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American counselors' acceptance of non-abstinence outcome goals for clients diagnosed with co-occurring substance use and other psychiatric disorders

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Abstract

Previous research has examined clinicians' acceptance of non-abstinence for clients who have a substance use disorder (SUD), but many SUD clients also present with a psychiatric disorder. To evaluate the acceptability of non-abstinence as a final outcome goal for clients with co-occurring diagnoses, we recruited a nationwide sample of 751 American substance abuse counselors to complete a web-based questionnaire. Respondents rated the acceptability of limited/moderate consumption by clients diagnosed with each of 18 co-occurring disorders: three psychiatric disorders (Major Depressive Disorder, Post-Traumatic Stress Disorder, Social Phobia) × three substances (alcohol, cannabis, opioids) × two levels of severity (DSM-5 Moderate SUD, DSM-5 Severe SUD). On average, non-abstinence was rated as unacceptable for clients with any of the 18 diagnostic pairs, although one-fourth to almost one-third rated limited/moderate use of cannabis somewhat or completely acceptable for clients diagnosed with a Moderate Cannabis Use Disorder when paired with any of the three psychiatric disorders. Furthermore, small proportions of respondents (13% to 20%) rated non-abstinence at least somewhat acceptable even when clients were diagnosed with a Severe SUD for any of the three substances and any co-occurring psychiatric disorder. Based on our findings, clients with co-occurring disorders who want to moderate their substance use will typically find their counselor does not accept that outcome goal. Because supporting non-abstinence respects client autonomy, could attract and retain clients in counseling, and is consistent with a recovery-oriented treatment model, we encourage continuing education about the benefits of non-abstinence as a treatment goal for clients with co-occurring disorders.

Keywords

substance use disorders; psychiatric disorder; non-abstinence; acceptability

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1. Introduction

One treatment outcome goal for people diagnosed with a SUD is to moderate or control their consumption of alcohol or drugs (often referred to as non-abstinence), rather than to abstain entirely (Marlatt et al., 2012; MacCoun, 1997; Ritter & Cameron, 2006). Successful non-abstinence may be defined as a reduction in the amount or frequency of consumption, a sense of mastery or self-efficacy regarding initiation and cessation of use, and experiencing few if any negative substance use-related consequences (e.g., Rosenberg, 2002). Research indicates that controlled drinking occurs commonly among those with less severe drinking problems, and is rare – but no less common than abstinence – among those dependent on alcohol (e.g., Maisto et al., 2007; Rosenberg, 1993; Saladin & Santa Ana, 2004; van Amsterdam & ven den Brink, 2013). Successful controlled or moderate consumption appears to be less prevalent among people who abuse or are dependent on illicit drugs (Martens et al., 2012), but there is notably little research available about the prevalence of controlled drug use by those diagnosed with SUDs. A variety of interventions have been proposed to assist clients who want to moderate their consumption, including setting explicit consumption goals, self-monitoring, contingency contracting, changing unrealistic outcome expectancies, behavioral self-control training, and cue exposure with a moderation goal (e.g., Miller & Munoz, 2013; Rosenberg, 2002; Walters, 2000).

Even if only a subset of people with SUDs achieve and maintain non-abstinence during recovery, there are advantages of supporting clients who wish to moderate their alcohol and drug use. For example, such support demonstrates respect for client autonomy, could attract and retain clients in treatment, and would provide clients a respite from more harmful levels of consumption (e.g., Ambrogne, 2002). Supporting non-abstinence goals may also help set the foundation for abstinence as an alternative if moderation is not sustained. Moreover, recent research supports including lower risk drinking as a measure of effective treatment outcome because reductions in consumption are often associated with fewer negative consequences and improved mental health (Hasin et al., 2017; Witkiewitz et al., 2017).

Despite these benefits, the acceptability and availability of non-abstinence as an outcome goal by treatment agencies and providers varies considerably by country and type of substance a client might consume. For example, non-abstinence is typically more acceptable in Australia (Dawe & Richmond, 1997; Donovan & Heather, 1997) and some European countries (e.g., Duckert, 1989; Klingemann, 2016; Klingemann & Rosenberg, 2009; Luquiens, Reynaud, & Aubin, 2011; Robertson & Heather, 1982; Rosenberg, Melville, Levell & Hodge, 1992; Rosenberg & Melville, 2005) than it is in Canada (e.g., Brochu, 1990; Rosenberg, Devine & Rothrock, 1996; Rush & Ogborne, 1986) or the United States (e.g., Davis & Rosenberg, 2013; Rosenberg & Davis, 1994; Rosenberg & Phillips, 2003). Over the past decade, non-abstinence as an outcome goal appears to have become somewhat more acceptable to American addiction counselors and counselors-in-training (Davis &Rosenberg, 2013; Rosenberg & Davis, 2014; Davis & Lauritsen, 2016). In addition, a recent study found that counselors rated non-abstinence more acceptable when clients intend to consume alcohol and cannabis than when clients intend to consume heroin, amphetamines, cocaine, or MDMA/ecstasy (Rosenberg & Davis, 2014). Examining possible predictors of acceptance, two recent studies found acceptance of non-abstinence was

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uncorrelated with years of professional experience, educational degree, and personal history of having a SUD (Davis & Rosenberg, 2013; Rosenberg & Davis, 2014).

One limitation of previous research on this topic is that respondents were asked to rate the acceptability of non-abstinence by clients who were but many clients are diagnosed with a SUD and a co-occurring psychiatric disorder. Co-occurrence of SUDs and anxiety, trauma-related, or mood disorders are common phenomena, although the prevalence varies depending on the specific co-occurring psychiatric disorder (e.g., Mericle, Ta Park, Holck, & Arria, 2012). Specifically, Mericle et al. (2012) reported Major Depression (36%), Social Phobia (23%), and Post-traumatic Stress Disorder (15%) as the three disorders co-occurring most commonly with a SUD among adults in the United States. In addition, people diagnosed with co-occurring disorders experience a variety of psychosocial problems, including poor health, unemployment, homelessness, and suicidality (e.g., Compton, Simmons, Weiss, & West, 2011; Greig, Baker, Lewin et al., 2006; Wilk, West, Rae et al., 2006). Given the complexities of treating clients diagnosed with co-occurring disorders (e.g., Flynn & Brown, 2008), including the possibility that even non-problematic use of alcohol, cannabis and other drugs could reduce the effectiveness of psychotropic medications and exacerbate psychiatric symptoms, counselors might be less accepting of non-abstinence by such clients.

Therefore, we designed the present study to assess whether American substance abuse counselors' acceptance of non-abstinence as an outcome goal varied as a function of a client's co-occurring psychiatric disorder, the specific substance they intended to consume, and severity of the SUD with which they were diagnosed. Specifically, based on previous research showing that acceptance of non-abstinence differed as a function of the specific substance consumed and severity of the SUD (Rosenberg & Davis, 2014), we created 18 types of co-occurring disorders by crossing Mericle et al.'s (2012) three most common co-occurring psychiatric diagnoses (Major Depressive Disorder, Post-Traumatic Stress Disorder, and Social Phobia) with three substances (alcohol, cannabis, opioids) with two levels of diagnostic severity (DSM-5 Moderate and DSM-5 Severe). We also asked clinicians to report any other client characteristics that influenced their attitudes regarding the acceptability of non-abstinence goals.

2. Method

2.1 Recruitment and Procedure

Following review of the study protocol by our university's Human Subjects Review Board (the study received exempt status), a representative from the International Certification and Reciprocity Consortium (internationalcredentialing.org) emailed our recruitment script three times at approximately one week intervals to the 16,896 people on their email list at the time of recruitment (March and April 2016). The Consortium is comprised, in part, of 52 American state addiction certification/licensure and prevention boards (some states have two boards, one for prevention specialists and one for other addiction counselors), and the boards of the District of Columbia, Puerto Rico, Guam, the Indian Health Service, and branches of the US military. Potential respondents were informed about the purpose of the study, that it would take approximately 15 minutes to fill out the survey (see description below), and that

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their responses would be anonymous. As an incentive to participate, potential respondents were notified that we would donate $2/person (up to a maximum of $150) to the American Psychological Association Foundation as a way to "pay it forward" for their time completing the survey.

By the conclusion of recruitment, 1,522 people (9% of total mailing list) had clicked a link to our online survey (hosted by SurveyGizmo.com). Of these, 438 did not consent to participate or begin filling out the survey. Of the remaining 1,084 respondents, we excluded 47 who did not reside in the US, 14 who were not credentialed (nor in the process of becoming credentialed) to practice addiction counseling, and 272 who did not complete all of the client ratings (in anticipation of listwise deletion on SPSS analyses). The final sample comprised 751 respondents (49% of those who clicked the link). A series of t-tests and two-proportion z-tests revealed no statistically significant differences on key demographic characteristics or means on the ratings of acceptability of non-abstinence between the respondents in the final sample and those excluded for completing only a subset of the 18 ratings.

2.2 Respondent Characteristics

As Table 1 reveals, we recruited a sample of middle-aged and older addiction counselors (72% were at least 45 years old), 66% of whom were female, and 64% of whom had a master's degree. Of particular relevance given the key question, respondents had been working with clients diagnosed with co-occurring SUD and other psychiatric disorders for an average of 15 years. This sample appears representative of the population of Consortium members from which we recruited respondents. Specifically, the sample was similar in terms of age (45+: 66% of Consortium members; 72% of current sample), gender (female: 69% of Consortium members; 66% of current sample), and education (Master's degree: 54% of Consortium members; 64% of current sample).

2.3 Survey

We developed the survey for this study based on previously-published questionnaires designed to assess the acceptability of non-abstinence goals by American and British administrators and counselors working in addiction treatment agencies (Davis & Rosenberg, 2013; Rosenberg & Melville, 2005; Rosenberg & Phillips, 2003). Each respondent was asked to rate how acceptable (Completely Unacceptable = −2; Somewhat Unacceptable = −1; Somewhat Acceptable = +1; Completely Acceptable = +2) it would be for a client to pursue non-abstinence (defined as "*limited or recreational use of a substance*") as their *final* outcome goal when they were diagnosed with one of 18 different types of co-occurring disorders: 3 types of psychiatric disorders (Major Depressive Disorder, Post-Traumatic Stress Disorder, Social Phobia) × 3 types of substance-specific SUDs (alcohol, cannabis, opioids) × 2 levels of severity (DSM-5 Moderate SUD, DSM-5 Severe SUD; see column headings of Table 2). We also included questions evaluating respondents' demographic (e.g., age, gender, state of residence) and educational/occupational characteristics (e.g., number of years counseling clients with co-occurring disorders, highest degree obtained, field of training, types of clients counseled). An opened-ended question asked respondents to list

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other client characteristics they considered when deciding whether non-abstinence was acceptable. The survey is available upon request from the corresponding author.

2.4 Data Analysis Plan

Frequency counts and descriptive analyses were conducted to summarize the demographic and employment characteristics of the sample. To test whether mean ratings of acceptability of non-abstinence as a final outcome goal differed as a function of co-occurring psychiatric diagnosis, type of SUD, and level of severity, we conducted six oneway repeated measures ANOVAs (including effect size estimates) with follow-up post hoc tests of mean pairwise comparisons. For all ANOVAs we used Bonferroni corrected alphas (alpha = .05/6 = .008) to evaluate statistical significance and used corrected alphas.

3. Results

3.1 Acceptability of non-abstinence for clients diagnosed with a Moderate SUD by type of substance and co-occurring psychiatric disorder

The first analysis revealed that average acceptance ratings of non-abstinence as a final outcome goal for clients diagnosed with a Moderate Alcohol Use Disorder differed as a function of co-occurring psychiatric diagnosis (Major Depressive Disorder/MDD, Post-traumatic Stress Disorder/PTSD, Social Phobia/SP), $F(2, 749) = 27.24$, $p < .001$, $\eta_p^2 = .07$, $M_{SP} = -0.99$ (1.36) > $M_{PTSD} = -1.09$ (1.33) > $M_{MDD} = -1.20$ (1.33). Next, for clients diagnosed with Moderate Cannabis Use Disorder, acceptability ratings also differed significantly as a function of co-occurring psychiatric diagnosis, $F(2, 749) = 25.56$, $p < .001$, $\eta_p^2 = .06$, $M_{PTSD} = -0.69$ (1.47) > $M_{SP} = -0.76$ (1.44) > $M_{MDD} = -0.88$ (1.42). In the third analysis, for clients diagnosed with Moderate Opioid Use Disorder, acceptability ratings again differed significantly as a function of co-occurring psychiatric diagnosis, $F(2, 749) = 6.46$, $p = .002$, $\eta_p^2 = .02$, $M_{SP} = -1.23$ (1.30) = $M_{PTSD} = -1.25$ (1.27) > $M_{MDD} = -1.31$ (1.27).

This set of ANOVAs indicated that non-abstinence was rated *least* acceptable as an outcome goal whenever a client had a co-occurring diagnosis of Major Depressive Disorder, regardless of the specific substance he or she consumed. Although the negative mean acceptability values indicate that non-abstinence was, on average, unacceptable for all nine types of clients, Table 2 reveals that at least one-quarter of respondents rated non-abstinence as a somewhat or completely acceptable outcome goal for clients diagnosed with a Moderate Cannabis Use Disorder, whereas approximately one-fifth rated non-abstinence acceptable for clients with Moderate Opioid or Alcohol Use Disorders, regardless of the co-occurring psychiatric disorder.

3.2 Acceptability of non-abstinence for clients diagnosed with a Severe SUD by type of substance and co-occurring psychiatric disorder

Average acceptance ratings of non-abstinence as a final outcome goal for clients diagnosed with a Severe Alcohol Use Disorder did *not* differ as a function of co-occurring psychiatric diagnosis, $F(2, 749) = 2.58$, $p = .076$, $M_{SP} = -1.36$ (1.23) = $M_{PTSD} = -1.40$ (1.24) = $M_{MDD} = -1.43$ (1.23). Similarly, for clients diagnosed with Severe Opioid Use Disorder,

acceptability ratings did *not* differ significantly as a function of the co-occurring psychiatric diagnosis, $F(2, 749) = 3.34$, $p = .036$, $\eta_p^2 = .01$, $M_{SP} = -1.38$ (1.23) = $M_{PTSD} = -1.37$ (1.26) = $M_{MDD} = -1.41$ (1.24). However, for clients diagnosed with a Severe Cannabis Use Disorder, acceptability ratings differed significantly as a function of co-occurring diagnosis, $F(2, 749) = 11.40$, $p < .001$, $\eta_p^2 = .03$, $M_{PTSD} = -1.13$ (1.37) = $M_{SP} = -1.15$ (1.34) > $M_{MDD} = -1.22$ (1.32).

This set of ANOVAs revealed that it was *less* acceptable for a client diagnosed with a Severe Cannabis Use Disorder to pursue non-abstinence as an outcome goal when he or she had a co-occurring diagnosis of Major Depressive Disorder, but there were no differences by type of disorder for the other two substances. Consistent with the negative mean acceptability values, Table 2 reveals that fewer than 20% of respondents rated non-abstinence as a somewhat or completely acceptable outcome goal for clients diagnosed with a Severe SUD regardless of the designated substance and co-occurring psychiatric diagnosis.

3.4 Client characteristics reportedly considered when determining whether non-abstinence is acceptable

We asked respondents to write in the specific client characteristics they considered when deciding whether non-abstinence goals were acceptable. Of the 751 respondents, 112 left the item blank, 56 replied that non-abstinence was unacceptable regardless of client characteristics, and 53 did not provide a relevant response. Of the 530 (71%) who provided a relevant codeable response, 45% (n=236) considered one or more aspects of the client's substance-related history (e.g., previous experience with treatment/abstinence/relapse, quantity used, duration and frequency of use, symptom severity of SUD, and consequences of client's use). An additional 26% (n=139) of replies mentioned treatment-related considerations (e.g., motivation and willingness to engage in treatment, client's own treatment goals) and another 26% (n=137) of replies mentioned the type, number, and/or severity of comorbid psychiatric diagnoses. Other less frequently mentioned characteristics included social and family environment (18%, n=97), psychological characteristics (14%, n=76), client's drug of choice (14%, n=74), socioeconomic status and stability (13%, n=69), and physical health (12%, n=64). The least frequently mentioned characteristics included criminal history (6%, n=31), family background (5%, n=25), age (5%, n=25), risk of harm to self or others (4%, n=21), history of trauma (2%, n=8), and client responsibilities to his/her family (1%, n=5).

4. Discussion

A nationwide sample of 751 addiction counselors credentialed in the United States completed a web-based questionnaire designed to assess whether their acceptance of limited or moderate substance use as a final outcome goal varied as a function of a client's co-occurring psychiatric diagnosis (Major Depression, Post-Traumatic Stress Disorder, Social Phobia), drug-specific SUD (alcohol, cannabis, opioids), and level of SUD severity (moderate or severe). Mean ratings of acceptability of non-abstinence were, on average, negative for all 18 comorbidity pairs, but frequency counts revealed that one-fourth to almost one-third of respondents rated non-abstinence an acceptable outcome goal for clients

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diagnosed with a Moderate Cannabis Use Disorder and any of the three co-occurring psychiatric disorders. Furthermore, small proportions of respondents (13% to 20%) rated non-abstinence acceptable for clients diagnosed with an Alcohol Use Disorder or Opioid Use Disorder and any of the three psychiatric disorders. Even when acceptance ratings differed significantly by type of comorbid psychiatric disorder, the effect sizes were generally small.

These findings are consistent with those of another recent survey of American alcohol and drug counselors who were asked to rate the acceptance of non-abstinence as a final outcome goal by type of substance for clients described as having *only* a SUD (Rosenberg & Davis, 2014). When the proportions appeared to vary between the two studies, somewhat *larger* proportions of counselors in the present study rated non-abstinence acceptable for a client diagnosed with a Severe SUD (alcohol, cannabis or opioids) and any of the three co-occurring disorders. For example, 13% of respondents in Rosenberg and Davis (2014) rated non-abstinence an acceptable goal for clients with Cannabis Dependence, whereas 20%, 20%, and 17%, respectively, of the respondents in the present sample rated non-abstinence acceptable for clients diagnosed with a Severe Cannabis Use Disorder and Major Depressive Disorder, Post-Traumatic Stress Disorder, or Social Phobia. Possible explanations for these differences include using DSM-5 rather than DSM-IV diagnostic labels, recruiting from different professional organizations (International Certification and Reciprocity Consortium rather than National Association of Alcoholism and Drug Addiction Counselors), and growing acceptability of cannabis use in the general population (Pacula et al., 2015). However, these relatively minor differences notwithstanding, similar and relatively small proportions of respondents in both studies rated non-abstinence acceptable for clients diagnosed with Substance Dependence or a Severe SUD, regardless of drug and type of co-occurring disorder.

There are several methodological limitations that may restrict the generalizability of the present study. For one, we recruited respondents from only one professional organization, and over three-quarters of those who responded worked in the Midwest or South; therefore, our sample may not represent the larger population of addiction counselors in the United States. Secondly, although we asked about three of the most common co-occurring psychiatric disorders reported by Mericle et al. (2012), limited or moderate drinking and drug use may be less acceptable to counselors when the co-occurring disorder involves psychotic symptoms (e.g., Schizophrenia), a personality disorder (e.g., Borderline or Antisocial Personality Disorder), or other impulsive features (e.g., Binge Eating Disorder, Intermittent Explosive Disorder). Additionally, the specific subset of SUD symptoms and specific symptoms of the co-occurring psychiatric disorder experienced by a client might also influence the acceptance of non-abstinence goals. Moreover, counselors may be less accepting of non-abstinence when a client has a SUD and more than one co-occurring psychiatric condition, and some may reject non-abstinence regardless of the specific co-occurring disorders or symptoms experienced by a client. Acceptance could also vary depending on a client's history of previous successful or unsuccessful attempts to moderate his/her consumption and whether moderation is one's initial or final outcome goal. Future research could also examine agency and counselor factors that might influence acceptance, including treatment setting, professional identity as an addictions or mental health counselor,

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agency policy regarding non-abstinence, and professional discipline (e.g., social work, counseling, psychology, nursing, psychiatry).

To the degree that our sample is representative of the population providing addiction treatment services in the United States, clients with co-occurring disorders who want to moderate or control their substance use will typically find their counselor does not accept that outcome goal. Although counselors may have the client's health and well-being in mind when they attempt to dissuade or refuse to support a client who wishes to pursue non-abstinence, such practices may put-off clients with co-occurring disorders who would benefit from therapy while attempting – either successfully or unsuccessfully – to moderate their use of substances. Whatever counselors' understandable personal, professional and theoretical reasons for rejecting moderation goals (Davis & Rosenberg, 2013; Rosenberg & Davis, 2014), acceptance of non-abstinence respects client autonomy, could attract and retain in therapy clients who may eventually be willing to abstain if unable to moderate consumption (Ambrogne, 2002), and recognizes that recovery means improvement in functioning (Hasin et al., 2017; Witkiewitz et al., 2017), even when clients continue to experience symptoms (Sheedy & Whitter, 2009). Therefore, we encourage continuing education and training of counselors regarding the benefits of lower risk drinking and drug taking as a treatment outcome goal for clients with co-occurring disorders.

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Highlights

- Participants rated moderation as an outcome goal for each of 18 comorbid disorders
- On average, moderation was unacceptable for clients with comorbid disorders
- Moderation was most unacceptable for clients with SUD and Major Depressive Disorder
- Depending on the comorbid pairing, 13%–29% rated a moderation goal acceptable

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Table 1

Demographic characteristics of the sample.

Characteristic/Variable	M(SD) or %[a]
Respondent Age	
18–24	1%
25–34	10
35–44	17
45–54	28
55–65	30
65+	14
Gender	
Female	66%
Highest Educational Degree	
Less than Bachelor's degree	10%
Bachelor's degree	19
Master's degree	64
Doctoral degree	8
Field of Training	
Addiction Counseling/Studies	31%
Counseling Psychology	21
Social Work	21
Clinical Psychology	8
Human Services	4
School Psychology	1
Other (e.g., criminal justice, mental health counseling)	14
Reside in which United States Census Region	
Midwest	52%
South	27
Northeast	17
West	4
Current Substance Abuse Counseling Credential[b]	
Advanced Alcohol and Drug Counselor	45%
Alcohol and Drug Counselor	44
Clinical Supervisor	31
Co-occurring Disorders Professional	7
Criminal Justice Addictions Professional	5
Prevention Specialist	5
Peer Recovery	4
Co-occurring Disorders Professional Diplomate	2
In process of obtaining first credential	4
Primary Theoretical Orientation	
Cognitive-Behavioral Therapy	37%

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Characteristic/Variable	M(SD) or %[a]
Motivational Enhancement Therapy	15
Humanistic/Person-centered Therapy	10
12-step principles	8
Integrative	7
Other(e.g., eclectic/combination of therapies)	24
Place of Employment[b]	
Outpatient Substance Use Disorders Treatment Agency	31%
Outpatient Community Mental Health Agency	17
Private Outpatient Clinic	16
Residential Rehabilitation for SUD	15
Corrections Center (Federal or State)	8
State/County or other Public Hospital	4
Residential Substance Detoxification	3
Other (e.g., private practice, tribal/rural mental health)	10
Patient Populations Served	
Primarily adults (18+)	55%
Both adults and adolescents/young people	43
Primarily adolescents/young people (younger than 18)	2
Years of experience providing treatment for co-occurring disorders	14.9 (9.1)
Beliefs about survey bias	
Survey was not biased in either way	65%
Survey was biased in favor of non-abstinence	29
Survey was biased against non-abstinence	6

[a]Number of respondents ranged from 691 to 703 due to missing data

[b]Could select more than one response option

[c]Other primary theoretical orientations included, reality, family systems, acceptance and commitment, rational-emotive, psychodynamic/analytic, other cognitive and behavioral treatments and eclectic.

[d]Other places of employment included Veteran's Affairs Medical Center, academic medical center, university counseling center, university department of psychiatry, university department of psychology, child and family outpatient mental health agency, and private psychiatric hospital.

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Table 2

Proportions of respondents (n=751) who rate non-abstinence completely or somewhat unacceptable and completely or somewhat acceptable as a function of moderate or severe substance use disorder and co-occurring mental health diagnostic pairs.

	Moderate Substance Use Disorder								
	Alcohol			Cannabis			Opioids		
Acceptability Ratings	MDD[a]	PTSD[b]	SP[c]	MDD	PTSD	SP	MDD	PTSD	SP
Completely Unacceptable	64%	57%	53%	49%	43%	45%	70%	65%	65%
Somewhat Unacceptable	18	24	24	25	26	27	15	18	18
Somewhat Acceptable	9	12	15	16	20	18	8	9	9
Completely Acceptable	9	8	8	10	11	11	8	8	8

	Severe Substance Use Disorder								
	Alcohol			Cannabis			Opioids		
Acceptability Ratings	MDD	PTSD	SP	MDD	PTSD	SP	MDD	PTSD	SP
Completely Unacceptable	77%	75%	74%	65%	62%	62%	76%	74%	73%
Somewhat Unacceptable	10	12	13	18	18	19	11	12	13
Somewhat Acceptable	5	6	6	8	11	11	5	7	6
Completely Acceptable	8	8	8	9	9	9	8	8	8

[a]MDD = Major Depressive Disorder

[b]PTSD = Posttraumatic Stress Disorder

[c]SP = Social Phobia