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What is This?
Strengthening Positive Parenting Through Intervention: Evaluating the Moms’ Empowerment Program for Women Experiencing Intimate Partner Violence

Kathryn H. Howell, PhD, Laura E. Miller, PhD, Michelle M. Lilly, PhD, Viktor Burlaka, EdS, MSW, MS, Andrew C. Grogan-Kaylor, PhD, and Sandra A. Graham-Bermann, PhD

Abstract
This study examined the effectiveness of an evidence-based intervention in changing the positive and negative parenting practices of 120 mothers who experienced intimate partner violence (IPV) in the last 2 years. Mothers assigned to the treatment group participated in a 10-session evidence-based intervention, known as the Moms’ Empowerment Program, which targets the mental health problems of women and works to increase access to resources and improve parenting abilities of women exposed to IPV.

1University of Memphis, Memphis, TN, USA
2University of Notre Dame, Notre Dame, IN, USA
3Northern Illinois University, DeKalb, IL, USA
4University of Michigan, Ann Arbor, MI, USA

Corresponding Author:
Kathryn H. Howell, Assistant Professor, Department of Psychology, University of Memphis, 356 Psychology Building, Memphis, TN 38152-3230, USA.
Email: k.howell@memphis.edu
Participants were interviewed at baseline and immediately following the intervention or waitlist period, representing an elapsed time of approximately 5 weeks. After controlling for relevant demographic variables, violence severity, and mental health, women showed significantly more change in their positive parenting scores if they were in the treatment condition. No significant differences were found between the treatment and comparison groups in their negative parenting practices change scores. These findings suggest that even short-term intervention can improve positive parenting skills and parenting knowledge for women who have experienced partner abuse.

**Keywords**

intimate partner violence, parenting, intervention, women

Intimate partner violence (IPV), which includes physical or sexual violence, threats of such violence, stalking, and psychological aggression by a current or former intimate partner, is a pervasive and destructive problem, impacting a significant number of women in the United States (Black et al., 2011). According to the 2010 National Intimate Partner and Sexual Violence Survey, IPV occurs at staggeringlly high rates in this country, with more than 1 in 3 women (35.6%) experiencing such violence in her lifetime and approximately 6%, or nearly 7 million women, experiencing IPV in the past 12 months (Black et al., 2011). The costs of chronic partner violence cannot be overstated, with abused women showing increased rates of financial, interpersonal, and mental health problems (Byrne, Resnick, Kilpatrick, Best, & Saunders, 1999; Golding, 1999).

Yet, IPV does not affect adults in isolation, as up to 15 million American children are exposed to such violence in their home each year (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). Furthermore, the majority of child witnesses to IPV are under the age of 6, as both single and recurring IPV events happen disproportionately more often in households with preschool-aged children (Fusco & Fantuzzo, 2009). While some children show evidence of resilient functioning and endure family violence without visible problems (Howell, Graham-Bermann, Czyz, & Lilly, 2010; Martinez-Torteya, Bogat, von Eye, & Levendosky, 2009), for many children, living with violence has profoundly debilitating effects that last into adulthood. IPV is particularly distressing for preschool children because they spend a significant proportion of time with their parents; unlike older children, preschoolers are not able to separate from the violence through...
peer or academic outlets (Margolin & Gordis, 2000). The consequences of witnessing IPV in early childhood include increased risk for emotional, behavioral, physical, and social problems (Evans, Davies, & DiLillo, 2008; Graham-Bermann, Castor, Miller, & Howell, 2012; Holt, Buckley, & Whelan, 2008; Howell, 2011; Kennedy, Bybee, Sullivan, & Greeson, 2010; Kuhlman, Howell, & Graham-Bermann, 2012). The presence of IPV, therefore, represents a potential threat to not only those women directly victimized but also to the family system as a whole. However, few empirically sound and evidence-based interventions exist to assist these families. Furthermore, there is a significant lack of research assessing families that include preschool-aged children. The present study reports the results of an intervention program aimed at empowering, educating, and supporting female survivors of IPV with the goal of improving their parenting skills and knowledge of the impact of IPV on their preschool-aged children.

The Effects of IPV on Parenting

Given that children are living in a large proportion of the households in which IPV occurs (McDonald et al., 2006), it is crucial to examine the impact of such violence on parenting. While IPV likely contributes to significant family chaos and instability, current research offers mixed results as to the specific impact of IPV on mothering. Some studies suggest that women who experience IPV are more likely to use physical punishment with their children and less likely to be emotionally available, involved, and warm (Holden, Stein, Ritchie, Harris, & Jouriles, 1998; Murray, Bair-Merritt, Roche, & Cheng, 2012).

This lack of effective, supportive parenting has been tied to women’s mental health, suggesting that symptoms of posttraumatic stress or depressed mood may be linked to a lack of warmth and responsiveness (Levendosky & Graham-Bermann, 2001; Levendosky, Huth-Bocks, Shapiro, & Semel, 2003). Levendosky et al. (2003) evaluated the mother–child parenting relationship in households where IPV was present and found that some mothers attempted to compensate for interparental violence by becoming more effective parents. These women paid more attention to their children and were more responsive to their children’s needs, despite the violence at home. While such a finding is encouraging, the finding only held for women who did not show psychopathology following the violence. Women who showed symptoms of depression and posttraumatic stress were less able to provide a supportive parenting environment, and they typically displayed poorer parenting skills (Levendosky et al., 2003).

Yet, some research finds that parenting is altogether independent from maternal mental health symptoms, suggesting that these factors operate
autonomously in families experiencing violence (Gewirtz, DeGarmo, & Medhanie, 2011). The broader concept of parenting can be delineated into positive and negative behaviors, each separately associated with violence exposure and outcomes. Positive parenting practices, such as consistency, emotional warmth, and involvement, may protect children from the potentially damaging effects of IPV (Levendosky & Graham-Bermann, 2000), but negative parenting practices, such as corporal punishment, inconsistent discipline, and a harsh, controlling style, may lead to vulnerability and poorer mental health in children (Alloy et al., 2001). In sum, parenting stress has a strong, direct effect on child behavioral and emotional difficulties in families experiencing IPV (Huth-Bocks & Hughes, 2008).

Interventions for Families Exposed to IPV

Treatment options for families experiencing IPV range greatly in content and form, with variable levels of theoretical grounding and empirical assessment (Graham-Bermann, 2011). For example, Pereira, D’Affonseca, and Williams (2013) conducted a pilot study of the Parceria Project, a Brazilian-based intervention for mothers with a history of IPV. This intervention aimed to teach parenting skills to abused women and preliminary findings indicated that women who participated in the program showed improved parenting competence and parenting style; however, the lack of a comparison group and the small sample size (N = 17) are significant limitations of this research. Becker, Mathis, Mueller, Issari, and Atta (2008) evaluated a community-based intervention for parents and children exposed to severe IPV. Mothers self-reported significant improvement in parenting skills (e.g., emotionally supportive behaviors) at post-treatment and children showed change in their internalizing and externalizing symptoms. While these findings are promising, the study did not include a no-treatment comparison group; thus, results should be interpreted with caution. Some research has shown that parenting is less responsive to intervention. In a Swedish study of 42 mothers, a 15-week intervention did not lead to improved parenting competence, despite the intervention’s positive impact on women’s trauma and other psychological symptoms (Grip, Almqvist, & Broberg, 2011).

Another intervention for women experiencing IPV and their children showing conduct problems, known as Project Support, used a more rigorous and sophisticated methodology to assess effectiveness. In a study of 66 families, Project Support therapists worked primarily with mothers, with children included to assess the mothers’ use of learned skills and the child’s responses to these skills. After an average of 20 home-based treatment sessions, mothers’ harsh and inconsistent parenting decreased in both the experimental and
comparison groups, but the decrease occurred at a faster rate for women in the treatment group. Such findings highlight the ability of intervention to change parenting practices, but it is limited by the use of a costly in-home service delivery design and the inclusion of only families connected to a shelter (Jouriles et al., 2009).

**Current Study**

The current study aims to expand on the relatively limited available research on interventions that focus on parenting for mothers experiencing partner violence. This study compares the positive and negative parenting practices of mothers exposed to severe IPV who participated in a community-based intervention to an analogous group of mothers who did not receive services and were randomly assigned to a waitlist condition. It was hypothesized that, after controlling for relevant demographic variables, violence severity, and maternal mental health, those women who participated in the intervention condition would show greater change in their positive and negative parenting practices post-intervention, relative to those in the comparison group.

**Method**

**Participants**

Participants were part of a larger, randomized control trial of the effectiveness of mother and child group intervention for families exposed to IPV (Graham-Bermann, 2006). The 120 mothers were drawn from Southeast Michigan and Southern Ontario, Canada. Women ranged in age from 21 to 54 years ($M = 31.8$, $SD = 7.2$). The sample was relatively diverse, with 48% of the mothers identifying as European American, 37% African American, 8% Biracial, 6% Hispanic American, and 1% Asian American. The majority of women completed at least some higher education (59%), but their reported monthly income was generally low ($M = US$ $1,414$, $SD = US$ $1,549$). At the time of evaluation, 43% of the women reported their relationship status as single, 34% separated or divorced, 16% married, and 7% living with a partner. Fifty-two percent of the sample had previously lived in, or were currently living in, a shelter for abused women.

**Procedures**

All study materials were reviewed and approved by the University of Michigan Institutional Review Board. Participants were recruited from
local shelters for abused women, hospitals, mental health agencies, legal aid services, and community centers using flyers, brochures, and presentations. Interested women contacted the study coordinator using a toll-free number and completed a brief pre-screening over the telephone. One hundred fifty women called the program coordinator to inquire about participation. Of these women, 25 did not meet inclusion criteria for participation most commonly because their child was not in the preschool age range. Five women declined to participate in the program due to time constraints. One hundred twenty women were then allocated to their respective treatment conditions. Only custodial mothers who experienced IPV within the last 2 years and had a child between the ages of 4 and 6 years were eligible to participate.

Women who remained interested in the study and met inclusion criteria were assigned to either the treatment or comparison condition using a sequential block assignment approach. A sequential block procedure assigns the first five women who qualify for the study to the experimental condition and then assigns the next five women to the comparison condition. This procedure allows group size to become large enough over a relatively short period of time to run an effective treatment group with limited attrition. Women in the experimental group were interviewed at baseline and post intervention (5 weeks apart). Women in the comparison condition were interviewed at baseline and then 5 weeks later, having not participated in the intervention during the interim. Women assigned to the comparison condition were given the opportunity to participate in the intervention following their second interview.

Study interviews were scheduled at a time and location convenient for the family. Interviews typically occurred at the woman’s home, unless she was living with a violent partner, at which point the interviews took place at the university, a community center, or another suitable setting. When necessary, transportation and childcare was arranged for the families. At the initial interview, mothers completed an informed consent to participate. Prior to giving consent, women were told that their participation was completely voluntary, that they could refuse to participate at any stage of the study, and that their information would be stored in a secure facility. Interviewers were graduate-level students who had prior experience conducting research interviews with high-risk families or had training and experience in clinical psychology or social work. All interviewers received formal training on interviewing procedures and instruments. Mothers completed all of the study measures and were monetarily compensated at each interview.
**Intervention**

The Moms’ Empowerment Program (MEP) is a 10-session group intervention that meets for 5 weeks (for access to the treatment manual, see Graham-Bermann, 2011). Each session lasts approximately 1 hr and there are typically 5 to 7 participants in each group. The MEP is held in community settings, such as education centers or shelter outreach sites. It was designed to enhance the social and emotional adjustment of mothers who experienced IPV in the past 2 years, with sessions focusing on strengthening social and instrumental support, enhancing coping skills, and increasing caregiving knowledge. Research on IPV suggests that women’s ability to utilize effective coping mechanisms and conflict resolution strategies, despite exposure to violence in the home, affects not only her functioning but also the functioning of her children (Hines & Saudino, 2002). This is especially relevant if women use emotion-focused and problem-focused coping strategies. Emotion-focused strategies are used to help control one’s emotional response to stressful events, while problem-focused techniques are characterized by actions centered on changing events. These coping strategies may lessen the impact of violence on the family (Folkman & Lazarus, 1991). Furthermore, it may be that women’s sense of empowerment is enhanced when they seek out support and knowledge to change their predicament. By problem solving and attempting to develop plans to change negative situations, women might create a sense of hope for the future, despite the currently challenging family environment. This more hopeful and empowered attitude likely contributes to improvements in parental functioning.

A primary element woven throughout the MEP is improving parenting knowledge and skills. During the intervention, mothers discuss how IPV has affected their child’s development and functioning, how their caregiving skillset has been affected by parenting under extreme stress, how to talk openly and directly with children about difficult topics, such as family violence, and how to create a consistent, supportive parenting environment. The psycho-educational element of the intervention program was designed to inform women about typical child development and to provide support and problem solving around parenting challenges (Graham-Bermann, 2011). Previous research suggests that a key component of intervention effectiveness is parent education (Bradley et al., 2003; Kendziora & O’Leary, 1993). Particularly in a group setting, psychoeducation and open discussion about typical and atypical child behaviors may help to ease parenting tension as women learn about the wide range of common child behaviors. As women gain perspective on typical child development, they may feel more comfortable...
with their child’s actions, thus leading to a more accepting, understanding, and flexible parenting environment.

Community social workers, advanced social work students, clinical psychologists, and advanced clinical psychology graduate students led the MEP, under the direct supervision of a licensed psychologist. All intervention group therapists were female and underwent 15 hr of clinical and didactic training before beginning groups. Furthermore, group therapists were in regular contact with the developer of the intervention. To ensure treatment fidelity, group therapists followed a manual for the treatment that detailed each session and attended 2-hr supervision meetings before each session. During supervision, process notes were shared and clinical concerns were discussed as was the degree of success in implementing the previously completed session. The section of the treatment manual that described the upcoming session was discussed during supervision. Group therapists then reviewed the components of the session and any concerns about implementation were addressed. Fidelity checks were not tracked quantitatively. The current study is part of a series of outcome evaluations of the MEP. Preliminary studies of the MEP have found that participation in the program is associated with more decreases in violence victimization over time and reductions in mothers’ posttraumatic stress compared with controls (Graham-Bermann & Miller, 2013; Miller, Howell, & Graham-Bermann, in press).

**Measures**

**Demographics.** Each mother completed a demographics questionnaire that asked about her age and the age of her children, racial and ethnic background, family income, education, and relationship status.

**Violence severity.** The revised version of the Conflict Tactics Scale (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) was used to measure women’s exposure to violence in their relationship, including the extent of psychological aggression, physical assault, sexual coercion, and injury. For the purposes of this study, only the 39 items assessing violence victimization were administered to participants. Mothers’ responses were assessed on a seven-point scale with 0 indicating the tactic was never used to 6 indicating it was used more than 20 times. Previous research indicates that the CTS2 has adequate reliability, with subscales ranging from $\alpha = .79$ to $\alpha = .95$ (Straus, et al., 1996). In the present study, the reliability for the total violence scale at baseline was $\alpha = .93$. 


Depressed mood. The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977), a 20-item self-report measure, was used to assess depressive symptomatology in participants. Women were asked to indicate how frequently they experienced each item within the past week using a four-point scale ranging from 0 (Rarely/none of the time) to 3 (Most/all of the time). The CES-D’s reliability, content validity, and discriminant validity have been established in a number of samples, with an internal reliability (α) of .85 and test–retest reliability of .54 (Radloff, 1977; Roberts, Andrews, Lewinsohn, & Hops, 1990). Total CES-D reliability for the present study was α = .79.

Posttraumatic stress. Symptoms of posttraumatic stress in study participants were assessed using the 49-item Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1995). The PDS provides a reliable measure of posttraumatic stress disorder (PTSD) for use in both clinical and research settings. Participants were asked to focus on the “worst” traumatic event associated with abuse from their partner and then answer questions to evaluate traumatic re-experiencing, avoidance, and physiological reactivity. Study participants indicated how frequently they experienced each symptom within the last month on a scale from 0 (not at all/once) to 3 (5 or more times a week/almost always). The PDS has high internal consistency and test–retest reliability for diagnosis and symptom severity, good sensitivity, and it correlates highly with other measures of PTSD. Cronbach’s alpha for the measure was originally reported at .92 (Foa, 1995) and was .89 for the current sample.

Parenting practices. Parenting practices were measured with the Alabama Parenting Questionnaire (APQ; Frick, Christian, & Wootton, 1999). The APQ consists of 42 items assessing positive and negative parenting practices grouped within six domains: (a) involvement, (b) positive parenting, (c) poor monitoring/supervision, (d) inconsistent discipline, (e) use of corporal punishment, and (f) use of discipline practices other than corporal punishment. Mothers rated the frequency with which these parenting practices typically occur in their home on a five-point scale ranging from 1 (never) to 5 (always). Involvement, positive parenting, and use of discipline practices other than corporal punishment comprise the APQ Positive Parenting Scale, while inconsistent discipline, poor monitoring/supervision, and use of corporal punishment comprise the APQ Negative Parenting Scale. The APQ has demonstrated sound psychometric properties in studies evaluating the association between parenting practices and child outcomes in the preschool population (Clerkin, Marks, Policaro, & Halperin, 2007). In the present study, α = .77 for the APQ Positive Parenting Scale and α = .70 for the APQ Negative Parenting Scale.
Results

At baseline, women endorsed high rates of IPV victimization over the past year, with an average report of 56 threatened or completed acts of physical violence \((SD = 59.68)\), 14 violence-related injuries \((SD = 18.44)\), 96 acts of psychological aggression \((SD = 55.45)\), and 18 instances of sexual violence \((SD = 30.25)\). At pre-intervention, the Positive Parenting Scale mean was 3.74 \((SD = .41)\) and the Negative Parenting Scale mean was 1.79 \((SD = .39)\). Parenting scores were normally distributed at both pre- and post-intervention. Intercorrelations among the study variables ranged from \(r = .00\) to \(.70\) and are found in Table 1.

Prior to evaluating the effectiveness of the MEP, pre-intervention differences between experimental and no-treatment comparison groups were assessed on all key study variables (maternal demographics, violence severity, maternal mental health, and parenting). There were no statistically significant differences between the experimental and no-treatment comparison groups at baseline on any of the above study variables, indicating successful randomization.

An attrition analysis was also conducted to determine if there were any differences between those women who dropped out of the study and those women who completed both pre- and post-intervention evaluations. Attrition from baseline to post-intervention was 14% for the experimental group and 21% for the comparison group. Of the 120 families in the study, 58 were allocated to the intervention program and 62 were allocated to the no-treatment comparison group. Experimental families attended an average of 6

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Table 1. Correlation Matrix of Variables in Regression Analyses.

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Child age</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Child sex</td>
<td>-.09</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Mom age</td>
<td>-.00</td>
<td>.15</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Violence severity</td>
<td>-.04</td>
<td>-.07</td>
<td>-.29**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Baseline positive parenting</td>
<td>-.07</td>
<td>.10</td>
<td>-.06</td>
<td>.27**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Baseline negative parenting</td>
<td>-.05</td>
<td>.07</td>
<td>-.26**</td>
<td>.09</td>
<td>.09</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Mom depression</td>
<td>-.04</td>
<td>.06</td>
<td>-.10</td>
<td>.26**</td>
<td>.08</td>
<td>.32**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>8. Mom PTSD</td>
<td>-.09</td>
<td>.11</td>
<td>-.14</td>
<td>.39**</td>
<td>.30**</td>
<td>.41**</td>
<td>.70***</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. PTSD = posttraumatic stress disorder.

**\(p < .01\). ***\(p < .001\).
(SD = 3) sessions. This attendance rate is similar to that of women with histories of IPV in other studies (e.g., Lieberman, Van Horn, & Ippen, 2005). Of the 58 families in the experimental group, 51 received the intervention and 7 did not receive the intervention citing sickness, work conflicts, and/or personal commitments. In all, 50 completed pre- and post-intervention assessments (1 family could not be reached for the second interview). Of the 62 comparison families, 8 were unable to be contacted for the second interview and 4 discontinued participation in the study. An attrition analysis was completed by comparing those who stayed in the study from baseline to the second interview with those who did not. Analyses comparing those participants who dropped out of the study with those who did not drop out of the study indicated that there were no significant differences between groups from baseline to the second interview on any relevant variables.

Multivariate linear regression models were used to evaluate change in positive and negative parenting skills from baseline to immediately following the MEP intervention (see Table 2). Women who received the intervention were compared with women in the comparison group. A regression model was fitted to each dependent variable. Models were run as “intent to treat” where group membership captured the original assignment procedure to either treatment or control, regardless of treatment adherence, a more conservative approach to analysis.

**Table 2.** Coefficients in the Model Predicting to Mother’s Positive and Negative Parenting Change Scores.

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Positive Parenting</th>
<th>Negative Parenting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>SE</td>
</tr>
<tr>
<td>Child age</td>
<td>.01</td>
<td>.03</td>
</tr>
<tr>
<td>Child sex</td>
<td>.09</td>
<td>.05</td>
</tr>
<tr>
<td>Mom age</td>
<td>.07</td>
<td>.01</td>
</tr>
<tr>
<td>Violence severity</td>
<td>−.07</td>
<td>.00</td>
</tr>
<tr>
<td>Baseline positive parenting</td>
<td>−.37</td>
<td>.07</td>
</tr>
<tr>
<td>Baseline negative parenting</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Mom depression</td>
<td>−.07</td>
<td>.01</td>
</tr>
<tr>
<td>Mom posttraumatic stress</td>
<td>−.08</td>
<td>.01</td>
</tr>
<tr>
<td>Group assignment</td>
<td>.22</td>
<td>.05</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01. ***p < .001.
The regression model for change in pre- to post-intervention positive parenting score was significant overall, $F(8, 90) = 4.35, p < .001, R^2 = .28$. In this regression, which controlled for demographic variables of the child (age, sex), mother’s age, violence severity at baseline, mother’s mental health (baseline depression and baseline posttraumatic stress), and baseline positive parenting score; group assignment was a significant predictor of change in positive parenting scores from baseline to post-intervention ($\beta = .22, p < .05$). The effect size of this difference from baseline to post-intervention was $d = .14$, indicating a small effect. The only other variable associated with change in positive parenting was the baseline parenting score ($\beta = -.37, p < .001$).

The same regression model was used to predict change in negative parenting. This regression was significant overall, $F(8, 90) = 2.05, p < .05, R^2 = .15$. Variables entered into the model included demographic variables of the child (age, sex), mother’s age, violence severity at baseline, mother’s mental health (baseline depression and baseline posttraumatic stress), baseline negative parenting score, and group assignment. The only significant predictor of the change score was baseline negative parenting ($\beta = -.33, p < .01$). There was no association between group assignment and change in negative parenting score. In sum, the study hypothesis was partially supported, as change in mother’s positive parenting scores was significantly related to treatment participation, however, there was no association found between attending the MEP and a decline in negative parenting.

**Discussion**

Findings from this study offer promising, though preliminary, insight into the benefits of a short-term, community intervention for women exposed to severe IPV. These results add to the growing body of literature suggesting that a cost-effective, group-based approach to treatment can lead to significant change in mother’s parenting behaviors (Becker et al., 2008). Furthermore, the more methodologically rigorous design of this evaluation trial allows for conclusions to be drawn about the unique benefits of participating in an intervention, as compared with past research without a comparison group, the latter of which cannot control for the effects of the passage of time or other extenuating variables (Pereira et al., 2013). While other methodologically sound interventions for families experiencing IPV have shown promising results with regard to altering parenting behaviors (e.g., Jouriles et al., 2009), the MEP is the only known community-based intervention to show significant change in the positive parenting practices of women mothering preschool-aged children in a short period of time (5 weeks) and in a group setting.
Consistent with what was hypothesized, participating in the MEP was associated with change in women’s positive parenting scores. Key aspects of positive parenting were emphasized throughout the intervention in both psychoeducation and group discussions. For example, women learn about, and generate ideas for, how to use fair but firm consequences and rewards to shape behavior, in addition to the importance of being involved in children’s activities and finding ways to engage with children, even in the midst of significant life stressors. Furthermore, group participants gain knowledge and support about praising children for appropriate behavior, the value of complementing their children, and showing affection both verbally and nonverbally. The group setting may have facilitated the development of new positive parenting practices, as women could learn strategies from each other that could increase their repertoire of parenting skills. Women also expanded their knowledge base regarding typical child development and what one can expect from children at differing levels of development (i.e., what is unique about the preschool period). This may have helped encourage women to set more reasonable expectations for their child’s behavior, which allows for more supportive parenting practices.

Even though participants’ use of parenting skills and knowledge were not directly assessed through monitored homework assignments or in vivo group activities over the course of the intervention, it appears that women were able to take what was discussed in the group and apply it to their individual families. This may have been facilitated by participants learning from other women in the group and supporting each other around which techniques were useful and which were less useful. Furthermore, increased knowledge about child development gained through the MEP may improve mothers’ understanding and tolerance for seemingly challenging child behaviors. Beyond a focus on parenting, the MEP also attempts to enhance coping and relaxation skills, which may have contributed to changes in positive parenting if women were able to use these skills to manage stress in difficult parent–child interactions.

Given the connection between the MEP and changes in positive parenting, it was surprising not to find an association between changes in negative parenting and the intervention program. It appears that change in negative parenting is associated with variables not assessed in the present study. For example, corporal punishment is a key aspect of negative parenting, which may be linked to women’s own use of violence or other violence exposure beyond IPV; therefore, it would be important to examine women’s own violent tactics and other experiences with aggression that may relate to this aspect of negative parenting. In addition, certain aspects of physical punishment, such as spanking, may not be considered a problematic or ineffective
parenting practice by some mothers. Furthermore, poor monitoring and a lack of supervision are other characteristics of negative parenting. These may be particularly challenging domains to change as they could be related to financial stress or a lack of available caretakers to assist mothers with parenting responsibilities. These mothers are likely not choosing to provide meager monitoring or supervision, rather they may feel forced to leave children in less than ideal circumstances due to, for example, employment demands. Finally, there may be reporting bias in participants who do not accurately endorse some aspects of negative parenting, for example corporal punishment, out of fear that they may be reported to authorities. Given the relatively low mean for negative parenting items, perhaps a floor effect was present that resulted in less room for change from pre- to post-intervention. Thus, this study may not have accurately captured negative parenting practices, particularly at the baseline assessment when participants are unfamiliar with the study team and intervention.

Clinical Implications

Results of this study suggest a variety of noteworthy clinical implications. These promising findings indicate that short-term treatment can lead to meaningful change; thus, service providers, whether they are at shelters, clinics, or other community agencies, should consider using a brief, group-based intervention, such as the one evaluated here, to assist women who have experienced IPV. In addition, study findings highlight the value of addressing adaptive behaviors and skills via intervention, rather than focusing solely on pathology. Group interventions such as the MEP, that promote positive practices and highlight strengths of women exposed to IPV, may help empower women and enhance support structures for a relatively vulnerable population. Furthermore, this approach is cost-effective, able to be administered in a variety of locations, and can serve a great number of families at any one time. These findings also support the use of manualized treatment approaches. Particularly when families or providers only have a limited time for treatment, it may be best to target specific areas of concern using a pre-specified plan.

Limitations

Notwithstanding this study’s novel contributions to the field of treatment research, there are a number of limitations that should be considered when interpreting results. First, there is a clear need for more objective, multi-informant measures of parenting, as there are potential issues of bias and social desirability when one person completes all measures used in a study. It
would be helpful to have direct observations, coded by trained clinicians, to create a more accurate representation of parenting behaviors. Furthermore, this study only examined parenting behaviors, without assessing other aspects of parenting, such as efficacy or beliefs. A more expansive evaluation of changes in these other facets of parenting, including the addition of measures that examine a wider range of parenting variables, could yield valuable information about key elements of the MEP intervention. Next, there was not an assessment of other potentially traumatic events, such as community violence or sibling aggression, which may have an impact on treatment response. In addition, bi-directional violence or violence by women toward their partners was not assessed and may be pertinent to parenting practices. The generalizability of these findings may also be limited, as participants were primarily low-income, mid-Western families who were interested in receiving services following exposure to IPV. This study also focuses solely on parenting practices and does not evaluate other relevant post-intervention outcomes, such as maternal mental health. Finally, methodological issues such as sample retention, the sequential assignment approach, and the lack of assessment of treatment fidelity are potential limits of this study design.

**Future Research**

While this study provides preliminary evidence of the effectiveness of the MEP on positive parenting practices, there are a number of additional research directions that should be pursued. Future studies should evaluate how change in parenting affects child functioning, change in other maternal outcomes, or additional relevant child and parent variables that are beyond the scope of the present study. Inclusion of additional measures of parenting, completed by informants such as the group therapists and children may create a more comprehensive assessment of parenting practices. Self-report measures completed by mothers should examine not only parenting behaviors but also parenting beliefs, parenting efficacy, and coping with parenting challenges. Beyond measures of parenting, data could also be gathered on bi-directional family violence, community violence, and other potentially traumatic events to discern the influence these variables have on parenting practices. Furthermore, children could be included in some sessions of the intervention to allow mothers to practice skills with the support of group therapists, who could then give immediate and direct feedback. Future iterations of the study could gather behavioral or psychophysiological data and examine the utility of same gender versus mixed-gender groups. In addition, whereas this study was designed to assess change in the broad areas of positive and negative parenting, future studies might also evaluate the building blocks that are
theorized to lead to change, including whether the intervention enhanced the mother’s coping, emotion regulation, social support, or the extent to which the program succeeded in providing a safe space for discussions of challenging parenting issues. These future projects could incorporate additional evaluations over a longer period of time that may more accurately evaluate pathways to positive and negative parenting. These follow-up assessments could be used to determine whether gains in positive parenting are maintained and whether parenting alters after families have had time to incorporate new skills into their home environments.

**Summary**

IPV is a chronic concern at the national and global levels, yet studies that offer evidence of effective treatment for women exposed to IPV are rare. Furthermore, most programs are costly and take a significant amount of time to complete. The current study provides preliminary evidence that a community-based, group intervention, delivered in a timely and efficient manner, can contribute to change in the parenting practices of women exposed to this form of violence. Such research disseminates important information on families who experience substantial hardship.

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**References**


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Kathryn H. Howell, PhD, is an Assistant Professor in the Department of Psychology at the University of Memphis. She received her PhD from the University of Michigan clinical psychology program in August 2011. Her research centers on risk and resilience in children exposed to potentially traumatic events, including intimate partner violence, parental loss, and chronic illness.

Laura E. Miller, PhD, is an Assistant Professor of Psychology and Peace Studies at the University of Notre Dame. Her research examines the developmental effects of exposure to violence in childhood with a focus on children who have multiple traumatic exposures. She investigates resulting patterns of resilience and psychopathology, including the development of posttraumatic stress symptoms. Her work also seeks to identify effective intervention practices for children and families affected by violence.

Michelle M. Lilly, PhD, began as an assistant professor of psychology at Northern Illinois University (NIU) in 2009. She received her PhD from the joint doctoral program in clinical psychology and women’s studies at the University of Michigan, where she studied how gender, ethnicity, trauma exposure, coping, and world assumptions influence mental health in female survivors of intimate partner violence as well as female police officers. At NIU, her research has focused on emotional and cognitive factors that predict clinical symptomatology in survivors of interpersonal trauma as well as factors that enhance risk for psychopathology in 911 telecommunicators.

Viktor Burlaka, EdS, MSW, MS, is a doctoral student at the University of Michigan. Before joining the doctoral program, he worked on the implementation of international development programs in Eastern Europe. As a joint social work and clinical psychology student at the University of Michigan, he is interested in interventions and research methods with children and youth. His research focuses on mothers exposed to intimate partner violence and their preschool children, the evaluation of evidence-based practices in the mental health sector, capacity building for substance abuse research in Central and Eastern Europe, and mental health literacy in Ukraine.

Andrew C. Grogan-Kaylor, PhD, examines the effects of schools, neighborhoods, and parenting on outcomes for children, such as aggression, anxiety, depression, academic performance, and substance use. Much of his current research focuses on corporal punishment, and he has published several pieces using longitudinal or cross-national data and advanced statistical methods indicating that parental use of corporal punishment is associated with increases in children’s antisocial behavior, anxiety, and depression.
Sandra A. Graham-Bermann, PhD, is professor of psychology and psychiatry at the University of Michigan, where she researches how different forms of violence affect children’s adjustment. Over 23 years, she has developed new measures of their fears and worries, traumatic stress, attitudes and beliefs about violence, family stereotyping, and conflict in sibling relationships. With support from national agencies, state, and local foundations, she has designed and evaluated interventions for women and children exposed to domestic violence using randomized control trials. Author of more than 70 peer-reviewed publications, she is co-editor of How Intimate Partner Violence Affects Children: Developmental Research, Case Studies, and Evidence-Based Treatment (2011), APA Books. As director of the Child Violence and Trauma Lab in the Department of Psychology, she and her team of postdoctoral fellows and graduate and honors students study the behavioral and emotional adjustment of children exposed to family violence and trauma and interventions designed to assist them. These interventions have been adopted for use in 28 states and 5 countries.