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Exploring Helping Professionals Attitudes toward Clients with Antisocial Personality Disorder

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Abstract

There is a lack of research regarding helping professionals' attitudes toward clients with antisocial personality disorder (ASPD). We examined factors associated with helping professionals' attitudes toward clients with ASPD through an online survey using a modified version of a validated instrument. We found the following three factors: security, acceptance, and enjoyment influenced helping professionals' attitudes towards clients with ASPD. Implications for clinical training, supervision, and education toward this population are discussed.

Keywords: antisocial personality disorder, attitudes, mental health

Exploring Helping Professionals Attitudes toward Clients with Antisocial Personality Disorder

Antisocial Personality Disorder (ASPD) is characterized by a chronic pattern of destructive, impulsive, and irresponsible behaviors that violate and disregard the rights of others (American Psychiatric Association [APA], 2013). People who have ASPD often engage in reckless and socially unacceptable behaviors throughout their lifespan that often result in criminal offenses and incarceration (APA, 2013; National Institute for Health and Care Excellence [NICE], 2009). People with ASPD have high rates of addictive disorders, co-occurring mental health issues, unemployment, strained social relationships, and premature death (APA, 2013; NICE, 2009). The disorder occurs in approximately four percent of the general population and up to 70 % of the prison population and is more common in men than women (APA, 2013; NICE, 2009). Importantly, many individuals that meet diagnostic criteria for ASPD are not formally diagnosed, but demonstrate characteristics consistent with the diagnosis (Black, 2013; NICE, 2009). Thus, throughout this manuscript we will collectively refer to this population as people with/who have ASPD regardless of the presence of a formal diagnosis.

People who have ASPD often engage in criminal behaviors including theft, conning others, and violent crimes (Black, 2013). Their destructive behaviors cause societal burdens in the forms of criminal costs, safety issues such as violence and robbery, and overuse of public assistance programs and resources (Black, 2013; NICE, 2009). People who have ASPD are often coerced or court-ordered to attend mental health and/or addictions treatment as a means of harm reduction in hopes that treatment will deter their destructive behaviors (NICE, 2009). People who have ASPD are treated in various clinical settings including emergency departments; crisis centers; incarceration settings such as prisons, jails, or pre-release centers; addictions treatment centers; and mental health treatment agencies (Black, 2013; NICE, 2009). Therefore, they interact with various helping professionals including professional counselors, social workers, psychologists, psychiatrists, nurses, and addictions counselors (APA, 2013; Black, 2013; NICE, 2009). They are most often treated for co-occurring mental health and/or addictive disorders rather than their personality disorders because people with ASPD typically do not think anything

is wrong with their personality (Black, 2013; NICE, 2009). However, helping professionals receive minimal training specific to treating clients who have ASPD (NICE, 2009) and may feel overwhelmed and unable to help clients who have the disorder (Black, 2013; NICE, 2009).

Helping professionals often have negative thoughts and feelings, (i.e., attitudes) toward clients who have ASPD because people who have the disorder can be aggressive, irritable, hostile, and callous (Bowers et al., 2006; Salekin, 2002; Schwartz, Smith, & Chopko, 2007). These negative attitudes are called therapeutic pessimism (Salekin, 2002) and can cause helping professionals to argue with, belittle, or disparage clients who have ASPD. Helping professionals' therapeutic pessimism can sabotage therapy and contribute to poor treatment outcomes for clients with ASPD (Black, 2013; Martens, 2004; NICE, 2009; Salekin, 2002).

There is limited research on helping professionals' attitudes toward clients who have ASPD, despite people with ASPD being treated in most clinical settings. Moreover, there are no validated instruments that measure helping professionals' attitudes toward clients with ASPD. The purpose of this study was to identify factors associated with helping professionals' attitudes toward clients with ASPD. This study builds upon previous research that examined helping professionals' attitudes toward all personality disorders (Bowers et al., 2006; Eren & Sahin, 2016) by identifying the essential factors influencing helping professionals' attitudes specific to ASPD.

Attitudes Toward Personality Disorders

Helping professionals can be pessimistic about treating clients who have personality disorders (Eren & Sahin, 2016; Lewis & Appleby, 1988). Personality disorders are longstanding, chronic conditions and treatment progress is often slow, which can exhaust and frustrate helping professionals (Bowers et al., 2006; Martens, 2004; NICE, 2009). People with personality disorders often have poor interpersonal skills and are prone to unpredictable and destructive behaviors that elicit aversive reactions in others, including helping professionals (APA, 2013; NICE, 2009). During treatment, people with personality disorders may have violent outbursts, engage in self-harm, bully others, and experience exacerbations of addiction and other co-occurring mental health issues (NICE, 2009; Salekin, 2002). Helping professionals who interact with clients who have personality disorders are prone to burnout (Freestone et al., 2015) and job dissatisfaction (Bowers et al., 2006)

Bowers and Allan (2006) developed the Attitudes Toward Personality Disorders Questionnaire (APDQ) to quantify helping professionals' attitudes toward people with personality disorders. Several studies using the APDQ suggest that helping professionals' attitudes toward clients with personality disorders are influenced by various interpersonal and environmental factors such as work setting, clinical discipline, and amount of experience treating people who have personality disorders (Bowers et al., 2005; 2006; Bowers & Allan, 2006). Positive attitudes toward clients with personality disorders were associated with improved job performance, decreased burnout, and increased career satisfaction (Bowers et al., 2006).

However, the APDQ measures participants' attitudes toward all personality disorders and is not specific to ASPD (Bowers & Allan, 2006). Although the APDQ is a valid measure of helping professionals' attitudes toward personality disorders in general, helping professionals may have varying attitudes toward each personality disorder (Black et al., 2011; Freestone et al., 2015). For example, a helping professional may enjoy treating clients who have borderline personality disorder and dislike treating clients who have antisocial personality disorder.

Attitudes Toward Antisocial Personality Disorder

Helping professionals often experience feelings of shock, outrage, anger, powerlessness, and disgust when they interact with clients who have ASPD due to these clients' behaviors that violate societal norms such as lying, stealing, and violence toward people or animals (Evans, 2011). Further, people who have ASPD use concrete, unemotional reasoning to explain their behaviors, which can be objectionable to helping professionals (Evans, 2011). For example, someone with ASPD may describe deceiving others as a way to meet his or her own basic needs and express no concern for victims of the deception, which can offend helping professionals.

To explore helping professionals' attitudes toward clients who have ASPD, Schwartz and colleagues (2007) showed master's level mental health professionals-in-training a recorded session of a client with ASPD and measured the students' responses with questionnaires and interviews. The participants reported feelings of intimidation and being dominated when they watched a recorded video of the client. Participants' negative reactions to these clients' bids for interpersonal power and control are fundamental in the development of therapeutic pessimism (Bandura, 1986; Schwartz et al., 2007). The researchers (Schwartz et al., 2007) examined the participants' responses through the lens of countertransference; however, the study did not account for factors associated with participants' attitudes.

Research Question

To measure factors associated with helping professionals' attitudes toward clients who have ASPD, we modified Bowers and Allan's (2006) Attitudes Toward Personality Disorders Questionnaire (APDQ) to make it specific to ASPD. We called this version the Adapted Attitudes toward Personality Disorders Questionnaire (A-APDQ). We used the following research question to guide our exploration of factors associated with helping professionals' attitudes toward clients who have ASPD: What is the factor structure of the adapted version of the APDQ (A-APDQ) with a sample of helping professionals?

Method

Participants

Participants (N = 103) were helping professionals who had been approved to provide mental health and/or addictions services to clients who have Medicaid benefits in a southeastern state. Clients with ASPD often lack employment and cannot pay for private insurance (Black 2013; NICE, 2009) so we surveyed professionals who accept clients with Medicaid benefits as they are more likely to interact with this population. Study participants met the following criteria: (a) fully licensed to practice mental health or addiction therapy; (b) approved as a treatment provider for individuals with Medicaid benefits, and (c) have at least a master's degree in counseling or other helping related fields.

The sample consisted of the following disciplines: professional counselors (n = 48; 46.6%), social workers (n = 28; 27.2%), psychologists (n = 18; 17.5%), psychiatrists (n = 3; 2.9%), marriage and family therapists (n = 2; 1.9%), and other (n = 4; 3.9%). Although the mean of the participants' years of professional experience was greater than 20 (M = 23.11, SD = 10.67), almost two-thirds of the participants (n = 65, 63.1%) reported treating fewer than two clients with APSD per week (M = 1.89, SD = 3.63). We did not select for partipants who commonly treat clients with ASPD to ensure our sample was representative of helping professionals who often, rarely, and never interact with clients who have ASPD.

Participants aged 60 to 69 years made up the largest age grouping (n = 31; 30.1%). Participants aged 20 to 29 made up the smallest age grouping (n = 1; 1.0 %). Participants identified as female (n = 69; 67%), male (n = 33; 32.0%), and other (n = 1; 1.0%). Participants

identified their race as White/Caucasian (*n* = 83; 80.6%), African American/Black (*n* = 15; 14.6%), Hispanic/Latino (*n* = 2; 1.9%), Native American/American Indian (*n* = 1; 1.0%), and other (*n* = 2; 1.9%).

Procedure

We obtained approval from the institutional review board for human subjects research prior to data collection and analysis. The study was introduced to the participants through a link to an online survey instrument sent to participants' email addresses obtained through an online provider directory for the state in which the study was conducted. We invited all helping professionals who were listed on the online provider directory (N = 5679) to participate in this study to compensate for the expected low response rates of exploratory online survey designs associated with invalid email addresses and email account filters (Nulty, 2008). Helping professionals who agreed to participate were emailed a link to an online survey that included a demographic questionnaire and the A-APDQ. Participation in this study was uncompensated, voluntary, and participants could elect to have any or all of their data excluded from future research. To protect the rights and confidentiality of the participants, all identifying information was removed and the data were aggregated.

Instrumentation

Demographic questionnaire. The demographic questionnaire was used to ascertain participants' primary descriptive data including age, gender, race, licensure, professional discipline, years of experience, and work setting. Participants' completed the demographic questionnaire before completing the A-APDQ.

Adapted Attitudes toward Personality Disorders Questionnaire. As discussed, to examine helping professionals' attitudes toward clients who have ASPD, we modified Bowers & Allan's (2006) APDQ and called the adapted version the Adapted Attitudes Toward Personality Disorders Questionnaire (A-APDQ). To emphasize our target population, we added "AS" (i.e. antisocial) to each "PD" (i.e. personality disorder) to "ASPD" (i.e. antisocial personality disorder). abbreviation from the original instrument. For example, item 4 which originally read "I respect PD patients" was modified to "I respect ASPD people". We also modified the instrument language by using the term *people* instead of *patients* to reflect multiple disciplines (e.g. counselors, social workers, psychologists) rather than the original instrument's emphasis on medical disciplines (Bowers and Allan & 2006). We did not implement person-first language (e.g. people who have ASPD versus ASPD people) to avoid further instrument adaptations which could affect this study's validity.

Psychometric properties. The APDQ is a 36-item Likert style questionnaire that measures participants' attitudes toward people with personality disorders (Bowers & Allan, 2006). Participants responded to each questionnaire item by selecting one response from the following options: 1 = "never," 2 = "seldom," 3 = "occasionally," 4 = "often," 5 = "very often," 6 = "always" (Bowers & Allan, 2006). Questionnaire items measure participants' positive feelings (e.g., protective, warmth, caring) and negative feelings (e.g., frustration, fear, anger) toward people with personality disorders.

The original APDQ was validated through test-retest procedures, principal components analysis, and follow-up confirmatory factor analysis (Bowers & Allan, 2006). The results yielded 5 distinct subscales with eigenvalues greater than 1 and test-retest reliability scores ranging from .72 to .85. The five APDQ subscales were given names that reflect the spectrum of thoughts and feelings they measure toward people with personality disorders (Bowers & Allan, 2006).

The enjoyment/loathing subscale consists of 15 items measuring positive emotions such as warmth and caring toward people with personality disorders (Bowers & Allan, 2006).
The security/vulnerability subscale consists of 10 items measuring participants' feelings of safety, anxiety, and fear in the presence of people with personality disorders (Bowers & Allan, 2006). The acceptance/rejection subscale consists of 5 items measuring feelings of anger and rejection toward clients with personality disorders (Bowers & Allan, 2006). The purpose/futility subscale consists of 3 items measuring feelings of hopelessness and pessimism toward clients with personality disorders (Bowers & Allan, 2006). The enthusiasm/exhaustion subscale consists of 2 items measuring participants' levels of satisfaction when working with people with personality disorders (Bowers & Allan, 2006).

Data Screening

Completed surveys were analyzed with statistical processing software. We screened for missing data and outliers; then we conducted analyses to examine appropriate statistical assumptions including sample size, normality, and linearity. Next, we conducted an exploratory factor analysis (EFA) to examine the instrument's factor structure. We then examined the internal consistency of the A-APDQ factors by calculating Cronbach's α to measure the degree of correlation between the items.

Data Analysis

The purpose of this study was to identify the essential factors of the A-APDQ that influence helping professionals' attitudes toward people who have ASPD. An examination of the data's univariate frequency distribution revealed no absolute values greater than 2.0 for skewness or 7.0 for kurtosis (Curran, West, & Finch, 1996; Kline, 2011), indicating no extreme deviation from normality. Therefore, we used a maximum likelihood (ML) extraction method (Costello & Osborne, 2005; Fabrigar, Wegener, MacCallum, & Strahan, 1999). To determine a rotation method, we first ran an oblique oblimin rotation and examined the factor correlations (Hair, Black, Babin, & Anderson, 2010; Tabachnick & Fidell, 2013). The examination of the factor correlations indicated correlations above an absolute value of .32, suggesting enough variance to warrant the oblique oblimin rotation (Costello & Osborne, 2005; Tabachnick & Fidell, 2013). We used the following criteria for the A-APDQ item retention: (a) statistically significant value for Bartlett's test of sphericity, (b) a value of .5 or greater for Kaiser–Meyer–Olkin (KMO) sampling adequacy for the whole instrument, (c) a .5 or greater measurement sampling accuracy (MSA) for each A-APDQ item, (d) a factor loading of .3 or greater (based on sample size), and (e) a .2 or greater difference between factor loadings for the same A-APDQ item (Hair et al., 2010; Henson & Roberts, 2006; Mvududu & Sink, 2013).

In their original article, Bowers and Allan (2006) used a principal components analysis with a varimax rotation. A varimax rotation assumes the factors are not correlated (i.e., each common factor only influences a specific subset of the items). However, for many constructs in psychology and counseling, there are extensive theoretical and empirical reasons for expecting the constructs to be correlated (Fabrigar et al., 1999). Therefore, because oblique rotations provide a more accurate and realistic view of the relationships among the constructs/factors (Fabrigar et al., 1999) we conducted this study using maximum likelihood exploratory factor analysis with oblimin rotation.

Results

The EFA consisted of 103 participants who completed the A-APDQ. The item to case ratio was approximately 2:15, which is commendable in EFA (Costello & Osborne, 2005;

Henson & Roberts, 2006; Mvududu & Sink, 2013). The ML EFA with oblimin rotation identified three factors with eigenvalues greater than 1.0. After removing A-APDQ items due to low commonalities and significant cross-loading, 14 items remained. The appropriateness of the data for EFA was re-evaluated by examining the three factors with Bartlett's test of sphericity (Bartlett, 1954) and the KMO (Kaiser, 1970, 1974). Bartlett's test of sphericity achieved statistical significance ($\chi 2$ (91) = 723.54, $p<.0001$). The KMO value was commendable with a value of .88 (Hair et al., 2010; Mvududu & Sink, 2013). Most of the extraction commonalities (10 of 14, 71.42%) were above .45, with four items (23, 25, 35, 36) having commonalities of .22, .37, .39, and .35, respectively.

Next, we examined the items' significant factor loadings (i.e., .3 or higher; Hair et al., 2010) and found that all items loaded statistically significantly on at least one of the factors. Then, we identified items with cross-loadings of .3 or higher (Hair et al., 2010; Mvududu & Sink, 2013). This process resulted in the retention of all 14 items.

Table 1 presents the pattern matrix of the A-APDQ. The EFA yielded three factors with factor loadings ranging from .46 to .91. Factor 1 consisted of items 3, 6, 9, and 16. Factor 2 consisted of items 23, 33, 34, and 35. Factor 3 consisted of items 10, 17, 25, 27, 30, and 36. Finally, the results produced an acceptable simple structure with the most insignificant cross-loadings having absolute values less than ±.20.

Table 1
ASPDQ-14 Pattern Matrix

		Factor Loading		
Item		1	2	3
9	I feel uncomfortable or uneasy with ASPD people.	.91		
6	I feel vulnerable in ASPD people's company.	.83		
16	I feel frightened of ASPD people.	.81		
3	I feel drained by ASPD people.	.68		
34	I feel able to help ASPD people.		.78	
35	I feel interested in ASPD people.		.66	
33	I feel patient when caring for ASPD people.		.66	
23	I feel protective toward ASPD people		.43	
27	I feel powerless in the presence of ASPD people.			.76
25	I feel that ASPD people are alien or strange.			.63
17	I feel angry toward ASPD people.			.58
36	I feel unable to gain control of the situation with ASPD people.			.55
30	I feel outmaneuvered by ASPD people.			.51
10	I feel I am wasting my time with ASPD people.			.47

Extraction Method: Maximum Likelihood.
Rotation Method: Oblimin with Kaiser Normalization.[a]

The three identified factors accounted for 63.53% of the total variance, which is appropriate for social science research (Hair at al., 2010; Henson & Roberts, 2006; Mvududu & Sink, 2013). The eigenvalues produced in this EFA met the condition for Kaiser's rule (Mertler & Vannatta, 2005): Factor 1 had an eigenvalue of 6.14, Factor 2 had an eigenvalue of 1.75, and Factor 3 had an eigenvalue of 1.00. Table 2 includes the cumulative factor loadings for the A-APDQ.

Table 2
A-APDQ Factor Loadings

	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings[a]
Factor	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	6.14	43.86	43.86	5.64	40.32	40.32	4.98
2	1.75	12.50	56.36	1.30	9.24	49.56	4.96
3	1.00	7.17	63.53	.62	4.43	53.99	3.28
4	.83	5.95	69.48				
5	.74	5.27	74.75				
6	.67	4.77	79.52				
7	.59	4.20	83.73				
8	.52	3.72	87.45				
9	.47	3.37	90.81				
10	.37	2.67	93.48				
11	.31	2.24	95.72				
12	.25	1.78	97.50				
13	.21	1.48	98.98				
14	.14	1.03	100.00				

Extraction Method: Maximum Likelihood.

a. When factors are correlated, sums of squared loadings cannot be added to obtain a total variance.

After finalizing the factors through EFA, we examined the data for internal consistency by evaluating the Cronbach's α for the instrument. We used a Cronbach's α of .70 or higher as a standard to determine acceptable inter-item consistency (Mitchell & Jolley, 2004; Streiner, 2003). The Cronbach's α for the instrument and scale scores on the A-APDQ indicated strong internal consistency (Leech, Onwuegbuzie, & O'Connor, 2011; Streiner, 2003). Cronbach's for the instrument, Factor 1, Factor 2, and Factor 3 are .90, .82, and .75 respectively.

We determined that Factor 1 (4 items) represents security/vulnerability, Factor 2 (4

Table 3

Loading	Factor	Item	Factor	Loading
0.81	1	I feel warm and caring toward (AS)PD patients	Dropped	
0.79	1	I enjoy spending time with (AS)PD patients	Dropped	
0.77	1	Caring for (AS)PD patients (people) makes me feel satisfied and fulfilled	Dropped	
0.74	1	I feel understanding toward (AS)PD patients	Dropped	
0.73	1	I have a feeling of closeness with (AS)PD patients	Dropped	
0.73	1	I feel protective toward (AS)PD patients	2	0.43
0.71	1	I like (AS)PD patients	Dropped	
0.71	1	I feel fondness and affection for (AS)PD patients	Dropped	
0.69	1	I feel happy and content in (AS)PD patients' company	Dropped	
0.67	1	I feel interested in (AS)PD patients	2	0.66
0.64	1	I feel able to help (AS)PD patients	2	0.78
0.63	1	I admire (AS)PD patients	Dropped	
0.59	1	I respect (AS)PD patients	Dropped	
0.58	1	I feel patient when caring for (AS)PD patients	2	0.66
0.54	1	I am excited to work with (AS)PD patients	Dropped	
0.81	2	I feel vulnerable in (AS)PD patients' company	1	0.83
0.76	2	I feel frightened of (AS)PD patients	1	.081
0.76	2	I feel oppressed or dominated by (AS)PD patients	Dropped	
0.75	2	I feel uncomfortable/uneasy with (AS)PD patients	1	0.91
0.73	2	I feel manipulated or used by (AS)PD patients	Dropped	
0.71	2	I feel powerless in the presence of (AS)PD patients	3	0.76
0.69	2	I feel outmaneuvered by (AS)PD patients	3	0.51
0.62	2	I feel exploited by (AS)PD patients	Dropped	
0.51	2	I feel helpless in relation to (AS)PD patients	Dropped	
0.51	2	I feel unable to gain control of the situation with (AS)PD patients	3	0.55
0.58	3	I feel that (AS)PD patients are alien or strange	3	0.63
0.57	3	I feel intolerant. I have difficulty tolerating (AS)PD patients' behavior	Dropped	
0.54	3	Interacting with (AS)PD patients makes me shudder	Dropped	
0.51	3	I feel angry toward (AS)PD patients	3	0.58
0.51	3	(AS)PD patients (people) make me feel irritated	Dropped	
0.73	4	I feel pessimistic about (AS)PD patients	Dropped	
0.59	4	I feel resigned about (AS)PD patients	Dropped	
0.50	4	I feel I am wasting my time with (AS)PD patients	3	0.47
0.75	5	I feel frustrated with (AS)PD patients	Dropped	
0.67	5	I feel drained by (AS)PD patients	1	0.68

items) represents enjoyment/loathing, and Factor 3 (6 items) represents acceptance/rejection. These factors are labeled with titles devised by the instrument's developers (Bowers & Allan, 2006). Table 3 compares the original APDQ (Bowers & Allan, 2006) and the A-APDQ. As

expected, the oblimin rotation revealed that these three factors are significantly correlated. Factor 1, security/vulnerability, was negatively correlated with Factor 2, rejection/acceptance, ($r = -.36$ $p < .001$). That is, as counselors felt more vulnerable, they were less willing to accept the client. Likewise, Factor 2, rejection/acceptance, was negatively correlated with Factor 3, enjoyment/loathing, ($r = -.37$, $p < .001$). Thus, counselors with stronger attitudes of acceptance were less likely to have loathing attitudes toward the client. Conversely, Factor 1, security/vulnerability, was positively correlated with Factor 3, enjoyment/loathing, ($r = .74$, $p < .001$). Thus, as counselors' security attitudes increased, their attitudes of enjoyment of therapy with APSD clients also increase. These strong correlations specify the shared unexplained common variance between the factors.

Discussion

We explored factors associated with helping professionals' attitudes toward clients who have ASPD. This study built upon previous research examining helping professionals' attitudes toward all personality disorders (Bowers & Allan, 2006; Eren & Sahin, 2016) by identifying factors associated with helping professionals' attitudes specific to people who have ASPD. The factor structure from the current study differed from Bowers & Allan's (2006) examination of attitudes toward all people with personality disorders. These differences warrant further exploration of helping professionals' attitudes toward clients who have ASPD. Helping professionals' attitudes toward ASPD may be associated with various factors not measured by the APDQ or the A-APDQ. Additionally, helping professionals attitudes toward clients who have ASPD are likely not representative of their attitudes toward all people with personality disorders.

Most noteworthy, our findings differed from Bowers and Allan's (2006) along the security/vulnerability factor. This factor measures participants' "fears, anxieties, and helplessness" (Bowers & Allan, 2006 p.12). In Bowers and Allan's (2006) study security/vulnerability was factor two and explained 16.9% of the variance whereas we found that security/vulnerability was primary and explained 40.3% of the total variance when we specified for ASPD. This suggests that helping professionals' attitudes are affected by their feelings of vulnerability when they interact with clients who have ASPD. Additionally, the strong significant correlation among the factors ($p < .001$) may suggest a developmental process for helping professionals. From a clinical perspective, these findings may indicate that as helping professionals' feelings of security increase so too does their acceptance and enjoyment of clients who have ASPD.

Educators and supervisors can address helping professional trainees' feelings of security, which may improve their overall attitudes toward this underserved population. Clients who have ASPD are often motivated by power and control (Black, 2013; Evans, 2011; NICE, 2009). They may manipulate, bully, and intimidate helping professionals, which contributes to helping professionals feeling vulnerable, anxious, and powerless (Black, 2013; Evans, 2011; Schwartz et. al, 2007). Helping professionals' who feel vulnerable or powerless when they interact with clients having ASPD are more likely to engage in negative interactions such as punitive responses or arguing (Bowers & Allan, 2006; Evans, 2011). Educators and supervisors can increase trainees feelings of safety by educating them about the symptoms and interpersonal dynamics of ASPD, processing countertransference, and normalizing feelings of vulnerability. Additionally, they can teach helping professionals-in-training practical tips for increasing personal safety such as maintaining professional boundaries and logistical safety tips such as office space setting and methods of responding to threats and aggression.

Clients who have ASPD are distrustful of authority figures and they often act out (e.g. violence, threats, bullying) to test professionals' boundaries or to gain a sense of power in their relationships with helping professionals (Black, 2013). These behaviors may be enactments of their earlier childhood experiences and can be used to better understand these clients (Evans, 2011). Educators and supervisors can help trainees develop skills for rapport building and responding to clients' troublesome behaviors by helping them conceptualize their behaviors and develop skills for responding to resistant behaviors. For example, teaching trainees Motivational Interviewing (Miller & Rollnick, 2013) may help them understand and respond to these clients' resistant behaviors and exploring countertransference may promote trainees' awareness of clients' underlying behavioral motivations (Evans, 2011). Educators and supervisors can help trainees conceptualize these behaviors through various theoretical frameworks to help trainees depersonalize their reactions to these clients and develop effective interventions.

Limitations

This study has specific limitations to consider when interpreting the results. First, participants in this study were helping professionals who elected to participate from a large population of participants (N = 5697), which likely reflects a non-response bias and influences the study's reliability and validity (Heppner, Kivlighan, & Wampold, 2008). Because of the study's online survey design, the cause of the non-response bias cannot be determined but may be attributed to the study's lack of monetary incentive, helping professionals' disinterest in clients with ASPD, or helping professionals' time constraints.

The sample for this study consisted of only self-selected participants, which likely introduced a sampling bias reflected in the data's unequal group representations. Specifically, helping professionals who work in private outpatient settings (n = 66; 64.1%) were overrepresented, whereas helping professionals who work in public outpatient settings (n = 23; 22.3%) and forensic settings (n = 2; 1.9%) were underrepresented. Clients who have ASPD are most often treated in forensic settings and public outpatient settings (NICE, 2009). Further, helping professionals in forensic settings and public outpatient agencies often have large caseloads, high stress levels, and have high rates of burnout (Lent & Schwartz, 2012). Although helping professionals in these agencies are more likely to encounter clients with ASPD, they may be less likely to participate in an online survey which limits this study's external validity. Nevertheless, because by nature and design EFA is *exploratory*, we considered it most appropriate to explore the data set obtained from mental health professionals regarding the therapeutic dynamics of clients with ASPD and helping professionals.

Perhaps some would argue that using a small sample size (n = 103) limits the generalizability of the findings. Because we had a small sample size, we incorporated design and statistical procedures that increased our confidence that our conclusions might warrant future attention and replication. Further, strict guidelines for determining sample size have mostly disappeared because adequate sample size is partly determined by the nature of the data (Fabrigar et al., 1999; MacCallum, Widaman, Zhang, & Hong, 1999). Furthermore, when considering the appropriate sample size, researchers have observed that variables with low reliabilities below .70 should be avoided (Fabrigar et al., 1999). The range of Cronbach alpha for the three A-APDQ scales exceeded that suggestion. Finally, although our communalities are not optimal, they are similar to the common magnitudes in the social sciences of .40 to .70 (Costello & Osborne, 2005).

The original APDQ was validated through multiple studies consisting of large samples, test re-test procedures, and follow up confirmatory factor analyses (Bowers & Allan, 2006).

Because the original instrument was developed on samples greater than 500 participants, this study's three-factor version may have resulted from a small sample size. Future studies are needed with larger and more diverse samples to validate the three factors of the A-APDQ.

Future Research

As previously discussed, studies examining helping professionals' attitudes toward clients who have ASPD are sparse. This study contributes to understanding helping professionals' attitudes toward clients with ASPD by exploring factors associated with helping professionals' attitudes toward clients with ASPD. Future studies can expound upon these findings through further instrument development and intervention studies.

Although this exploratory study identified the role of helping professionals' feelings of security and vulnerability toward clients who have ASPD, it may not account for other variables that influence their attitudes. The data set used to develop our scale is likely to have its idiosyncrasies. Building on the EFA and CFA findings, future studies could utilize larger and more diverse sample sizes to determine the instrument's generalizability. Likewise, new items could be incorporated items to measure helping professionals' self-efficacy, beliefs about clients with ASPD, and beliefs or feelings about environmental factors, such as supervisors or work settings. These future studies may reveal additional variables associated with helping professionals' attitudinal development toward clients with ASPD that will result in effective educational and supervisory interventions. In this regard, our findings are considered a starting point rather than a finalized instrument for measuring helping professionals' attitudes toward clients who have ASPD.

Future studies can explore the efficacy of educational and supervisory interventions. Although prior research has determined that helping professionals with little clinical experience are vulnerable to therapeutic pessimism (Schwartz et al., 2007), no studies have examined how these attitudes develop over time. Future studies can explore how these attitudes develop through longitudinal repeated-measures designs. For example, the A-APDQ could be used to measure helping professionals' attitudes throughout graduate programs and during helping professionals' first two years of clinical work to determine risk and protective factors associated with their attitudinal development toward clients who have ASPD.

Conclusion

Results from this study outline three factors that are associated with helping professionals' attitudes toward clients who have ASPD: security, acceptance, and enjoyment. Security/vulnerability was the primary factor that influenced helping professionals' attitudes toward clients who have ASPD and these findings can help educators and supervisors train helping professionals to better serve clients who have ASPD. Because this study was exploratory and utilized a small convenience sample, future studies with larger and more diverse samples are needed to develop additional instrument items, explore attitudes longitudinally, and further validate the psychometric properties of an adapted version of the original instrument.

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