

**Helping to Overcome PTSD through Empowerment (HOPE)**

Johnson, D., Zlotnick, C. and Perez, S. (2011)

Johnson, D. M., Johnson, N. L., Perez, S. K., Palmieri, P. A., & Zlotnick, C. (2016)

<p><b>Description of intervention</b></p>	<p>Helping to Overcome PTSD through Empowerment (HOPE) is a 9-12 session manualized, cognitive-behavioral, empowerment-based individual treatment for survivors of intimate partner violence (IPV) residing in shelter. It incorporates many of the traditional components of CBT for PTSD (e.g., cognitive-restructuring, skill building) with a focus on helping women to realistically appraise the degree of threat they are under and to learn how to manage their PTSD symptoms in ways that do not put their safety at risk or further intensify their PTSD. Early sessions of HOPE involve psychoeducation about IPV, PTSD, and safety planning. HOPE also incorporates empowerment strategies, helping women to identify aspects of their situation that are under their control and teaching empowerment skills to help establish independence, make informed choices, and access resources. HOPE also emphasizes the need for collaboration with DV advocates/case managers and other resource providers.</p> <p>All sessions follow a similar structure: checking in about safety and accomplishments, setting the session agenda, discussing the session topic and setting goals for between session accomplishments. The Intervention is comprised of three core multi-session modules (establishing safety and empowerment, managing PTSD with empowerment tools and improving relationships) plus five optional modules.</p> <p>The expanded version of HOPE (2016) included a maximum of 10 shelter sessions and 6 sessions in the 3 months following shelter stay. Modifications included: (a) a re-evaluation of goals and safety after leaving shelter; (b) ongoing case management post-shelter, including a monthly post-shelter case management group; (c) expanded modules on substance relapse and emotional numbing; and (d) two booster sessions to reinforce what participants previously learned in treatment and to help women cope with new and ongoing stressors after shelter.</p>
<p><b>What was the intervention designed to do?</b></p>	<p>HOPE is designed to treat IPV-related PTSD and address the needs of IPV survivors related to accessing and utilizing resources and establishing long-term safety.</p>
<p><b>Underlying conceptual or theoretical model(s)</b></p>	<p>HOPE is based on the literature on cognitive theory, treatment of PTSD and chronic trauma, and the needs of IPV survivors. It is informed by Herman's (1992) Multi-Stage Model of Recovery (Establishing Safety, Remembrance and Mourning, Reconnection) and incorporates Herman's model into a Cognitive Behavioral Therapy framework. The intervention focuses primarily</p>

	on Herman’s first stage, using a present-centered approach that emphasizes safety and stabilization. HOPE also draws on the empowerment model articulated by Worell and Johnson (2001) including the importance of increasing survivor choice and control.
<b>Rationale for developing the intervention</b>	Women who seek shelter services often experience more severe abuse and have higher rates of PTSD. PTSD symptoms can impact IPV survivors’ abilities to fully utilize and benefit from shelter services (i.e. safety planning, accessing resources, finding jobs and housing, etc.). Previously developed interventions (Kubany et al. 2004), did not address the needs of women still in contact with an abusive partner. There was a need for an intervention for women with ongoing safety concerns that addressed PTSD symptoms; that supported safety, stabilization and empowerment; and that was easily integrated into a shelter environment.
<b>Who is the intervention designed to help?</b>	IPV survivors in and post-shelter
<b>What are the eligibility criteria for the intervention study?</b>	<p><b>Inclusion Criteria:</b></p> <ul style="list-style-type: none"> <li>• IPV-related PTSD or sub-threshold PTSD</li> <li>• One incident of IPV in the month prior to shelter admission</li> </ul> <p><b>Exclusion criteria</b></p> <ul style="list-style-type: none"> <li>• Current psychotropic medication, unless stable for at least one month</li> <li>• No concurrent psychotherapy</li> <li>• No bipolar disorder diagnosis, psychosis, or suicidal ideation with intent and plan</li> </ul>
<b>Rationale for specific inclusion/exclusion criteria</b>	Women with a diagnosis of bipolar disorder or schizophrenia or who were actively suicidal were not included in this study because they were already engaged in and/or would benefit more from treatment specifically tailored to their needs.
<b>Study Design</b>	<p>(2011) Randomized controlled clinical trial comparing HOPE (<math>n = 35</math>) + standard shelter services (SSS) to standard shelter services (<math>n = 35</math>). Follow-up at 1-week, 3-months and 6-months post-shelter</p> <p>(2016) Randomized controlled clinical trial comparing HOPE + SSS (<math>n=30</math>) to SSS alone (<math>n=30</math>). Follow-up at 1-week, 3-months and 6-months post-shelter</p>
<b>Outcome variables and Measures</b>	<ul style="list-style-type: none"> <li>• <b>Reabuse</b> (Conflict Tactics Scale (CTS-2))</li> <li>• <b>PTSD</b> (Clinician Administered PTSD Scale (CAPS))</li> <li>• <b>Depression</b> (Beck Depression Inventory (BDI))</li> </ul>

	<ul style="list-style-type: none"> <li>• <b>Empowerment</b> (Personal Progress Scale -Revised (PPS-R))</li> <li>• <b>Resource Loss</b> (Conservation of Resources-Evaluation (COR-E))</li> <li>• <b>Social Support</b> (Inventory of Socially Supportive Behaviors (ISSB))</li> </ul>
<b>Level of scientific rigor</b>	<p>Randomized Controlled Trial:          Appropriate outcome measures: Yes          Active Control Group: Yes  <b>Effect size:</b></p>
<b>What adaptations were made specifically for IPV survivors</b>	<ul style="list-style-type: none"> <li>○ Team continually monitored safety</li> <li>○ Safety check-ins were used throughout the program</li> <li>○ Modules included how to evaluate safety</li> <li>○ Psychoeducation was provided on the potential effects of PTSD on a survivor’s ability to evaluate safety and assess risk</li> <li>○ Ongoing safety planning incorporated into the intervention (i.e., intervention built on initial safety planning, with ongoing reevaluation and modification as needed.</li> </ul>
<b>Considerations and/or adaptations related to culture and identity</b>	<p>Early on in treatment including during psychoeducation modules the research team talked with participants about their gender socialization history, including how IPV was discussed within their culture and how their experience of IPV was affected by their cultural background. In working with survivors for whom culture was an important factor, cultural considerations were integrated throughout the intervention.</p> <p>Although the majority of women in the shelters where HOPE was piloted were cisgender, heterosexual women whose abusive partners were male, the authors worked to make the material as gender neutral as possible. They emphasized that what is most important is presenting the material in ways that are consistent with each participant’s experience.</p>
<b>Considerations and/or adaptations related to experiencing multiple types of trauma (individual and collective)</b>	<p>The research team asked about other traumatic experiences as part of the assessment process. In addition, early psychoeducation modules included information about the impact of multiple traumas on symptomatology. Although the symptom management components of the intervention focus on IPV-related PTSD, the skills that participants learn are generalizable to PTSD associated with other types of trauma, as well.</p>
<b>What is the mode of delivery?</b>	Individual treatment
<b>What were the key findings?</b>	<p><b>Johnson et al., 2011</b>          HOPE treatment relative to standard shelter services (SSSs) was significantly associated with a lower likelihood of reabuse over the 6-month follow-up period (OR = 5.1, RR = 1.75; OR = 12.6, RR = 3.12, respectively). Hierarchical linear model analyses found a significant treatment effect for emotional</p>

	<p>numbing symptom severity in the ITT sample, <math>t(67) = -2.046, p &lt; .05</math>, and significant treatment effects for effortful avoidance symptom severity, <math>t(49) = -2.506, p &lt; .05</math>, and arousal symptom severity, <math>t(49) = -2.04, p &lt; .05</math>, in the MA sample. Significant effects were also found for depression severity, empowerment, and social support.</p> <p><b>Johnson et al., 2011</b> Shelter-only version of HOPE found to be feasible, acceptable, and associated with significant improvements in depression symptoms (Cohen's <math>d = 0.96</math>), empowerment (Cohen's <math>d = 0.34</math>), and social support (Cohen's <math>d = 0.35</math>), as well as lower rates of reabuse over 6-month post-shelter follow-up (Johnson, Worell, &amp; Chandler, 2005). No significant difference was found for PTSD symptom severity. A majority of women left shelter prior to completing treatment (62.9%). Further, at post-shelter, a significant number of women still met full or partial criteria for PTSD (45.9%) and had ongoing contact with their abusive partner (87.9%).</p> <p><b>Johnson et al., 2016</b> Latent growth curve analyses found significant treatment effects for PTSD from intimate partner violence (IPV) (<math>\beta = -.007, p = .021</math>), but not for future IPV (<math>\beta = .002, p = .709</math>) across follow-up points. Significant effects were also found for secondary outcomes of depression severity (<math>\beta = -.006, p = .052</math>), empowerment (<math>\beta = .155, p = .022</math>), and resource gain (<math>\beta = .158, p = .036</math>). Additionally, more women in HOPE + SSSs were employed at 3- and 6-month follow-up compared to those in SSSs only. Results showed the acceptability and feasibility of adding IPV-related treatment to standard services.</p>
<b>Author's reflection on study results/ findings</b>	After the 2011 study, it was determined that while HOPE is a manualized intervention, it is most effective when it is tailored to the individual and while the modules themselves are set, the order in which the modules are delivered can be varied to match the needs of the individual.
<b>Implementation challenges and strategies for addressing those challenges</b>	See Author's Reflections (below)
<b>What, if any, professional qualifications are required to deliver the intervention?</b>	<ul style="list-style-type: none"> <li>• MA level therapists (e.g., counseling and social work)</li> <li>• Preference for clinicians who have been trained on intimate partner violence and have experience working in DV shelters and/or community clinics that provide trauma treatment services</li> </ul>
<b>What intervention-specific training is</b>	HOPE training includes a 12-hr workshop that covers HOPE's theoretical approach as well as instructions on how each module is to be delivered.

<p><b>required to use this model?</b></p>	
<p><b>In what settings has the intervention been delivered?</b></p>	<p><b>From published research:</b> Originally (Johnson et al., 2011), HOPE was conducted in residential DV shelters. In more recent work (Johnson et al., 2016), HOPE has been extended to the 3-months post-shelter stay. In post-shelter sessions, participants choose the setting. Many sessions are home-based although depending on the circumstances, it may be preferable to identify safer locations such as the therapist’s office or private areas in community centers and libraries.</p> <p><b>Additional settings:</b> (include citation or link, if available)</p>
<p><b>Ongoing research regarding this intervention</b></p>	<p>HOPE3: Comparing HOPE to Attention-Matched Placebo Present-Centered Therapy; Dissemination to Community Therapists and to 8 shelters in 6 counties; 1-year follow-up with 172 participants</p>
<p><b>Author’s recommendations and reflections</b></p>	<p>Some HOPE modules are better delivered in shelter or earlier on in the program. The authors try to prioritize modules that focus on symptoms or problems that may be affecting women’s ability to access and benefit from shelter resources. For example, for women experiencing hyperarousal symptoms who are finding it difficult to achieve their shelter or post-shelter goals, the intervention can be tailored to focus on anxiety management or on psychoeducation about the connection between PTSD symptoms on the person’s ability to utilize resources. HOPE is individualized, but the overarching goal is to help women to be as successful as possible within the shelter.</p> <p>Building in flexibility is also critical. In traditional treatment settings lack of “compliance” and inability to keep regular appointments is often seen as an issue. Clients may be discharged or have their therapy terminated if they miss too many appointments. For survivors of IPV, regular participation in treatment can be especially challenging, particularly when they are dealing with multiple competing concerns and priorities, including safety. Under these circumstances, what the authors found to be most helpful was the idea “being there.” For example, many women held the study team off for weeks while they focused on resolving other issues but once those issues were settled, they were ready to commit to participation. Though there may be frequent instances of disengagement and re-engagement, what is most important is to be there when people are ready to engage. Because many of the survivors who participated in these studies expected people to let them down, conveying a message of always being can be especially important.</p>

<p><b>Citations – article of intervention</b></p>	<p>Johnson, D. M., &amp; Zlotnick, C. (2006). A cognitive-behavioral treatment for battered women with PTSD in shelters: Findings from a pilot study. <i>Journal of Traumatic Stress, 19</i>(4), 559-564. DOI: 10.1002/jts.20148</p> <p>Johnson, D. M., Zlotnick, C., &amp; Perez, S. (2011). Cognitive behavioral treatment of PTSD in residents of battered women's shelters: Results of a randomized clinical trial. <i>Journal of Consulting and Clinical Psychology, 79</i>(4), 542-551. DOI: 10.1037/a0023822</p> <p>Johnson, D. M., Johnson, N. L., Perez, S. K., Palmieri, P. A., &amp; Zlotnick, C. (2016). Comparison of adding treatment of PTSD during and after shelter stay to standard care in residents of battered women's shelters: results of a randomized clinical trial. <i>Journal of traumatic stress, 29</i>(4), 365-373.</p>
<p><b>Author contact information</b></p>	<p>Dawn M. Johnson          Department of Psychology          University of Akron          Akron, OH 44325-4301          johnsod@uakron.edu</p>