64)%	13/19 (41/59)%
Years of experience (SD)	12.7 (8.8)	11.9 (9.7)	19.0 (11.5)	17.7 (12.9)
Work setting (regular/forensic)	6/4 (60/40)%	38/36 (51/49)%	5/9 (36/64)%	15/17 (47/53)%
Regular inpatient	0 (0%)	1 (.01%)	0 (0%)	2 (.06%)
Regular outpatient	6 (60%)	37 (50%)	5 (36%)	15(47%)
Forensic inpatient	3 (30%)	16 (22%)	4 (29%)	12 (38%)
Forensic outpatient	1 (10%)	20 (27%)	5 (36%)	3 (9%)
Experience with ASPD patients (yes/no)	8/1 (89/11)%	49/18 (73/27)%	12/1 (92/8)%	23/8 (74/26)%

TABLE 2 Scores on the theory of planned behaviour questionnaire for ASPD treatment (TPBaspdT) and the feeling word checklist (FWC-30)

Measures	Regular mental health service (n = 66)				Forensic mental health service (n = 64)			
	Psychiatrist (n = 6)	Psychologist (n = 38)	Social worker (n = 5)	Psychiatric nurse (n = 15)	Psychiatrist (n = 4)	Psychologist (n = 36)	Social worker (n = 9)	Psychiatric nurse (n = 17)
<i>TPBaspdT</i>								
Attitude (A)	4.8 (1.9)	5.3 (1.1)	5.9 (.3)	4.9 (1.3)	5.8 (.3)	6.3 (.5)	4.9 (1.8)	5.5 (1.2)
Perceived social norm (PSN)	3.7 (1.7)	3.5 (1.4)	3.7 (.9)	3.5 (1.7)	6.5 (.7)	6.1 (.9)	5.7 (1.4)	5.8 (1.0)
Perceived behavioural control (PBC)	3.4 (1.9)	3.1 (1.3)	3.1 (1.1)	3.1 (1.1)	5.5 (.2)	4.7 (.8)	4.8 (1.6)	4.4 (1.1)
Intention (I)	3.0 (2.2)	2.7 (1.7)	3.3 (.6)	2.8 (1.4)	5.8 (1.1)	5.7 (1.0)	4.4 (1.9)	3.8 (1.5)
<i>(FWC-30)</i>								
Negative feelings	.7 (.4)	.7 (.5)	.6 (.3)	.6 (.3)	.4 (.0)	.4 (.3)	.4 (.6)	.6 (.4)
Positive feeling	.6 (.4)	1.0 (.5)	.7 (.4)	.8 (.4)	1.0 (.3)	1.3 (.4)	1.4 (.4)	1.2 (.5)

specific feeling towards the patient (0 = *not at all*, 1 = *little*, 2 = *much*, 3 = *very much*). The scores of the 30 feelings on the FWC-30 were subjected to a principal component analysis (PCA) using varimax rotation. The Kaiser-Meyer-Olkin (KMO) measure showed good sampling adequacy (KMO > .8 exceeded the recommended value of .6, which is considered good). PCA revealed eight factors with eigenvalues exceeding 1. Inspection of the scree plot revealed a break after the second factor. Therefore, we applied PCA forcing two factors. Six items contributed less than .5 to a factor and were consequently excluded from further analyses. The two-factor solution explained a total of 43.2% of the variance, with Factor 1 (internal consistency reliability is high; Cronbach's alpha is .84) contributing 26.6% to the explained variance, and 16.6% by Factor 2 (internal consistency reliability is high; Cronbach's alpha is .86). Inspection of the items loading on the two factors revealed that Factor 1 comprised negative feelings (disappointed, angry, frustrated, sad, anxious, confused, threatened, manipulated, tired, suspicious, overwhelmed, bored, embarrassed and inadequate) and that Factor 2 comprised positive feelings (enthusiastic, helpful, happy, interested, sympathetic, affectionate, receptive, relaxed, objective and strong).

To measure whether clinicians had experience working with ASPD patients, we asked them whether or not they had working experience with ASPD patients (0 = *no*; 1 = *yes*).

To gain a deeper understanding of the impact of having experienced verbal or physical aggression on the intention to treat ASPD patients, the respondents answered the following question 'Have you ever been a victim of aggression in the workplace?' (0 = *no*, 1 = *yes*, a victim of verbal aggression; 2 = *yes*, victim of physical aggression; 3 = *yes*, victim of verbal and physical aggression).

2.3 | Procedures

To gain insight into clinicians' motivations for working with ASPD patients, we asked mental health care professionals to complete a TPB-based questionnaire to examine predictors of willingness to treat patients with ASPD. In addition, because patients with ASPD may evoke strong emotions, we also measured the nature and intensity of emotions experienced by clinicians with The Feeling Word Checklist

(FWC-30; Whyte et al., 1982) determined whether they influenced the willingness to provide psychological treatment.

Two research assistants visited the various teams of the participating mental health institutions during a staff meeting. They requested the clinicians to complete the questionnaires after signing an informed consent declaration. Completion of the questionnaires took less than 15 min.

2.4 | Ethics

We obtained approval of the study from the ethical committees of the participating institutions. The researchers declare that they have no conflicts of interest regarding this study. The data were gathered and analysed anonymously by separating the informed consent declaration from the questionnaires to guarantee that the answers on the questionnaires would have no consequences for the participating clinicians.

3 | RESULTS

Characteristics of the participants are summarized in Table 1.

Analyses of the characteristics of the professions showed that they differed from each other regarding age $F(3, 126) = 5.88, p < .01$, years of experience $F(3, 126) = 3.25, p < .05$, approached statistical significance on gender (chi-square = 6.8, $p = 0.08$), but did not differ from each other on the work setting. Post hoc comparisons using the Bonferroni Test indicated no differences between the groups. Gender, age and years of experience were added as covariates in all subsequent analyses to eliminate their potential effects on responses. We also compared the work settings on age, gender and years of experience. Analysis revealed that there were no significant differences in these variables between the regular and the forensic setting.

Scores on the theory of planned behaviour questionnaire for ASPD treatment (TPBaspdT) and the Feeling Word Checklist (FWC-30) are presented in Table 2.

An analysis of covariance with the profession groups as a between-subjects variable, age and years of experience as covariates, and the TPBaspdT scores and FWC-30 scores as dependent variables showed no significant differences between the professions. An ANOVA analysis with work setting as a between-subjects variable, and the TPBaspdT scores and FWC-30 scores as a dependent variables showed significant more positive attitude $F(1, 128) = 10.64, p < .01$, higher perceived social norm $F(1, 123) = 120.97, p < .001$, more perceived behaviour control $F(1, 116) = 52.20, p < .001$, more intention to provide treatment $F(1, 123) = 58.52, p < .001$, less negative emotions $F(1, 122) = 8.87, p < .01$ and more positive emotions $F(1, 118) = 24.09, p < .001$ in forensic mental health compared to regular mental health service. To investigate whether clinicians experienced more positive emotions than negative ones, we performed a paired t test with positive and negative emotions measured with the FWC sub-scales for positive and negative emotions as variables.

Clinicians appeared to experience more positive emotions than negative ones towards ASPD patients, $t = 9.8, p < .001$. This appeared to be especially true for forensic health care $t = 7.6, p < .001$, compared to regular health care, $t = 2.2, p < .05$. To investigate whether experience with ASPD patients influenced clinicians' emotions, we performed an ANOVA with experience as the independent variable and emotions as the dependent variable. Clinicians with experience working with ASPD patients experienced more positive emotions, $F(1, 112) = 9.2, p < .001$, and less negative, $F(1, 109) = 3.8, p = .05$, emotions towards ASPD patients compared to clinicians without that experience.

To get insight into the practical implication of the scores on intention to provide treatment, we classified the scores on TPBaspdT-I in three groups: not motivated to provide treatment ($I \leq 3$), ambivalent to provide treatment ($I = 3-5$) and motivated to provide treatment ($I \geq 5$). We compared them for the motivation categories to explore relations between experience working with ASPD, education on cluster B personality disorders and having experience verbal and/or physical violence in clinical practice. The results are presented in Table 3.

A Mann-Whitney U test showed that clinicians in forensic mental health care were more motivated than their colleagues in regular mental health care to treat ASPD patients ($z = -6.59, p < .001$). However, concerning experience working with ASPD patients, education on cluster B personality disorders, having experienced verbal and/or physical violence in clinical practice for regular and forensic mental health care separately, the results were not significant (all chi-squares $> .18$).

We calculated correlations between the scores on the theory of planned behaviour questionnaire for ASPD treatment (TPBaspdT), the Feeling Word Checklist (FWC-30), age and experience to get insight into relations between the variables. Results are presented in Table 4.

We performed a stepwise hierarchical regression with the TPB factors in the first step and emotions (FWC) in the second step. From reviewing the betas presented in Table 5, we can conclude PBC contributed most strongly to behavioural intention. On the other hand, emotions contributed little to the model, with only positive emotions significantly contributing to behavioural intention.

4 | DISCUSSION

Patients with ASPD can evoke strong negative emotions in others. This phenomenon also occurs in mental health, resulting in the exclusion of ASPD patients in many treatment programmes. The current study confirms the limited willingness to work with these patients. In regular mental health care, approximately 60% of the clinicians indicated that they were not motivated to work with ASPD patients, approximately 28% were ambivalent and 12% were motivated. As can be expected, this motivation is substantially higher (65%) in forensic mental health care, where the prevalence of ASPD patients is more elevated. Nonetheless, even in forensic mental health care, one third of the clinicians are not motivated or ambivalent about providing mental help to this group of patients.

TABLE 3 Motivation to work with ASPD patients of clinicians working in regular mental health services and forensic mental health services in relation to experience with ASPD, education on cluster B personality disorders and experienced violence in clinical practice and experienced burden due to the violence

	Regular mental health service (n = 64)			Forensic mental health service (n = 61)		
	Not motivated (I ≤ 3)	Ambivalent (I = 3–5)	Motivated (I ≥ 5)	Not motivated (I ≤ 3)	Ambivalent (I = 3–5)	Motivated (I ≥ 5)
Total	38 (59.4%)	18 (28.1%)	8 (12.5%)	6 (9.8%)	16 (26.2%)	39 (63.9%)
Experience with ASPD patients						
Yes (n = 33)	17 (51.5%)	10 (31.3%)	6 (18.2%)	5 (9.3%)	14 (25.9%)	35 (64.8%)
No (n = 24)	17 (70.8%)	6 (25%)	1 (4.2%)	1 (25%)	2 (50%)	1 (25%)
Post graduate education on cluster B personality disorders						
Yes (n = 24)	14 (58.3%)	6 (25%)	4 (16.7%)	2 (6.3%)	7 (21.9%)	23 (71.9%)
No (n = 40)	24 (60%)	12 (30%)	4 (10%)	4 (13.8%)	9 (31%)	16 (55.2%)
Experienced violence in clinical practice						
Yes, verbal aggression (n = 16)	9 (56.3%)	4 (25%)	3 (18.8%)	1 (4.2%)	7 (29.2%)	16 (66.7%)
Yes, verbal and physical aggression (n = 21)	11 (52.4%)	9 (42.9%)	1 (4.8%)	5 (22.7%)	5 (22.7%)	12 (54.5%)
No (n = 19)	14 (73.7%)	2 (10.7%)	3 (15.8%)	0 (0%)	4 (33.3%)	8 (67.7%)
Burden due to experienced violence in clinical practice						
Yes (n = 14)	8 (57.1%)	4 (26.6%)	2 (14.3%)	4 (25%)	2 (12.5%)	10 (62.5%)
No (n = 27)	14 (51.9)	11 (40.7%)	2 (7.4%)	2 (6.5%)	10 (32.3%)	19 (61.3%)

TABLE 4 Correlations between the scores on the theory of planned behaviour questionnaire for ASPD treatment (TPBaspdT), the feeling word checklist (FWC-30), age and years of experience

	Age	Experience	A	PSN	PBC	I	NEG
Experience	.87**						
Attitude (A)	-.10	-.08					
Perceived social norm (PSN)	-.08	-.10	.28**				
Perceived behavioural control (PBC)	.05	.00	.30**	.67**			
Intention (I)	-.25**	-.25**	.41**	.60**	.63**		
Negative feelings	-.00	.01	-.25**	-.34**	-.40**	-.40**	
Positive feeling	-.21*	-.24**	.42**	.40**	.47**	.53**	-.24**

* $p < .05$. ** $p < .001$.**TABLE 5** Hierarchical regression analyses with intention as dependent variable.

Step	Predictor variables	R ²	ΔR ²	Standardized B after step 1	Standardized B after step 2
1	Attitude (A)			.22*	.15*
	Perceived social norm (PSN)			.32*	.29*
	Perceived behavioural control (PBC)	.50	.50**	.35**	.25*
2	Negative feelings				-.11
	Positive feeling	.55	.04*		.21*

* $p < .05$. ** $p < .001$.

An explanation for this finding may be the often described dichotomy made in forensic mental health between the 'mentally ill' and the personality disordered (Richman et al., 1999). Recent research indicates that this tendency has not changed (Beryl & Völlm, 2018; Fox et al., 2018; T. Mason et al., 2009). The

'mentally ill' are deemed not responsible for their actions and evoke sympathy, while the personality disordered is considered fundamentally flawed, culpable and remorseless. Research shows that clinicians in forensic mental health are inclined to sympathize with the mentally ill and be antagonistic towards the personality

disordered individuals (Beryl & Völlm, 2018; T. Mason et al., 2008; T. Mason et al., 2010).

Surprisingly, the intensity of negative and positive emotions evoked by ASPD patients was not strong (see mean scores FWC in Table 2). On average, the strength of the emotions indicated as having little intensity. Moreover, although also a little intense, the positive emotions appeared to be stronger than the negative emotions, especially in forensic mental health care. A possible explanation for the relatively weak strength of the emotions in comparison to the strong emotions found in other studies might be that we did not present clinicians with actual ASPD patients (e.g., Colli et al., 2014) but asked them to report the strength of emotions without a specific ASPD patient in mind.

Moreover, not all of the clinicians in our study ever worked with ASPD patients. However, the clinicians who had worked with ASPD patients reported more positive and less negative emotions than clinicians without that experience. A possible explanation is that clinicians with more positive feelings towards ASPD patients may choose their field of work based on what they feel motivated to do. Thus, clinicians with interest in ASPD may continue to work in a forensic setting, while those with no interest in this patient group may leave the clinic. An alternative explanation may be that the actual working experience with ASPD allows the opportunity to experience the positive effect of treatment and reduces negative feelings. Several studies showed that actual contact between clinicians and patients with personality disorders reduces stigma and increases positive attitude (E.T. Dunbar et al., 2019; Egan et al., 2014; Sheehan et al., 2016).

However, we also found that experience working with ASPD patients, education on cluster B personality disorders, having experienced verbal and/or physical violence in clinical practice did not satisfactorily explain motivation (or lack of) for working with this group. We observed a difference between regular and forensic mental health care concerning working experience and motivation. Relations between experience working with ASPD patients and education on cluster B personality disorders were not evident when we analysed them in the context of a specific setting, either regular mental health or forensic mental health. For example, more than half of the clinicians who had experience working with ASPD patients in regular mental health care were not motivated to work with them again. Thus, working experience is not enough to enhance motivation to provide ASPD treatment. We observed the same concerning education on cluster B personality disorders and negative experiences. More than half of the clinicians who received post-graduate education on cluster B personality disorders were not motivated to work with ASPD patients. Negative experiences with aggression in clinical practice, which is highly prevalent in ASPD (Daffern, 2007; Hildebrand et al., 2004), do not adversely affect the motivation to treat ASPD patients. Half of the clinicians who experienced verbal and physical aggression in the workplace were still motivated to provide psychological treatment to ASPD patients.

Our finding that experience alone, whether negative or positive, is insufficient to explain motivation is not surprising. Motivation is a complex concept involving various factors and mechanisms

(Jochems et al., 2011). Motivation theories provide insight into the processes that moderate the effect of gained experiences on intentions and behaviour (I. Ajzen, 2011; Deci & Ryan, 2008). The accumulated knowledge of clinicians with ASPD patients may affect various factors concerning self-confidence, feelings of trust and safety. In addition, the effects are dependent on several factors like social support, personality, coping and personal circumstances (Beattie et al., 2019; E.T. Dunbar, 2017; Priebe & Reininghaus, 2011; Wolf et al., 2017).

Another explanation for the limited influence of gained experience on attitude may be a stigma. Research shows that clinicians believe those with the clinical diagnostic label of a personality disorder to be more challenging to manage than personality-disordered patients without the label (Newton-Howes et al., 2008). Therefore, the label ASPD may very well shape the experience of clinicians, resulting in a self-fulfilling prophecy (Beryl & Völlm, 2018; Corrigan, 2007; Newton-Howes et al., 2008).

As expected, negative emotions were related to less motivation to treat patients with ASPD. However, positive emotions appeared to be more strongly associated with the motivation to provide treatment to ASPD patients. This suggests that interventions aimed at improving a positive attitude may be more effective than reducing negative emotions. This would support studies that demonstrate the importance of a positive attitude and emotions towards patients with personality disorders on effectiveness (Bowers et al., 2005; Egan et al., 2014; L.M.C. Van den Bosch et al., 2018; Webb & McMurrin, 2007). The influence of emotions towards ASPD patients on the motivation to provide treatment to ASPD patients is somewhat limited, however, compared to the factors proposed by the TPB.

Attitude (A), perceived social norm (PSN) and especially perceived behavioural control (PBC) appeared to predict the motivation to provide psychological treatment to this group of patients to a much larger degree than emotions. This is an important finding because it may provide insight into how experience gained, training and supervision might improve the motivation to provide mental health care to ASPD patients or not.

Concerning attitude (A), it is relevant that clinicians become convinced that it is helpful to provide treatment to ASPD patients. This can be achieved by providing information about favourable treatment outcomes from various approaches, for example, DBT (van den Bosch et al., 2012; Wetterborg et al., 2020), MBT (A. Bateman et al., 2016; McGauley et al., 2011), SFT (D.P. Bernstein et al., 2012; D.P. Bernstein et al., 2021; Doyle et al., 2016) and CBT (Crawford et al., 2009; B. Thylstrup et al., 2017). Second, the attitude of clinicians may become more positive when they think working with ASPD patients is intriguing. This may be the case if this work is perceived as challenging, highly specialized work, demanding high levels of competence (I. Ajzen, 2011; Deci & Ryan, 2008). Third, attitudes could be positively enhanced if clinicians are convinced of the importance of providing treatment to ASPD patients. Treatment may reduce their suffering and improve their environment in terms of interpersonal, financial and emotional consequences (Goldstein et al., 2012; Quinsey et al., 1998; Rijckmans et al., 2020).

Perceived social norm may be increased when clinicians encounter examples of colleagues who provide mental health care to ASPD patients and talk about it. If they also say to their colleagues that they are achieving successes and that providing treatment to this group is rewarding, it may also affect the attitude (A) factor. This is an overlooked group that is often excluded from mental health care (L.M.C. Van den Bosch et al., 2018; Rijckmans et al., 2020), and therefore, those colleagues who work with ASPD patients must be stimulated and facilitated by the management to share their knowledge and skills among colleagues as well as in educational settings such as universities and post-graduate education. The use of role models is probably essential to make maximum use of the perceived social norm (PSN) factor.

Perceived behavioural control is the most substantial factor contributing to providing mental health care to ASPD patients. Therefore, it is essential that training leads to a sense of mastery. Clear manuals and instructions (e.g., the Impulsive lifestyle coaching manual [B. Thylstrup et al., 2017] or the Practitioner's Guide to antisocial behaviour and personality disorders [Rijckmans et al., 2020]) may increase that sense of mastery. In addition, training and supervision should be aimed at the clinician's feelings of control and competence. Several studies show that clinicians' positive attitudes are indeed related to having received training about personality disorders (Bowers et al., 2005; E.T. Dunbar et al., 2020; Egan et al., 2014; Keuroghlian et al., 2016). This training aims to increase knowledge and self-efficacy when working with personality disorders and adequate supervision. Another way to increase perceived behavioural control (PBC) might be by providing the clinician with feedback about competence and positive treatment results. Supervision on the spot when working with ASPD patients may be useful in that respect (Weck et al., 2016).

The study had several limitations that must be acknowledged. First, although we used a well-researched and widely applied motivation theory, it cannot be ruled out that we would have obtained other information with a different motivation theory. Second, motivation is a complex concept that has been operationalized in various ways that differ in the underlying theories regarding the behavioural change (Jochems et al., 2011). For example, self-determination theory (SDT) of motivation assumes the fulfilment of basic needs as the basis for changing behaviour, whereas TPB studies conscious cognitions and perceptions of the target behaviour (I. Ajzen, 2011; Deci & Ryan, 2008). Although the theories complement each other, they can differ in predictive value for specific behaviour and, because of their particular theoretical backgrounds, also lead to other recommendations (Jochems et al., 2011). For further research, it could also be of added value to also use other motivational theories such as SDT to predict therapist behaviour.

Second, the results may have been different when we asked participants to consider actual patients when scoring the questionnaires. In other studies, clinicians were instructed to keep specific patients in mind, filling out the FWC (V. de Vogel & Louppen, 2016; B. Thylstrup & Hesse, 2008). Thus, although the intensity of the

emotions seems to be comparable to our results, it cannot be ruled out that respondents will react differently to specific patients. Therefore, we suggest that future research should focus on whether clinicians' experiences with actual patients influence their motivation to invest in treatment.

Third, participants may have answered the questionnaire socially desirable manner to appear more altruistic, positive and non-judgmental. These factors may have resulted in the low levels of negative emotions reported towards ASPD patients. Thus, the results may reflect a more favourable attitude than exists, although the attitude cannot be regarded as very favourable with the current results. Another limitation is that we asked clinicians of various professional backgrounds and settings to participate. Because of this broad spectrum, there may be considerable variability in education, training and management. However, even though this may reduce generalizability to specific settings, it may also be advantageous because of a broad range of attitudes and experience.

The strength of our study is that it provides insight into the possible pathways through which the motivation of clinicians in forensic and regular mental health services concerning working with patients with ASPD can be enhanced. This is important because the exclusion of ASPD patients in many treatment programmes is a serious problem because of the significant impact ASPD has on society and the patients' suffering.

Another strength of the study is that we developed a TPB questionnaire that monitors the intention to provide treatment to ASPD patients, according to the manual for constructing a theory of planned behaviour questionnaire (I. Ajzen, 2013; Fishbein & Ajzen, 2010). We also investigated the psychometric qualities and the psychometric qualities of the FWC, which were all adequate. These questionnaires may therefore be helpful to use in future research regarding motivation to provide treatment.

Conclusively, this study provided more insight into why some clinicians are willing to work with ASPD patients, while others are not and which factors should be targeted to increase motivation. The study also provides insight into the added value of the theory of planned behaviour in order to understand the processes through which experience and training may influence the clinicians motivation to work with ASPD patients or not. Longitudinal studies are needed to investigate whether training and supervision increase this motivation.

ACKNOWLEDGEMENTS

The authors wish to thank Lisa Davies and Hannah Hayward for their feedback on the manuscript.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon request.

ORCID

Arno van Dam  <https://orcid.org/0000-0002-5604-9837>

REFERENCES

- Ajzen, I. (1991). The theory of planned behaviour. *Organisational Behavior and Human Decision Processes*, 50, 179–211.
- Ajzen, I. (2011). The theory of planned behaviour: reactions and reflections. *Psychology & Health*, 26(9), 1,113–1,127.
- Ajzen, I. (2013). Theory of Planned Behaviour Questionnaire. Measurement Instrument Database for the Social Science. Retrieved from www.midss.ie
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.
- Bahlmann, M., Preuss, U. W., & Soyka, M. (2002). Chronological relationship between antisocial personality disorder and alcohol dependence. *European Addiction Research*, 8(4), 195–200.
- Bateman, A., Bolton, R., & Fonagy, P. (2013). Antisocial personality disorder: A mentalising framework. *Focus*, 11(2), 178–186.
- Bateman, A., O'Connell, J., Lorenzini, N., Gardner, T., & Fonagy, P. (2016). A randomised controlled trial of mentalisation-based treatment versus structured clinical management for patients with comorbid borderline personality disorder and antisocial personality disorder. *BMC Psychiatry*, 16(1), 304.
- Beattie, J., Griffiths, D., Innes, K., & Morphet, J. (2019). Workplace violence perpetrated by clients of health care: A need for safety and trauma-informed care. *Journal of Clinical Nursing*, 28(1–2), 116–124.
- Bernstein, D. P., Keulen-de Vos, M., Clercx, M., de Vogel, V., Kersten, G. C., Lancel, M., ... Arntz, A. (2021). Schema therapy for violent PD offenders: A randomized clinical trial. *Psychological Medicine*, 1–15.
- Bernstein, D. P., Nijman, H. L., Karos, K., Keulen-de Vos, M., de Vogel, V., & Lucker, T. P. (2012). Schema therapy for forensic patients with personality disorders: Design and preliminary findings of a multi-center randomised clinical trial in The Netherlands. *International Journal of Forensic Mental Health*, 11(4), 312–324.
- Beryl, R., & Völlm, B. (2018). Attitudes to personality disorder of staff working in high-security and medium-security hospitals. *Personality and Mental Health*, 12(1), 25–37.
- Betan, E., Heim, A. K., Zittel Conklin, C., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *American Journal of Psychiatry*, 162(5), 890–898.
- Black, D. W., & Larson, C. L. (1999). *Bad boys, bad men: Confronting antisocial personality disorder*. New York, NY: Oxford University Press, Inc.
- Blackburn, R., Logan, C., Donnelly, J., & Renwick, S. (2003). Personality disorders, psychopathy and other mental disorders: Co-morbidity among patients at English and Scottish high-security hospitals. *The Journal of Forensic Psychiatry & Psychology*, 14(1), 111–137.
- Bowers, L., Carr-Walker, P., Paton, J. O., Nijman, H., Callaghan, P., Allan, T., & Alexander, J. (2005). Changes in attitudes to personality disorder on a DSPD unit. *Criminal Behaviour and Mental Health*, 15(3), 171–183.
- Breivik, R., Wilberg, T., Evensen, J., Røssberg, J. I., Dahl, H. S. J., & Pedersen, G. (2020). Countertransference feelings and personality disorders: a psychometric evaluation of a brief version of the Feeling Word Checklist (FWC-BV). *BMC Psychiatry*, 20, 1–12.
- Chartonas, D., Kyratsous, M., Dracass, S., Lee, T., & Bhui, K. (2017). Personality disorder: still the patients psychiatrists dislike? *BJPsych bulletin*, 41(1), 12–17.
- Clough, B. A., Nazareth, S. M., & Casey, L. M. (2017). The therapy attitudes and process questionnaire: a brief measure of factors related to psychotherapy appointment attendance. *The Patient-Patient-Centered Outcomes Research*, 10(2), 237–250.
- Colli, A., Tanzilli, A., Dimaggio, G., & Lingardi, V. (2014). Patient personality and therapist response: An empirical investigation. *The American Journal of Psychiatry*, 171, 102–108. <https://doi.org/10.1176/appi.ajp.2013.13020224>
- Cooke, R., Dahdah, M., Norman, P., & French, D. P. (2016). How well does the theory of planned behaviour predict alcohol consumption? A systematic review and meta-analysis. *Health Psychology Review*, 10(2), 148–167.
- Corrigan, P. W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work*, 52(1), 31–39.
- Crawford, M. J., Sahib, L., Bratton, H., Tyrer, P., & Davidson, K. (2009). Service provision for men with antisocial personality disorder who make contact with mental health services. *Personality and Mental Health*, 3(3), 165–171.
- Daffern, M. (2007). The predictive validity and practical utility of structured schemes used to assess risk for aggression in psychiatric inpatient settings. *Aggression and Violent Behavior*, 12(1), 116–130.
- Dahl, H. S. J., Røssberg, J. I., Bøgdal, K. P., Gabbard, G. O., & Høglend, P. A. (2012). Countertransference feelings in one year of individual therapy: An evaluation of the factor structure in the Feeling Word Checklist-58. *Psychotherapy Research*, 22(1), 12–25.
- de Vogel, V., & de Ruiter, C. (2004). Differences between clinicians and researchers in assessing risk of violence in forensic psychiatric patients. *The Journal of Forensic Psychiatry and Psychology*, 15, 145–164. <https://doi.org/10.1080/14788940410001655916>
- de Vogel, V., & Louppen, M. (2016). Measuring feelings of staff members towards their most complex female and male forensic psychiatric patients: A pilot study into gender differences. *International Journal of Forensic Mental Health*, 15(2), 174–185.
- Deci, E. L., & Ryan, R. M. (2008). Self-determination theory: A macrotheory of human motivation, development, and health. *Canadian Psychology/Psychologie Canadienne*, 49(3), 182–185.
- Dernevik, M., Falkheim, M., Holmqvist, R., & Sandell, R. (2001). Implementing risk assessment procedures in a forensic psychiatric setting: Clinical judgement revisited. In D. P. Farrington, C. R. Hollin, & M. McMurrin (Eds.), *Sex and violence: The psychology of crime and risk assessment* (pp. 83–101). London, UK: Routledge.
- Djadoenath, A., & Decoene, S. (2015). De antisociale-persoonlijkheidsstoornis en psychopathie in de reguliere ambulante geestelijke gezondheidszorg. In W. Canton, D. van Beek, L. Claes, L. Gijs, I. Jeandarme, & E. K. Haneveld (Eds.), *Handboek psychopathie en de antisociale persoonlijkheidsstoornis* (pp. 199–220). De Tijdstroom.
- Doyle, M., Tarrier, N., Shaw, J., Dunn, G., & Dolan, M. (2016). Exploratory trial of schemafocussed therapy in a forensic personality disordered population. *The Journal of Forensic Psychiatry & Psychology*, 27(2), 232–247.
- Dunbar, E. T. Jr. (2017). *Mental Health Professionals' Attitudes Toward Clients with Antisocial Personality Disorder*. Dissertation. East Carolina University.
- Dunbar, E. T. Jr., Koltz, R. L., Elliott, A., & Hurt-Avila, K. M. (2020). The Role of Clinical Supervision in Treating Clients with Antisocial Personality Disorder. *The Journal of Counselor Preparation and Supervision*, 13(3), 4.
- Dunbar, E. T. Jr., Sias, S. M., Leierer, S., Atherton, W. L., Campbell, R. J., & Goodwin, L. R. Jr. (2019). Mental health professionals' attitudes toward clients with antisocial personality disorder: An exploratory study. *The Journal of Counselor Preparation and Supervision*, 12(3), 4.
- Egan, S. J., Haley, S., & Rees, C. S. (2014). Attitudes of clinical psychologists towards clients with personality disorders. *Australian Journal of Psychology*, 66(3), 175–180.
- Fishbein, M., & Ajzen, I. (2010). *Predicting and changing behaviour: The reasoned action approach*. New York: Psychology Press.
- Fox, A. B., Earnshaw, V. A., Taverna, E. C., & Vogt, D. (2018). Conceptualising and measuring mental illness stigma: The mental illness stigma framework and critical review of measures. *Stigma and health*, 3(4), 348.
- Frances, A., Fyer, M., & Clarkin, J. (1986). Personality and suicide. *Annals of the New York Academy of Sciences*, 487(1), 281–295.

- Galbraith, T., Heimberg, R. G., Wang, S., Schneier, F. R., & Blanco, C. (2014). Comorbidity of social anxiety disorder and antisocial personality disorder in the National Epidemiological Survey on Alcohol and Related Conditions (NESARC). *Journal of Anxiety Disorders, 28*(1), 57–66.
- Gibbon, S., Khalifa, N. R., Cheung, N. H., Völlm, B. A., & McCarthy, L. (2020). Psychological interventions for antisocial personality disorder. *Cochrane Database of Systematic Reviews, 9*.
- Goldstein, R. B., Dawson, D. A., Smith, S. M., & Grant, B. F. (2012). Antisocial behavioral syndromes and 3-year quality-of-life outcomes in United States adults. *Acta Psychiatrica Scandinavica, 126*(2), 137–150.
- Goodwin, R. D., & Hamilton, S. P. (2003). Lifetime comorbidity of antisocial personality disorder and anxiety disorders among adults in the community. *Psychiatry Research, 117*(2), 159–166.
- Hildebrand, M., de Ruiter, C., & Nijman, H. (2004). PCL-R psychopathy predicts disruptive behavior among male offenders in a Dutch forensic psychiatric hospital. *Journal of Interpersonal Violence, 19*.
- Holzer, K. J., & Vaughn, M. G. (2017). Antisocial personality disorder in older adults: A critical review. *Journal of Geriatric Psychiatry and Neurology, 30*(6), 291–302.
- Jochems, E. C., Mulder, C. L., van Dam, A., & Duivenvoorden, H. J. (2011). A critical analysis of the utility and compatibility of motivation theories in psychiatric treatment. *Current Psychiatry Reviews, 7*, 298–312.
- Keuroghlian, A. S., Palmer, B. A., Choi-Kain, L. W., Borba, C. P., Links, P. S., & Gunderson, J. G. (2016). The effect of attending good psychiatric management (GPM) workshops on attitudes toward patients with borderline personality disorder. *Journal of Personality Disorders, 30*(4), 567–576.
- Lenzenweger, M. F., Lane, M. C., Loranger, A. W., & Kessler, R. C. (2007). DSM-IV personality disorders in the National Comorbidity Survey Replication. *Biological Psychiatry, 62*(6), 553–564.
- Lindqvist, K., Falkenström, F., Sandell, R., Holmqvist, R., Ekeblad, A., & Thorén, A. (2017). Multilevel exploratory factor analysis of the Feeling Word Checklist-24. *Assessment, 24*(7), 907–918.
- Lion, J. (1978). Outpatient treatment of psychopaths. In W. Reid (Ed.), *The psychopath: A comprehensive study of antisocial disorders and behaviors* (pp. 286–300). New York: Brunner/Mazel.
- Mason, T., Caulfield, M., Hall, R., & Melling, K. (2010). Perceptions of diagnostic labels in forensic psychiatric practice: A survey of differences between nurses and other disciplines. *Issues in Mental Health Nursing, 31*(5), 336–344.
- Mason, T., Coyle, D., & Lovell, A. (2008). Forensic psychiatric nursing: Skills and competencies: II Clinical aspects. *Journal of Psychiatric and Mental Health Nursing, 15*(2), 131–139.
- Mason, T., Dulson, J., & King, L. (2009). Binary constructs of forensic psychiatric nursing: a pilot study. *Journal of Psychiatric and Mental Health Nursing, 16*(2), 158–166.
- McGauley, G., Yakeley, J., Williams, A., & Bateman, A. (2011). Attachment, mentalisation and antisocial personality disorder: The possible contribution of mentalisation-based treatment. *European Journal of Psychotherapy & Counselling, 13*(4), 371–393.
- Meloy, J. R., & Yakeley, A. J. (2014). Antisocial personality disorder. In G. O. Gabbard (Ed.), *Treatments of Psychiatric Disorders* (Fifth ed.) (pp. 1015–1034). Arlington: American Psychiatric Publishing.
- Newton-Howes, G., Weaver, T., & Tyrer, P. (2008). Attitudes of staff towards patients with personality disorder in community mental health teams. *Australian and New Zealand Journal of Psychiatry, 42*(7), 572–577.
- Priebe, S., & Reininghaus, U. (2011). Fired up, not burnt out—Focusing on the rewards of working in psychiatry. *Epidemiology and Psychiatric Sciences, 20*(4), 303–305.
- Quinsey, V. L., Harris, G. T., Rice, M. E., & Cormier, C. A. (1998). *Violent offenders: Appraising and managing risk*. Washington DC: American Psychological Association.
- Raine, A. (2013). *The Anatomy of Violence: The Biological Roots of Crime*. New York: Pantheon Books.
- Rebergen, D., Hoenen, J., Heinemans, A., Bruinvels, D., Bakker, A., & van Mechelen, W. (2006). Adherence to mental health guidelines by Dutch occupational physicians. *Occupational Medicine, 56*(7), 461–468.
- Reid, W. H., & Gacono, C. (2000). Treatment of antisocial personality, psychopathy, and other characterologic antisocial syndromes. *Behavioral Sciences & the Law, 18*(5), 647–662.
- Richman, J., Mercer, D., & Mason, T. (1999). The social construction of evil in a forensic setting. *The Journal of Forensic Psychiatry, 10*(2), 300–308.
- Rijckmans, M. J. N., van Dam, A., & van den Bosch, I. M. C. (2020). *Praktijkboek antisociaal gedrag en persoonlijkheidsproblematiek [practitioners guide for antisocial behaviour and personality disorders]*. Houten: Bohn Stafleu van Loghum.
- Sareen, J., Stein, M. B., Cox, B. J., & Hassard, S. T. (2004). Understanding comorbidity of anxiety disorders with antisocial behavior: Findings from two large community surveys. *The Journal of Nervous and Mental Disease, 192*(3), 178–186.
- Schwartz, R. C., Smith, S. D., & Chopko, B. (2007). Psychotherapists' countertransference reactions toward clients with antisocial personality disorder and schizophrenia: An empirical test of theory. *American Journal of Psychotherapy, 61*(4), 375–393.
- Sheehan, L., Niewegłowski, K., & Corrigan, P. (2016). The stigma of personality disorders. *Current Psychiatry Reports, 18*(1), 11.
- Thylstrup, B., & Hesse, M. (2008). Substance abusers' personality disorders and staff members' emotional reactions. *BMC Psychiatry, 8*(1), 1–6.
- Thylstrup, B., & Hesse, M. (2016). Impulsive lifestyle counseling to prevent dropout from treatment for substance use disorders in people with antisocial personality disorder: A randomised study. *Addictive Behaviors, 57*, 48–54.
- Thylstrup, B., Schröder, S., Fridell, M., & Hesse, M. (2017). Did you get any help? A post-hoc secondary analysis of a randomised controlled trial of psychoeducation for patients with antisocial personality disorder in outpatient substance abuse treatment programs. *BMC Psychiatry, 17*(1), 1–10.
- Ulberg, R., Falkenberg, A. A., Nærdal, T. B., Johannessen, H., Olsen, J. E., Eide, T. K., ... Dahl, H. S. J. (2013). Countertransference feelings when treating teenagers. A psychometric evaluation of the Feeling Word Checklist-24. *American Journal of Psychotherapy, 67*(4), 347–358.
- van Dam, A., & Rijckmans, M. J. N. (2020). Antisociaal gedrag en persoonlijkheidsproblematiek, van exclusie naar inclusie. In M. J. N. Rijckmans, A. van Dam, & I. M. C. van den Bosch (Eds.), *Praktijkboek antisociaal gedrag en persoonlijkheidsproblematiek [practitioner guide for antisocial behaviour and personality disorders]* (pp. 3–12). Houten: Bohn Stafleu van Loghum.
- Van den Bosch, I. M. C., Hysaj, M. M., & Jacobs, P. P. (2012). DBT in an outpatient forensic setting. *International Journal of Law and Psychiatry, 35*(4), 311–316.
- Van den Bosch, I. M. C., Rijckmans, M. J. N., Decoene, S., & Chapman, A. L. (2018). Treatment of antisocial personality disorder: Development of a practice focused framework. *International Journal of Law and Psychiatry, 58*, 72–78.
- van Dijk, M. K., Verbraak, M. J., Oosterbaan, D. B., & van Balkom, A. J. (2012). Implementing practice guidelines for anxiety disorders in secondary mental health care: a case study. *International Journal of Mental Health Systems, 6*(1), 20.
- Webb, D., & McMurrin, M. (2007). Nursing staff attitudes towards patients with personality disorder. *Personality and Mental Health, 1*, 154–160.
- Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997). *HCR-20. Assessing the risk of violence. Version 2*. Burnaby, Canada: Simon Fraser University and Forensic Psychiatric Services Commission of British Columbia.
- Weck, F., Jakob, M., Neng, J. M., Höfling, V., Grikscheit, F., & Bohus, M. (2016). The effects of bug-in-the-eye supervision on therapeutic

alliance and therapist competence in cognitive-behavioural therapy: A randomised controlled trial. *Clinical Psychology & Psychotherapy*, 23(5), 386–396.

- Wetterborg, D., Dehlbom, P., Långström, N., Andersson, G., Fruzzetti, A. E., & Enebrink, P. (2020). Dialectical behavior therapy for men with borderline personality disorder and antisocial behavior: A clinical trial. *Journal of Personality Disorders*, 34(1), 22–39.
- Whyte, C. R., Constantopoulos, C., & Bevans, H. G. (1982). Types of countertransference identified by Q-analysis. *British Journal of Medical Psychology*, 55, 187–201.
- Wolf, L. A., Perhats, C., Delao, A. M., & Clark, P. R. (2017). Workplace aggression as cause and effect: Emergency nurses' experiences of working fatigued. *International Emergency Nursing*, 33, 48–52.

How to cite this article: van Dam, A., Rijckmans, M., & van den Bosch, L. (2022). Explaining the willingness of clinicians to work with patients with antisocial personality disorder using the theory of planned behaviour and emotional reactions. *Clinical Psychology & Psychotherapy*, 29(2), 676–686. <https://doi.org/10.1002/cpp.2661>

2. I think it is interesting to provide psychological treatment to ASPD patients (A).
3. I think it is important to provide psychological treatment to ASPD patients (A).
4. My fellow colleagues expect me to provide psychological treatment to ASPD patients (PSN).
5. My fellow colleagues provide psychological treatment to ASPD patients (PSN).
6. My fellow colleagues think it's important to provide psychological treatment to ASPD patients (PSN).
7. I am well capable of providing psychological treatment to ASPD patients (PBC).
8. I have sufficient knowledge to provide psychological treatment to ASPD patients (PBC).
9. The treatments I provide to ASPD patients usually have a good result (PBC).
10. I choose to provide psychological treatment to ASPD patients (I).
11. If I had the choice, I would choose to provide psychological treatment to ASPD patients (I).

A = attitude, PSN = perceived social norm, PBC = perceived behavioural control, I = intention.

APPENDIX A

THE THEORY OF PLANNED BEHAVIOUR QUESTIONNAIRE FOR ASPD TREATMENT (TPBaspdT)

1. It think is useful to provide psychological treatment to ASPD patients (A).