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A Pilot Study of Seeking Safety in a Sample of German Women Outpatients with Substance Dependence and Posttraumatic Stress Disorder

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Abstract—*Seeking Safety* is an integrated coping skills therapy for substance use disorder (SUD) and posttraumatic stress disorder (PTSD). Our aim was to examine the effects of *Seeking Safety* in a sample of female German outpatients with current SUD and PTSD. A total of 53 women were offered 12 weekly sessions of *Seeking Safety*, conducted in group modality. Women (N = 33) who attended at least six sessions were considered minimum-dose completers and were in the analysis. We measured PTSD and substance use symptoms using the *Posttraumatic Diagnostic Scale* (PDS) and the *Addiction Severity Index* (ASI-Lite) at end-of-treatment and three-month follow-up. Additional measures were the *Brief Symptom Checklist* (BSI) and the *Inventory of Interpersonal Problems* (IIP-25). Our sample reported chronic SUD, multiple prior detoxifications, and serious childhood trauma. We found medium to large effect sizes for improvements in PTSD symptoms, general psychopathology, and interpersonal problems at end-of-treatment, all of which were sustained at follow-up. Alcohol use improved significantly only at follow-up. This study suggests that the model was associated with positive effects, at least in a subgroup of women attending a minimum of sessions. Limitations include the lack of a control condition as well as an intention-to-treat analysis.

Keywords—addiction, posttraumatic stress disorder, seeking safety, substance abuse, trauma therapy

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Among patients treated for substance use disorders (SUD), 26% to 52% have a lifetime diagnosis of posttraumatic stress disorder (PTSD) and 15% to 41% currently meet criteria for PTSD (Jacobsen, Southwick, and Kosten 2001; Schäfer and Najavits 2007). In European studies, the rate of current PTSD is slightly lower in some studies, but still substantial (e.g., 15% to 36%; Driessen et al. 2008). The prevalence of PTSD varies per sample. For example, current PTSD is more prevalent in females than in males (Dom et al. 2007; Driessen et al. 2008). Moreover, some substances of abuse show a higher association with PTSD than others (e.g., “hard drug” and polydrug use compared to alcohol or cannabis).

Patients with both PTSD and SUD have a more severe clinical profile, especially when traumatic events occurred early in life (Schäfer and Najavits 2007). Such patients have earlier onset of substance abuse, report more polydrug use (Mills et al. 2005; Dragan and Lis-Turlejska 2007), and show greater severity of current substance use (Clark et al. 2001; Mills et al. 2005). Finally, patients with both disorders are more likely than those with just one disorder to meet criteria for additional psychiatric disorders, especially major depression and anxiety disorders (Langeland, Draijer, and van den Brink 2004). Patients who experience early and complex trauma also suffer from impulsivity and suicidal ideation, self-destructive behavior, and higher vulnerability to revictimization (Hien, Cohen, and Campbell 2005).

Studies on the relationship between a history of trauma and treatment utilization in patients with SUD are inconclusive. In a large sample of German outpatients with alcohol dependence, a history of sexual violence was related to higher use of SUD services in females, but not in males (Schäfer et al. 2009). Victims of both genders were significantly younger at first contact with addiction treatment. Other authors reported that patients with a history of sexual abuse seek less treatment for SUD (Peltan and Cellucci 2011). When they engage in SUD treatment, patients with PTSD and other consequences of traumatic events have a poorer adherence to treatment, a shorter duration of abstinence, and worse outcomes across a variety of measures (Schäfer and Najavits 2007). The importance of treating symptoms of PTSD in SUD patients is further supported by studies showing that reductions of PTSD severity during treatment were likely to be associated with substance use improvement. For example, Ouimette, Moos, and Finney (2003) conducted a five-year follow-up study on 100 male patients with co-occurring PTSD who attended SUD treatment. Patients who received PTSD treatment in the first three months following discharge and those who received treatment for a longer duration in the first year were more likely to have remitted from their SUD five years later. Conversely, Hien et al. (2010) reported in another study that a reduction in the symptoms of substance use had little impact on symptoms of PTSD.

With regard to treatment of co-occurring SUD and PTSD, preference is given to integrated treatments that conceptualize both disorders as related and plan treatment accordingly. While it is unclear if integrated treatments have a superior efficacy compared to one efficacious treatment alone (Torchalla et al. 2012), the clinical needs of patients with SUD and PTSD often make an integrated approach necessary. The most studied integrated treatment thus far is *Seeking Safety* (Najavits 2002). The program covers 25 topics that teach coping skills for PTSD and SUD in four domains (cognitive, behavioral, interpersonal, and case management) and has been translated into several European languages. It has been evaluated in over 20 studies, including various randomized controlled trials (RCTs) (Najavits and Hien 2013; Hien et al. 2015). The literature indicates overall positive outcomes on SUD and PTSD symptoms, as well as other variables, in various different populations with PTSD/SUD, all of which were highly chronic and severe in both disorders. Nonetheless, there is a need for more research on *Seeking Safety* and on treatments generally for PTSD/SUD, given the early stage of the literature and methodological limitations of several of the trials.

In Europe, integrated treatments for patients with the dual diagnosis of SUD and PTSD are not provided in a routine way, representing a substantial gap of services for these patients. Given the differences between health care systems and the potential influence of culture on patients' preferences and expectations, there is a need to further evaluate the existing programs in the respective countries. A German pilot trial of *Seeking Safety* showed good feasibility, acceptance, and a high retention rate (85%) for female patients with PTSD and SUD (Schäfer et al. 2010). The aim of the present study was to assess the efficacy of the program in a sample of female outpatients with SUD and co-occurring PTSD in the context of the German health care system.

METHOD

Participants

All participants were women with substance dependence and PTSD related to interpersonal trauma. They were recruited mainly through counseling services and outpatient treatment facilities in Hamburg. A smaller number of participants was informed of the study via the media. Eligibility criteria were: (1) age 18 years or higher; (2) DSM-IV diagnosis of current drug and/or alcohol dependence with active use in the past six months; (3) meeting DSM-IV criteria for either partial (i.e., criterion B and criterion C or D) or full PTSD. Exclusion criteria were: (1) opiate-substitution medication; (2) acute psychosis; (3) suicidal intent; and (4) severe cognitive impairment. The reasons for including only female patients

in the study were that a higher prevalence of PTSD is found in females with SUD as compared to males (Schäfer and Najavits 2007) and that trauma treatment should preferably be offered in gender-specific groups (Greenfield et al. 2007).

Procedures

Women interested in the treatment were offered an initial appointment to inform them about the aims of the study and assess their eligibility. No monetary or other incentives were offered for participation. Eligible women who agreed to take part were contacted again when a place in the group was available, which was in no case later than six weeks after assessment of eligibility. Before they entered the group, they completed the baseline interview (t1) and received an introduction session in an individual format. In the subsequent 12 consecutive weeks, they were offered weekly group sessions. The final session was in an individual format again, followed by the end-of-treatment assessment (t2). Follow-up interviews took place three months later (t3). There was no attempt made to contact the participants between post-treatment and three-month follow-up. All participants gave written informed consent and the study was approved by the responsible ethics committee (Chamber of Physicians, Hamburg, Germany).

Measures

Trauma History and Posttraumatic Symptoms

The PTSD module of the International Diagnostic Checklists for ICD-10 and DSM-IV (IDCL) (Hiller, Zaudig, and Mombour 1990) was used to confirm the diagnosis of PTSD at baseline. The IDCL assess all criteria of the respective disorder based on a clinical interview. It includes focused diagnostic questions from the clinician and all other available information. Hiller et al. (1990a) reported good to excellent inter-rater reliability and test-retest reliability.

The Childhood Trauma Questionnaire (CTQ) (Bernstein et al. 1997) was used to collect additional information on the type and severity of early traumatic experiences at baseline. This 28-item self-report questionnaire assesses physical and sexual abuse, emotional neglect, emotional abuse, and physical neglect. Items are rated on a likert-scale from 1 (*never true*) to 5 (*very often true*). The five subscales can range from 5 to 25. Strong psychometric properties have been demonstrated for the CTQ in clinical, as well as in community, samples (Scher et al. 2001).

The German version of the Posttraumatic Diagnostic Scale (PDS) (Foa 1995) was used to assess the participants' trauma history and PTSD symptoms according to DSM-IV. The PDS consists of four different sections, with a total of 49 items. The first part addresses the A1-criterion of PTSD

using a checklist of 12 potentially traumatic events. The second part addresses criterion A2. The third part consists of 17 items assessing criteria B, C, and D on the subscales *Re-experiencing* (five items), *Avoidance* (seven items), and *Arousal* (five items). The frequency of symptoms in the last month is rated on a four-point Likert-scale (0 = *not at all or only one time* to 3 = *five or more times a week/almost always*). Foa et al. (1997) and Powers et al. (2012) found good internal consistencies of the total score ($\alpha = .92$) and all subscales ($\alpha = .78-.84$). Good psychometric properties have also been reported for the German version of the PDS (Griesel, Wessa, and Flor 2006).

The Trauma Symptom Checklist (TSC-40) (Elliott and Briere 1992) was used to assess a broader spectrum of posttraumatic symptoms. The TSC is a 40-item rating scale instrument, which intends to measure a wide spectrum of trauma symptoms in adults. The instrument comprises of six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma, Sexual Problems, and Sleep Disturbance. For each item, the score ranges from 0 (*never*) to 3 (*often*). The TSC-40 has been found to have good internal consistency, reliability, and predictive validity (Zlotnick et al. 1996).

To assess thoughts and beliefs related to trauma, the Post Traumatic Cognitions Inventory (PTCI) (Foa et al. 1999) was used. This 33-item self-report questionnaire contains three subscales (negative cognitions about self, negative cognitions about the world, self-blame for the traumatic event). Answers are rated on a seven-point Likert-scale ranging from 1 (*totally disagree*) to 7 (*totally agree*). The total score can range from 33 to 231. Foa et al. (1999) and Lommen and Restifo (2009) reported good to excellent internal consistencies for the subscales (from $\alpha = .74$ to $\alpha = .94$) and for the total-score ($\alpha = .68$).

Substance Use

The alcohol and drug use module of the *International Diagnostic Checklists for ICD-10 and DSM-IV* (IDCL; Hiller, Zaudig, and Mombour 1990) was used to confirm the diagnosis of alcohol or drug dependence at baseline.

Data on the severity of problems related to substance abuse and the days of alcohol and drug use were obtained using the German version of the Addiction Severity Index "Lite" (ASI-Lite) (McLellan et al. 1980, 1992). The German version of the ASI has been developed on the basis of the fifth version of the American ASI (McLellan et al. 1992). Like the original version, it yields severity scores across six subscales (Medical, Employment, Social, Psychiatric, Legal). *Composite scores* represent the ratings of severity and range between 0 (*no treatment required*) and 1 (*treatment extremely required*). A large number of studies showed good to excellent results with regard to the validity and reliability of the ASI (Weisner, McLellan, and Hunkeler 2000; Butler et al. 2001; Samet et al. 2007).

General Symptoms and Interpersonal Functioning

The Brief Symptom Inventory (BSI) (Derogatis and Melisaratos 1983) is a 53-item self-report scale that measures nine symptom dimensions of mental health problems. Participants are asked how much a problem has distressed them in the past seven days. Possible responses range from 0 (*not at all*) to 4 (*extremely*). The *Global Severity Index* (GSI) averages symptoms on all 53 items of the BSI and higher scores represent greater psychological distress. Broday and Mason (1991) reported a very strong test-retest ($\alpha = .91$) and internal reliability ($\alpha = .85$).

The Inventory of Interpersonal Problems (IIP-25) (Gude et al. 2000) is a 25-item self-report measure of interpersonal problems. Participants use a five-point scale to rate how often they have experienced various interpersonal difficulties, including being too open, aggressive, caring, or dependent, as well as having difficulty with being assertive, involved, supportive, or sociable. For the German version, Harfst et al. (2004) found good internal consistencies for the different subscales (between $\alpha = .72$ and $\alpha = .85$) and also for the total-score ($\alpha = .84$).

Treatment Satisfaction

The End-of-Session Questionnaire (Najavits 2002) is an instrument to assess satisfaction with *Seeking Safety*. It is scaled from 0–100% when global opinions about Seeking Safety are assessed, and from –3 (very harmful) to +3 (very helpful) when more specific aspects are assessed. It was used to rate the satisfaction with each treatment topic. General helpfulness questions focused on participants' experience with *Seeking Safety* and their overall assessment of the handouts, their satisfaction with the clinician, and the number of sessions they attended. The questionnaire also aimed to identify helpful aspects of the treatment.

Intervention

Seeking Safety (Najavits 2002) is a present-focused model that provides education on substance abuse and trauma symptoms, as well as coping skills to help clients overcome these symptoms. The model is designed to be optimistic and inspiring, and to address various domains: cognitive, behavioral, interpersonal, and case management. A pilot study suggested a high acceptance of *Seeking Safety* among female German outpatients with substance dependence and PTSD (Schäfer et al. 2010).

The treatment was offered in an open-enrollment group with a maximum group size of six women. The duration of the weekly group sessions was 90 minutes. The session's *introduction to treatment/case management* and *termination* were administered in individual format. The following 12 topics were provided in group format and included an equal amount of behavioral, cognitive, and interpersonal topics: *Safety*, *PTSD: Taking Back Your Power*, *Detaching from Emotional Pain (Grounding)*, *When*

Substances Control You, *Asking for Help*, *Red and Green Flags*, *Honesty*, *Recovery Thinking*, *Setting Boundaries in Relationships*, *Coping with Triggers*, *Healing from Anger and Self-Nurturing*. Women who attended at least the two individual sessions and six group sessions during the 12-week period of their participation were considered completers. The treatment was conducted by two female clinical psychologists. They received intensive *Seeking Safety* training in the form of a two-day workshop and ongoing supervision by two of the authors (CS and IS), who performed the German translation of the program (Najavits 2008) in close collaboration with the author of *Seeking Safety*.

Data Analysis

To compare baseline characteristics between completers and non-completers, t-tests for continuous variables and chi-square tests for categorical variables were used. These groups were compared on relevant baseline sociodemographic characteristics, trauma exposure, PTSD symptoms, and substance use. The PDS was used to measure the effect of the treatment with regard to symptoms of PTSD from baseline to end-of-treatment. Further measures of effects from baseline to end-of-treatment included the TSC-40, the BSI, the PTCI, the IIP-25, and the *composite scores* for alcohol and drug use from the ASI-Lite. Effect sizes were calculated by using Cohen's *d* (Cohen 1988). Referring to Cohen's criteria $d = .20$, $d = .50$, and $d = .80$ represent small, medium, and large effects, respectively. Moreover, we analyzed the stability of the effects at three-month follow-up. We used the statistical software package SPSS 18 for Windows (IBM Corp. 2010) to perform the analyses.

RESULTS

Baseline Characteristics

A total of 66 women were screened for eligibility. Of these, 11 (17%) did not meet the inclusion criteria and two (3%) decided to not participate after the aims of the study had been explained. Of the 53 women that could be included in the study, 33 (62%) completed at least six sessions (minimum-dose completers) and were included in the analysis. The full course of treatment was completed by nine participants. Those who did not meet the minimum dose completed 2–5 group sessions. These 33 minimum-dose completers participated in the assessments after treatment, and 31 women completed the three-month follow-up. There were no significant differences on sociodemographic characteristics (age, years of education, marital status, employment status), trauma history (number of different traumatic events reported in the PDS, CTQ total score), or baseline symptoms (PDS and TSC total score, BSI, IIP-25, ASI-Lite) between minimum-dose completers and non-completers.

The final sample (i.e., the minimum-dose completers, $n = 33$) had a mean age of 40.8 years ($SD = 9.6$). On average, they had 10.9 years ($SD = 2.2$) of education. Nearly half were unmarried or single (48%), and 45% were unemployed. Most of the women (89%) reported exposure to physical or sexual abuse at some point in their life, 70% reported sexual abuse, and 64% reported physical abuse, and all of them met full diagnostic criteria of PTSD. Most patients ($n = 32$) reported at least “moderate to severe” childhood trauma as measured with the CTQ. The majority of women (81%) met IDCL criteria for alcohol dependence and a smaller proportion (55%) also met criteria for drug dependence (15% cannabis dependence, 12% cocaine dependence). The average age at onset of problem alcohol use was 24.0 years ($SD = 10.9$) and 15.9 years ($SD = 7.7$) at onset of drug use. The average duration of alcohol problems according to the ASI-Lite was 13 years ($SD = 9.9$) and the participants reported an average of 2.6 previous detoxifications ($SD = 3.3$). $n = 20$ had used alcohol or other drugs in the month prior to baseline assessment. Half of the sample ($n = 17$) had used alcohol in the prior month to baseline assessment and $n = 7$ had used any drugs in the past 30 days.

Treatment Outcomes

Baseline to End-of-Treatment Results

Of the 23 variables we tested, all but six evidenced significant improvement from baseline to end-of-treatment. The 17 variables that improved were the total scores and all subscales for all of the PTSD measures (the PDS, TSC-40, and PTCI), global psychopathology (the GSI), and interpersonal problems (the IIP-25). Effect sizes for the significant variables were in the medium to large range for 15 variables, with the other two just below medium. The only measure that did not show significance at end-of-treatment was the ASI-Lite (the alcohol and drug composites in Table 1, and mean days of substance use in Table 2).

Baseline to Three-Month Follow-Up

Tables 1 and 2 also provide t-tests for this comparison. The findings at three months’ follow-up suggested that the effects at end-of-treatment were highly stable over time. At follow-up, of the 23 variables tested, all but six evidenced significant improvements from baseline. However, one variable that had been significant at end-of-treatment no longer was (the PTCI self-blame subscale) and, conversely, one that was not significant at end-of-treatment now was significant at follow-up (the ASI-Lite alcohol composite). Of the 17 significant variables, 14 had effect sizes in the medium to high range, and the other three variables were all just below medium.

Treatment Satisfaction

Mean ratings for each item on the *End-of-Treatment Questionnaire* indicated a high level of satisfaction. On the scale from -3 (*greatly harmful*) to $+3$ (*greatly helpful*), participants reported that *Seeking Safety* was helpful overall (mean = 2.2, $SD = 0.9$), including specifically for trauma (mean = 2.0, $SD = 0.9$), substance use (mean = 2.0, $SD = 0.9$), and to learn safe coping skills (mean = 2.4, $SD = 0.8$). The highest ratings were found for the topics *Setting Boundaries in Relationships* (mean = 2.5, $SD = 1.1$), *Honesty* (mean = 2.4, $SD = 1.0$), *Safety* (mean = 2.7, $SD = 1.0$), and *Detaching from Emotional Pain—Grounding* (mean = 2.6, $SD = 0.9$).

DISCUSSION

Although *Seeking Safety* has been evaluated in many studies in the United States (Najavits and Hien 2013), there was only one published study on *Seeking Safety* in a European sample so far. This study reported a high acceptance of the program among outpatients with substance dependence (Schäfer et al. 2010). As in our prior study, the patients in the current study were female outpatients with both current PTSD and SUD ($n = 38$), and they were offered 12 group sessions and two individual sessions of *Seeking Safety*. In contrast to our feasibility study, the current study provides first assessment of outcomes of the model in Germany. Our results indicate positive associations between treatment and outcomes in the context of German SUD services, at least for the subgroup of women attending the minimum dose of six group sessions plus two single sessions. Positive changes were found with regard to posttraumatic symptoms and other problems typically related to complex trauma, at least in the group of women with a high adherence to the treatment.

In this study, we evaluated a group modality of partial-dose *Seeking Safety* (12 *Seeking Safety* topics instead of the full array of 25 that have been studied in most prior trials). Even with this partial dose, we found a pattern of consistent and strong improvement for minimum-dose completers on almost all variables tested, both at end-of-treatment and follow-up. This included measures of PTSD (the PDS, TSC-40, and PTCI), general psychopathology symptoms (the GSI), and interpersonal problems (the IIP-25). Moreover, not only were results on these variables statistically significant, but they showed medium to high effect sizes on all of these measures, indicating that the degree of improvement was substantial for the subgroup of completers.

Substance use, however, showed no change at end-of-treatment. We found improvement on the ASI-Lite alcohol composite at follow-up, which is commonly interpreted as a delayed-emergence effect. No significant changes were observed regarding the ASI-Lite drug use composite

TABLE 1
Outcomes from Baseline (t1) to End-of-Treatment (t2) and Three-Month Follow-Up (t3)

	t1		t2		t3		t1-t2		t1-t3	
	M	(SD)	M	(SD)	M	(SD)	p	d	p	d
PDS										
Re-experiencing	7.4	(3.6)	5.4	(4.1)	5.6	(3.6)	.001	0.67	.016	0.46
Avoidance	12.2	(5.2)	9.2	(6.0)	8.7	(3.6)	.000	0.70	.001	0.66
Arousal	8.6	(3.8)	7.1	(4.0)	6.6	(3.9)	.006	0.51	.035	0.40
Total Score	28.2	(10.9)	21.5	(14.1)	20.9	(10.9)	.000	0.78	.002	0.63
PTCI										
Neg. cog. self	3.7	(1.0)	4.5	(1.4)	4.6	(1.4)	.000	0.73	.000	0.81
Neg. cog. world	3.2	(1.1)	3.6	(1.4)	3.7	(1.2)	.048	0.37	.005	0.54
Self-blame	3.9	(1.2)	4.4	(1.5)	4.3	(1.3)	.025	0.42	.104	—
Total	115.1	(27.7)	142.4	(40.1)	143.8	(41.9)	.000	0.80	.000	0.88
TSC-40										
Dissociation	9.1	(3.9)	6.1	(3.7)	6.0	(4.2)	.000	0.83	.000	0.72
Anxiety	11.0	(3.9)	8.8	(5.0)	8.2	(4.9)	.003	0.56	.000	0.71
Depression	14.2	(4.2)	11.1	(5.3)	11.3	(5.9)	.001	0.61	.004	0.56
Sexual abuse	9.8	(4.1)	7.6	(4.7)	7.1	(5.0)	.000	0.73	.002	0.61
Sleep disturbance	12.0	(4.1)	10.3	(4.9)	9.7	(4.8)	.026	0.41	.007	0.52
Sexual problems	7.6	(5.0)	6.0	(5.4)	6.3	(5.8)	.011	0.47	.174	—
Total score	54.2	16.4	42.8	19.6	40.9	21.7	.000	0.79	.000	0.70
BSI										
Global Severity Index	1.6	(0.6)	1.2	(0.6)	1.1	(0.8)	.000	0.77	.001	0.67
IIP-25										
Total score	2.0	(0.4)	1.7	(0.4)	1.6	(0.6)	.000	0.69	.000	0.81
ASI-Lite Composite Score										
Alcohol use	0.29	(0.21)	0.23	(0.20)	0.20	(0.19)	.117	—	.015	0.47
Drug use	0.07	(0.10)	0.07	(0.11)	0.07	(0.12)	.729	—	.663	—

Notes: t1 = baseline; t2 = end-of-treatment; t3 = 3-month follow-up.

TABLE 2
Days of Alcohol Use and Drug Use at Baseline (t1), End-of-Treatment (t2) and Three-Month Follow-Up (t3)

	n	t1		t2		t3		t1-t2		t1-t3	
		M	(SD)	M	(SD)	M	(SD)	diff	p	diff	p
Alcohol	27	6.3	(8.1)	6.0	(7.6)	6.2	(8.6)	-0.3	.91	-0.1	.94
Cannabis	7	9.1	(11.6)	9.7	(11.8)	9.3	(11.3)	+0.6	.92	+0.2	.94
Cocaine	4	1.3	(1.9)	7.8	(14.8)	2.5	(3.0)	+6.5	.33	+1.2	.42

Notes: t1 = baseline; t2 = end-of-treatment; t3 = three-month follow-up.

score. Only a minority of the sample, however, had used drugs at intake, at end-of-treatment, and at three-month follow-up. Also, our study was conducted in the context of SUD treatment, which may have mitigated the change in SUD variables (e.g., participants may have been less likely to report active substance use as it would be perceived negatively by the treatment program). Our pattern of results is also consistent with the broader literature on PTSD/SUD treatment, which has consistently found that

most models are more likely to show an impact on PTSD than on SUD symptoms (Najavits and Hien 2013). *Seeking Safety* is the only model thus far to outperform treatment as usual on both PTSD and SUD, even when including results of exposure-based therapies that have been studied in PTSD/SUD samples (Najavits and Hien 2013).

Limitations include the lack of a control condition; no control for Type 1 error; no intention-to-treat analysis; no objective measure of substance use (i.e., urine analysis);

no fidelity monitoring; and lack of statistical power for the alcohol and drug use variables. Moreover, the minimum dose of sessions used to define completer status was lower in other studies (e.g., about 20%; Brown et al. 2006) and our sample included a relatively low rate of patients with active substance use in the month prior to treatment. Finally, in this pilot study, we did not examine any covariates (e.g., psychiatric symptoms or type of substance use) that may have had an impact on outcomes.

Future research suggested by our findings include conducting a randomized controlled trial in a German sample, given that our results were positive and also support our German translation of *Seeking Safety* (Najavits 2008). Also, expanding to men as well as women in German studies would be useful, as *Seeking Safety* was designed for both genders. Conducting the full dose of *Seeking Safety*

may be useful, and greater dosage of SUD treatment is associated with better outcomes (Najavits and Hien 2013). A substantial subgroup (n = 20; 38%) of our study did not reach that minimum dose, which may suggest that, for such patients, a longer dosage, more support, or alternative treatments may be helpful to encourage them to stay in treatment. The PTSD/SUD population is one with major public health needs, and providing effective treatments for them can help to address the often very chronic and painful life histories they have endured.

The authors report no conflicts of interest, except for Lisa M. Najavits, who is the developer of *Seeking Safety*. She was not involved in the study design, data collection, nor analyses; her role was in providing the initial training and commenting on drafts of this article. The authors alone are responsible for the content and writing of this paper.

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