



Validation of two screening instruments for PTSD in Dutch substance use disorder inpatients

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HIGHLIGHTS

- ▶ We test the psychometric properties of two screening instruments for PTSD.
- ▶ The MINIplus (interview) and the SRIP (self-report) are compared to the CAPS.
- ▶ The MINIplus is inadequate in detecting PTSD in substance use disorder patients.
- ▶ The SRIP is a reliable screener for PTSD in substance use disorder patients.

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ABSTRACT

Posttraumatic stress disorder (PTSD) is highly prevalent in substance use disorder (SUD) populations. Because resources for extensive and thorough diagnostic assessment are often limited, reliable screening instruments for PTSD are needed. The aim of the current study was to test two short PTSD measures for diagnostic efficiency in predicting PTSD compared to the Clinician-Administered PTSD Scale (CAPS). The sample consisted of 197 SUD patients receiving residential substance use treatment who completed questionnaires regarding substance use and trauma-related symptoms, all abstinent from substance for 4 weeks. The PTSD section of the Mini International Neuropsychiatric Interview plus (MINIplus) and the Self-Report Inventory for PTSD (SRIP) are compared to the CAPS. Results showed low sensitivity (.58) and high specificity (.91) for the PTSD section of the MINIplus. The SRIP showed high sensitivity (.80) and moderately high specificity (.73) at a cut-off score of 48. The prevalence of PTSD as measured with the CAPS was 25.4% current and 46.2% lifetime. Results indicate that the MINIplus, a short clinical interview, has insufficient quality as a screener for PTSD. The SRIP, however, is a reliable instrument in detecting PTSD in a SUD inpatient population in The Netherlands. Screening for PTSD is time efficient and increases detection of PTSD in SUD treatment settings.

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1. Introduction

Research has yielded important information on the prevalence of posttraumatic stress disorder (PTSD) among substance use disorder (SUD) samples. Lifetime prevalence of PTSD in the general population ranges from 3.4% in Europe (Darves-Bornoz et al., 2008) to 6.8% in the United States (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). Among treatment-seeking samples of SUD patients, the rate of co-occurring PTSD ranges from 11% to 51% current and 33% to 75% lifetime PTSD (Brown, Recupero, & Stout, 1995; Najavits, Weiss, &

Shaw, 1997). In SUD inpatients, the prevalence rate of PTSD ranges from 25% to 51% (Driessen et al., 2008; Kimerling, Trafton, & Nguyen, 2006; Ouimette, Read, & Brown, 2005; Reynolds et al., 2005). In outpatient settings, prevalence rates between 8% and 27% have been found (Clark, Masson, Delucchi, Hall, & Sees, 2001; Driessen et al., 2008; Najavits et al., 2003, 2007). Addiction severity in patients with SUD and PTSD is higher than in patients with SUD alone (Driessen et al., 2008). Furthermore, patients with comorbid SUD and PTSD show worse treatment outcomes (Brown & Wolfe, 1994; Hien, Nunes, Levin, & Fraser, 2000). Therefore, assessment of PTSD is essential for the purpose of treatment planning and providing appropriate care (Brown et al., 1995; Read, Brown, & Kahler, 2004).

One of the most widely used measures of PTSD is the Clinician-Administered PTSD Scale (CAPS) (Blake et al., 1995), a semi-structured

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Table 1
Validated screening instruments for PTSD in SUD.

Instrument	No. items	Gold standard	Sensitivity	Specificity	Sample
PTSD Symptom Scale Self-Report (Coffey, Dansky, Falsetti, Saladin, & Brady, 1998)	17	DIS ^a (modified)	.89	.65	118 SUD in- and outpatients
Addiction Severity Index (Najavits et al., 1998)		Combination of THQ ^b and PCL ^c	.91	.46	110 cocaine dependent outpatients
Penn Inventory (Harrington & Newman, 2007)	26	CAPS ^d	.82	.64	44 inpatient substance users
Primary Care PTSD screening questionnaire (Kimerling, Trafton, et al., 2006)	4	SCID-I ^e	.91	.80	97 SUD veteran inpatients
Primary Care PTSD screening questionnaire (van Dam et al., 2010)	4	SCID-I	.86	.57	142 Dutch SUD patients

^a DIS = diagnostic interview schedule.

^b THQ = trauma history questionnaire.

^c PCL = PTSD Checklist.

^d CAPS = Clinician-Administered PTSD Scale.

^e SCID = structured clinical interview for DSM disorders.

interview that is often referred to as the “gold standard” measure for PTSD. Unfortunately, this diagnostic tool is lengthy (up to 90 min) and, moreover, requires substantial training. Many SUD programs do not have the staffing nor resources for such a measure. However, considering the high prevalence of PTSD in SUD patients and the impact on treatment, standard assessment of this disorder may be crucial. For this purpose, screening instruments may be a valuable first step in evaluating trauma-related problems in SUD populations (Kimerling, Ouimette, et al., 2006; Najavits, 2004).

A number of questionnaires have been evaluated as screening measures for PTSD in SUD samples. A summary is given in Table 1. Thus far, the PC-PTSD is the only instrument that has been validated in The Netherlands (van Dam, Ehring, Vedel, & Emmelkamp, 2010), but results are not yet convincing. Changing the original cut-off score of the PC-PTSD from 3 to 2 resulted in a high sensitivity (.86), but low specificity (.57). The rationale for validating measures in SUD samples when they are already validated in samples of the general population is that in general, the cut-off scores for screening measures are lower in SUD samples, as can be seen in the PC-PTSD study as well as with the PTSD Checklist—Civilian version (PCL-C) and the Penn Inventory. It has been suggested too that female substance users minimize PTSD symptoms, which may justify a lower cut-off score (Harrington & Newman, 2007).

There are two different types of instruments that can be used for screening and diagnosis of psychiatric disorders: interviews (structured or semi-structured) and self-report questionnaires. Each has advantages and disadvantages (Eaton, Neufeld, Chen, & Cai, 2000; Wilson & Keane, 2004). In the current study, one short structured interview, the Mini International Neuropsychiatric Interview plus (MINIplus) (Sheehan et al., 1998), and one self-report questionnaire, the Self-Report Inventory for PTSD (SRIP) (Hovens et al., 1994), were tested as PTSD screens.

The MINIplus is a structured diagnostic interview that is already used regularly within SUD programs. The MINI has been proposed as a screening instrument in previous research (Black, Arndt, Hale, & Rogerson, 2004) and the PTSD section of the MINIplus could be used as a potentially helpful PTSD screen. The MINIplus closely follows the DSM criteria and is therefore expected to show good reliability. Furthermore, assessment time is short because the measure allows for skip-outs as soon as it is clear that the patient does not meet criteria for the disorder, sometimes in just one to two questions per disorder. However, there are doubts about the quality of this measure for diagnosing psychiatric disorders (Black et al., 2004). The PTSD module of this instrument, in particular, may be too brief to be useful.

The second measure that is tested in this study is the SRIP. The SRIP is an assessment tool that has been developed to be used as a screening instrument in The Netherlands. It is a self-report questionnaire containing 22 items and takes approximately 5 min to complete. Subscores can be obtained for the DSM-IV PTSD clusters. The items do not require the patient to name a particular trauma, which may be an important advantage for patients who may be hesitant or unable to disclose their traumatic experiences. Men, for example, may

underreport some traumatic experiences, such as sexual or physical abuse, if they perceive these to violate their image of masculinity (Lisak, 1994). The scale has been validated in a Swedish sample of psychiatric outpatients, treatment seeking and non-treatment seeking traumatized veterans, and a Dutch sample of elder people (Al-Saffar, Borgå, & Hällström, 2002; Van Zelst et al., 2003). The fact that the measure has already been validated in Dutch makes this measure preferable over other international screening instruments for our work. However, the scale has not yet been validated in a SUD population. Routine screening for PTSD in SUD patients has long been recommended to ensure that SUD patients who are suffering from PTSD symptoms are recognized and treated accordingly (Najavits, 2004). Also for this reason, high sensitivity of an instrument will be preferred over specificity, so that patients suffering from PTSD will not be overlooked.

In sum, the primary aim of this study was to test the psychometric properties of the MINIplus and the SRIP in screening for PTSD in an inpatient SUD population.

2. Methods

2.1. Participants

The study participants were 197 patients admitted to one of four different inpatient addiction treatment facilities¹ in The Netherlands between 2008 and 2011. All participants met DSM-IV-TR criteria for SUD. Participants were selected according to the following inclusion criteria: 1) current substance use disorder (alcohol or drug abuse or dependence) per DSM-IV criteria; and 2) capable of understanding and speaking the Dutch language. Exclusion criteria were the following: 1) severe cognitive impairment; 2) severe self-destructive behavior, defined as patients who are known to self-mutilate or have suicidal tendencies as assessed during intake; and 3) patients who were considered inappropriate to participate according to his or her clinician. Of the 263 eligible patients, eight did not meet inclusion criteria, 53 refused to participate and five did not complete all the interviews and were therefore excluded from the analyses (Fig. 1).

2.2. Measures

2.2.1. Clinician-Administered PTSD Scale

The CAPS (Blake et al., 1995) has been previously translated into Dutch and validated by Hovens, Luinge, and Van Minnen (2005). It is considered the gold standard for assessing PTSD severity. The original CAPS has good psychometric properties and the Dutch translation appears to have excellent properties as well, with inter-rater reliability between .92 and 1.00 and internal consistency of .89 (Hovens et al., 1994; Weathers, Keane, & Davidson, 2001). The interviewer determines which traumatic events the individual has experienced

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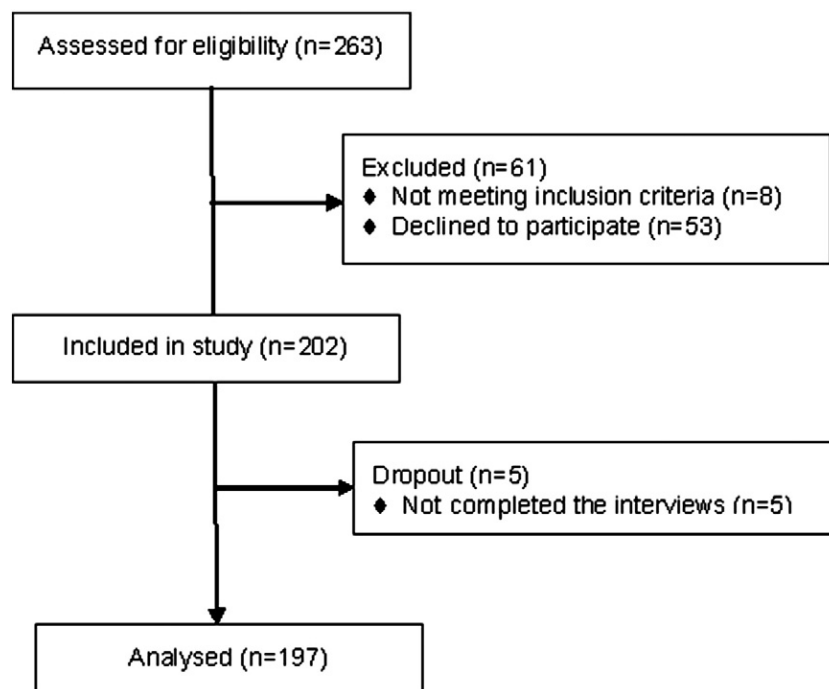


Fig. 1. Flowchart of enrolment of participants.

and assesses the 17 symptoms of PTSD in relation to a specific trauma, using DSM-IV-TR criteria. Each symptom is rated on a 0–4 scale for frequency and intensity (e.g., distress or functional impairment). A diagnosis of PTSD is given when a patient meets the necessary number of symptoms in criterion B (re-experiencing), C (avoidance) and D (increased arousal). In our project, all research assistants received training in administration, scoring and interpretation of the CAPS.

2.2.2. Mini International Neuropsychiatric Interview plus

The MINI plus is a brief structured interview consisting of questions with 'yes' or 'no' answers to detect present and past DSM-IV-TR and ICD-10 Axis I disorders. It explores 26 disorders and is a more detailed version of the MINI (which explores 17 disorders). In the present study, only the PTSD section was used. This section assesses current PTSD and starts with criterion A ("experienced a traumatic event involving actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others"), followed by the DSM-IV-TR criteria B, C, D, E and F. Inter-rater reliability analysis for this section revealed a kappa of 0.95 (Sheehan et al., 1998). It must be noted, that although the original version has been validated and found to be a reliable diagnostic instrument (Bohnen, De Winter, & Hoencamp, 2011), the Dutch translation of the MINIplus is currently being studied for validation purposes (van Vliet & De Beurs, 2007).

2.2.3. Self-Report Inventory for PTSD

The SRIP (Hovens, Bramsen, & van der Ploeg, 2002) is a Dutch self-report questionnaire that was developed to measure PTSD. The scale contains 22 items that are rated on frequency on a 4-point scale. The questions are divided into three categories based on the DSM criteria, namely re-experience (B), avoidance (C) and hyperarousal (D), for which subscores can be obtained. Criterion A is not assessed in this measure. The questionnaire takes 5 min to complete, which makes it very time-efficient. The internal consistency has been found to be .92. Convergent validity has also been tested, comparing the SRIP to the results of the Mississippi PTSD Scale (Keane, Caddell, & Taylor, 1988) and the Impact of Events Scale (IES) (Horowitz, Wilner, & Alvarez, 1979). Intercorrelation with the Mississippi PTSD Scale was

high (.82) and somewhat lower with the IES (.69). The moderate correlation with the IES may be explained by the fact that there are no items incorporated in the IES that measure hyperarousal. For criterion validity the Dutch version of the CAPS was used, which resulted in an optimal cut-off score of 52 and sensitivity and specificity of .86 and .71, respectively.

2.3. Procedure

All research assistants were psychologists with a bachelors' or masters' degree. They visited treatment centers at consecutive points in time to inform all current patients about the purpose of the study. The SRIP was administered to all patients in the facility during the research period. Subsequently, patients could voluntarily choose to participate in the remainder of the study. The filled out SRIP questionnaires of the non-participating patients were used to compare them with the results of the participating patients regarding PTSD related symptoms to control for selection bias. If these patients met the inclusion criteria, an appointment was scheduled. A minimum of 4 weeks of abstinence was required before the actual interviewing took place to control for withdrawal symptoms. Before the interview, written informed consent was obtained. The duration of the assessment was approximately 2 h, in which all measures were administered. The study has been approved by the local medical ethical committee (METC\11270.haa).

2.4. Analyses

Descriptive statistics were used to describe the sociodemographic characteristics of the sample and to determine prevalence of PTSD according to the CAPS. T-tests were used to compare the age and the mean scores on the SRIP between the participants and non-participants. To compare gender between these two groups, chi-square was calculated. Mean scores and standard deviations were calculated for scores on the SRIP and CAPS for the total sample. Correlational analyses were used to test the psychometric properties of the SRIP and its subscales compared to the CAPS. Finally, for the MINIplus and the SRIP,

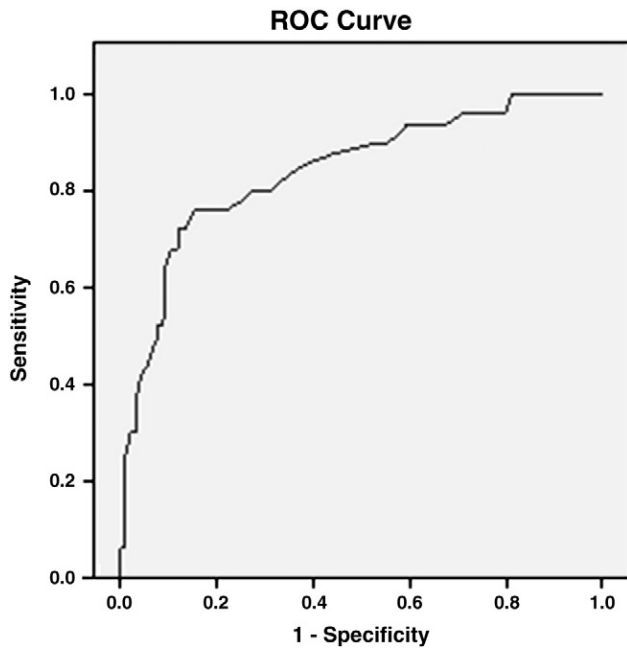


Fig. 2. Receiver operating characteristic curve SRIP prediction score sensitivity and specificity estimates against the CAPS.

sensitivity, specificity, positive predictive power (PPP), negative predictive power (NPP) and overall efficiency were calculated. To determine the optimal cut-off score for the SRIP, receiver operator characteristic curve (ROC) analyses were conducted (Fig. 2).

3. Results

Socio-demographic characteristics of the subjects are shown in Table 2. The prevalence of PTSD according to the CAPS was 25.4% current and 46.2% lifetime. Comparison of participants and non-participants yielded no significant differences for gender, age or total score on the SRIP, 46.7 (SD = 13.3) versus 46.4 (SD = 13.2) respectively, nor on the subscales of the SRIP (Table 3).

The mean CAPS total score for patients that did not meet criteria for PTSD was 23.4 (SD = 17.6) and the mean CAPS total score for those who did meet criteria was 63.8 (SD = 19.3). Mean SRIP score was 46.6 (SD = 13.3, range 22–85). Participants who met criteria for PTSD according to the CAPS had higher mean scores on the SRIP (59.0, SD = 12.1) when compared to participants that did not meet the criteria (42.3, SD = 10.7), $t(1,191) = 9.151, p < 0.001$.

Table 2 Characteristics of the study population.

Sociodemographics	Total sample (n = 197)	PTSD-positive (n = 50)	PTSD-negative (n = 146)	
Gender (% male)	75.1	74	75.3	
Mean age (sd)	38.7 (12.6)	38.7 (10.7)	38.8 (13.2)	
Marital status (%)	Married/cohabitating	12	21	
	Single	63	63	
	Divorced/widowed	18	16	
	No education, primary school	7.7	12	6.3
Education (%)	Secondary school, lower level	31.4	30	31.2
	Secondary school, higher level	46.9	44	48.3
	Postsecondary	13.9	14	14
Substance	Alcohol	46.6	45.8	46.9
	Cocaine/amphetamines	22.5	27.1	21.0
	Cannabis	10.5	8.3	11.2
	Opiates	3.1	2.1	3.5
	Polysubstance	8.4	10.4	7.7
	Other	8.9	6.3	9.8

Table 3 Comparison of participants and non-participants.

	Participants (n = 197)	Non-participants (n = 58)	
Gender (% men)	73.5	81.3	$\chi^2 = 1.235, p = 0.35$
Age, mean (SD)	38.7 (12.6)	37.3 (13.5)	$t(1,234) = 0.54$
SRIP total, mean (SD)	46.8 (13.3)	45.7 (14.0)	$p = 0.58$
SRIP intrusion	11.9 (4.4)	11.4 (5.3)	$p = 0.48$
SRIP avoidance	19.8 (5.9)	19.0 (5.6)	$p = 0.39$
SRIP hyperarousal	15.2 (4.6)	15.3 (4.5)	$p = 0.83$

The correlation between the total scores on the CAPS and the SRIP was high [$r(192) = .69 (p < .001)$]. Correlations for the subscales were moderate to high (Table 4). Results from the PTSD section of the MINIplus showed that according to this instrument, a total of 42 (21.4%) patients are diagnosed with PTSD. Overall efficiency was relatively high with .83, but this was mainly because of the high specificity of .91. The sensitivity was .58, meaning that 42% of the patients that were diagnosed with PTSD according to the CAPS were missed as such by the MINIplus.

The standard cut-off score of the SRIP is 52 (Hovens et al., 1994). When applying this cut-off score, the sensitivity was .76 and the specificity was .85. Other diagnostic efficiency results were evaluated using different cut-off scores. The sensitivity, specificity, positive predictive power, negative predictive power and efficiency of the SRIP at different cut-off scores are shown in Table 5. ROC-analyses yielded an area under the curve (AUC) of .84 and an optimal cut-off score of 48. For this cut-off score, sensitivity was .80 and specificity was .73.

4. Discussion

The purpose of this study was to test two possible screening instruments to detect PTSD in a Dutch sample of SUD inpatients for diagnostic accuracy compared to the CAPS. The MINIplus is very successful in excluding false-positives (specificity of .91) but this strict screening process results in a high percentage of PTSD-positive patients that are missed (sensitivity of .53) and therefore remain undetected. One possibility to increase the sensitivity of this instrument is to change the diagnostic scoring rules by making them less stringent. A positive score for each of the first three criteria (A, B, C) for example yields a sensitivity of .70 and specificity of .87. However, the MINIplus does not reach the sensitivity score of the SRIP (.80), and therefore the SRIP is a better screener for PTSD positives in an inpatient SUD-population. While information from the MINIplus can be used when the measure is administered in addiction treatment settings, this is limited to information from the first question only; namely, whether or not the patient has experienced a traumatic

Table 4

Pearson correlations for subscales of the SRIP and CAPS.

	CAPS intrusion	CAPS avoidance	CAPS hyperarousal
SRIP intrusion	.647**	.460**	.485**
SRIP avoidance	.523**	.631**	.499**
SRIP hyperarousal	.450**	.427**	.688**

** Significant at a level of $p < .001$.

event. This results in a relatively reliable estimate of patients at risk for PTSD. As can be expected, this leads to many patients in the “at risk” group that do not suffer from PTSD. In our sample, 85% of the patients answered “yes” to the question about a traumatic event, of which 28.7% had a current episode of PTSD. A reliable screening instrument is therefore necessary, and for that purpose, the SRIP shows better properties than the MINIplus.

Correlation between the SRIP and the CAPS showed evidence for convergent validity of the scale. Correlations of the three subscales, measuring the three symptom clusters of PTSD, were significant. For intrusion the correlation was .65, for avoidance it was .63 and for hyperarousal .69. The original proposed cut-off point of 52 yielded a sensitivity of .76 and specificity .85. Efficiency of the instrument is higher at higher cut-off scores, but this will be at the expense of the sensitivity. Especially in a population where PTSD has a great influence on treatment outcome, it can be argued that high sensitivity is preferred over high specificity in order to ascertain that a minimal number of cases will be overlooked (Baldessarini, Finkelstein, & Arana, 1983). At a cut-off score of 32 the screener showed a sensitivity of 1.00, meaning that all PTSD-positives will be detected; however, the associated specificity dropped to .19 when using this threshold. This results in a large number of false-positives, which leads to a subsequent investment in largely unnecessary follow-up diagnostics.

The lack of assessment of criterion A in the SRIP could potentially pose a problem, because it could be expected that the number of false-positives increase if criterion A is missed. In total, there were 39 false-positives. A review of the data showed that 4 of these patients did not meet criterion A on the CAPS. If these patients would have been correctly classified as not meeting current PTSD criteria, for example by including a question concerning criterion A in the SRIP, the overall efficiency would increase with 1.2%. However, including such a question increases the risk for false-negatives, as can be seen from the results of the MINIplus.

It is important to note that screening is only the first step and further assessment of PTSD is necessary when screening results for PTSD are positive. For this purpose, the CAPS can be used as well as an assessment of trauma history conducted by a therapist. However, a careful trade-off should be considered between extra time for diagnosing PTSD or extra time for treating patients without PTSD. For

Table 5

Diagnostic efficiency of the SRIP at different cut-off scores.

SRIP cut-off score	Sensitivity	Specificity	PPP	NPP	Efficiency
43	0.90	0.47	0.37	0.93	0.58
45	0.86	0.61	0.43	0.93	0.67
47	0.80	0.69	0.48	0.91	0.72
48	0.80	0.73	0.51	0.91	0.75
50	0.76	0.78	0.55	0.90	0.78
52	0.76	0.85	0.63	0.91	0.82
53	0.72	0.87	0.65	0.90	0.83
54	0.72	0.88	0.68	0.90	0.84
55	0.68	0.88	0.67	0.89	0.83
57	0.64	0.91	0.71	0.88	0.84
59	0.52	0.92	0.68	0.85	0.81

SRIP = Self-Report Inventory for PTSD.

PPP = positive predictive power.

NPP = negative predictive power.

example, when using the SRIP as a diagnostic tool, of all the patients that test positive for PTSD, 49% will not actually have PTSD (low positive predictive power) and will be treated unnecessarily. When a thorough assessment of PTSD can reduce the number of patients that are treated unnecessarily, it seems that this would be worth the time investment of an hour for assessment using the CAPS. In a sample of 200 subjects, this would mean that 82 will screen positive on the SRIP when using a cut-off score of 48. To be certain of the diagnosis for PTSD, all of these patients should be assessed further with the CAPS, leading to a subsequent time investment of approximately 82 h. Another option is to offer treatment for all patients that screen positive on the SRIP. When treating all these screen-positives, 40 will be treated unnecessarily. The extra effort and resources this may cost can be estimated, but are also dependent on which treatments are available, as cost and duration may vary between different treatments. Note however that when the optimal cut-off score is used, 20% of the patients that suffer from PTSD will still be missed during the screening procedure. It is therefore important to remain alert for signs of PTSD that may emerge later during treatment.

This study is the first to report the prevalence of PTSD in a SUD inpatient population in The Netherlands. The prevalence of 25.4% current and 46.2% lifetime PTSD is comparable to the percentages found in previous studies in other European countries (Reynolds et al., 2005; Schäfer & Najavits, 2007) and the United States (Brown et al., 1995; Jaycox, Ebener, Damesek, & Becker, 2004; Kimerling, Trafton, et al., 2006). The high number of patients with comorbid PTSD and SUD indicates the need for reliable and valid screening and assessment instruments for PTSD. Our study provides valuable information on screening in clinical practice. We advise to use information from the MINIplus, only when this is already available, and to use this as a first step in determining which patients are at risk for PTSD. For patients that have indicated to have experienced a traumatic event on the MINIplus, the SRIP should be used to assess PTSD symptoms and to estimate reliably whether or not PTSD is present. When information from the MINIplus is not available, the SRIP could be used for all patients. All patients that score 48 or above should be assessed further by means of the CAPS to affirm the PTSD diagnosis.

A limitation of this study is that there was a relatively high rate of patients that refused to participate. External validity was controlled by means of collecting data from these patients as well, but this information was limited to age, gender and PTSD symptoms as measured by the SRIP. The participating patients and the patients that refused to participate did not differ significantly on these factors. It should be noted, however, that other factors that were not measured, such as depression or anxiety, may also have influenced the results.

Another limitation is that the measurements were assessed in an inpatient population after a minimum of 4 weeks of abstinence. While this is a good way of establishing the theoretical strength of the screening instruments, the practical implications are only valid for this subpopulation of SUD patients. This is relevant because a considerable number of the patients in substance use treatment centers often drop out within the first 3 weeks. The average length of stay for patients that drop out of residential treatment has been found to be 13.9 days (SD = 7.2) (McKellar, Kelly, Harris, & Moos, 2006). Ideally, screening should therefore take place as soon as possible, especially since effective integrated treatments for comorbid PTSD and SUD are becoming increasingly available (Riggs & Foa, 2008). Replication of our findings in patients within the first 3 weeks of treatment should provide insight into the validity of the SRIP in that instance.

This study has focused on a population of inpatients in SUD treatment. This limits the generalizability to other populations (e.g. outpatient settings). The cut-off score for the SRIP that was found differed from the one proposed in previous research in samples of the general population and other psychiatric populations (Hovens et al., 2002). Replication of the cut-off score of 48 in a comparable population of SUD patients in residential settings would strengthen the generalizability

of the current findings. Furthermore, future research is needed to test the validity of the SRIP in outpatient settings.

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Contributors

Author T. Kok has been involved in the data collection during the research and is the principal author of the manuscript. H. A. de Haan and C. A. J. de Jong are the initiators of the study and were involved in the coordination of the research project as well as the writing of the manuscript. M. van der Meer was initially involved in the research project and wrote the protocol. Furthermore she provided critical feedback during the writing of the manuscript. H. J. W. van der Velden has been involved in the data collection and as a co-author. L. M. Najavits has also been involved as a co-author and provided valuable feedback. All authors have contributed to and have approved the final manuscript.

Conflict of interest

All authors declare they have no conflict of interest.

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