

Mom’s Empowerment Program (MEP)

Graham-Bermann, S., and Miller, L. E. (2013)

Miller, L. E., Howell, K. H., & Graham-Bermann, S. A. (2014)

<p>Description of intervention</p>	<p>The Mom’s Empowerment Program (MEP) looks at the role and function of social supports and relationships to address trauma symptoms resulting from IPV. MEP addresses advocacy needs, psychoeducation about violence and its effects, and skills for promoting positive mental health. A group format facilitates the sharing of the IPV story and companionship. A children’s program was also designed to help identify and process feelings, address any self-blame they may have about the witnessed abuse, and teach safety skills and coping strategies.</p>
<p>What was the intervention designed to do?</p>	<p>The Mom’s Empowerment Program (MEP) is described as a program “designed with and designed for mothers who experience IPV”. This group centered approach seeks to provide support and build life skills of participating mothers by discussing the impact of violence on child development, building parenting competence, and creating a safe and supportive group setting for discussing their fears and worries.</p>
<p>Underlying conceptual or theoretical model(s)</p>	<p>MEP emphasizes the whole person and explores strengths and abilities, with specific focus on interpersonal relationships. MEP is based in part on Sullivan’s (1953) interpersonal theory and in part on empowerment theory (Gutierrez, 1990). As empowerment theory addresses issues of power imbalance and marginalization, MEP operates on the hypothesis that assisting women to regain their power better equips them act on and improve their present situations.</p>
<p>Rationale for developing the intervention</p>	<p>Empowerment encapsulates the entire process of MEP; it moves beyond sharing personal experiences to discovering mothers’ strengths and abilities that can be used throughout life. Dr. Graham-Bermann describes that “every part of the program empowers the woman to gain back agency in her life”. Mothers are better prepared to face challenges when the program supports them in taking charge of their own lives, enhancing coping skills, obtaining resources and caring for themselves. One such set of skills developed targets parenting related stress and difficulties, a major presenting problem for participating mothers. As a significant number of participating mothers’ children have diagnosable mental health problems (as a result of or alongside experiencing IPV), mothers often report feeling overwhelmed and not well-prepared to parent their children, especially for if they also experienced a stressful environment growing up.</p>
<p>Who is the intervention</p>	<p>Mothers who had experienced or are currently experiencing IPV</p>

designed to help?	
What are the eligibility criteria for the intervention study?	Women had to have experienced one incident of IPV over past year and have a child (the different published RCT had different eligibility criteria concerning the age of the child).
Rationale for specific inclusion/exclusion criteria	N/A
Study Design	<p>Graham-Bermann & Miller (2013)</p> <ul style="list-style-type: none"> • Randomized controlled trial with three conditions • Assessments at baseline and at 6- to 8-month follow-up <p>Miller et al. (2014)</p> <ul style="list-style-type: none"> • Randomized control trial with treatment and comparison conditions • Assessments at baseline and at 6- to 8-month follow-up
Outcome variables and Measures	<p>Graham-Bermann & Miller (2013)</p> <ul style="list-style-type: none"> • Intimate Partner Violence: Conflict Tactics Scale (CTS; Straus, 1979); Severity of Violence Against Women Scales (SVAWS; Marshall, 1992) • Posttraumatic Stress: The Posttraumatic Stress Scale for Domestic Violence (Saunders, 1991) • Social Desirability Response Bias: Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1964) <p>Miller et al. (2014)</p> <ul style="list-style-type: none"> • Intimate Partner Violence: Conflict Tactics Scale (CTS; Straus, 1979)
Level of scientific rigor	<p>Randomized Controlled Trial: Yes. Waitlist control</p> <p>Appropriate outcome measures: Yes</p> <p>Active Control Group: No</p> <p>Effect size: Medium effect size for M+C condition, smaller effect size for CG condition</p>

<p>What adaptations were made specifically for IPV survivors?</p>	<ul style="list-style-type: none"> ○ Building sense of safety and confidentiality within the group ○ Safety behaviors around contact and therapy <ul style="list-style-type: none"> ○ Established ‘safe times’ for calls ○ Interviews conducted in safe locations such as the shelter or university ○ All group sessions carried out in community setting or shelter ○ Community center policies on safety adhered to: <ul style="list-style-type: none"> ○ Men are not allowed in center or in session ○ Protocols followed for what to do in unsafe situation ○ Safety plans developed <ul style="list-style-type: none"> ○ Mothers are required to discuss in detail a plan that highlights ifs and whens for escaping a dangerous situation
<p>Considerations and/or adaptations related to culture and identity</p>	<p>See Current research</p>
<p>Considerations and/or adaptations related to experiencing multiple types of trauma (individual and collective)</p>	<p>Not provided</p>
<p>What is the mode of delivery?</p>	<p>MEP is delivered in an in-person group format. The intake interview is set up over the phone and takes place either at an independent safe location or at the shelter or university.</p>
<p>What were the key findings?</p>	<p>Graham-Bermann & Miller (2013)</p> <ul style="list-style-type: none"> ● Across the treatment conditions, a very high and reliable change rate in trauma symptoms was produced with a reliable change rate of 85% no longer diagnosed with PTSD. <p>Miller et al. (2014)</p> <ul style="list-style-type: none"> ● “Violence victimization significantly decreased for women in both conditions between the baseline interview and the 6- to 8-month follow-up. Participation in treatment was related to an augmented effect of violence reduction such that women participating in the intervention experienced greater declines in violence than those who did not participate in the treatment program.”
<p>Author’s reflection on study results/ findings</p>	<p>Across the three randomized control trials, a very high and reliable change rate in trauma was produced with an 85% change in those who had PTSD. MEP has outperformed other standard trauma focused CBT measures and programs. MEP focuses primarily on the women over the course of the 10</p>

	<p>sessions, and as a result trauma is reduced, but so much more is being done such as helping parenting and empowering people to make good choices about their relationships.</p>
<p>Implementation challenges and strategies for addressing those challenges</p>	<p>Not provided</p>
<p>What, if any, professional qualifications are required to deliver the intervention?</p>	<p>The intervention does not require a clinician for delivery or implementation and there is no need for a specific clinical background in order to implement MEP.</p> <p>MEP group therapists are often community service providers and are already involved in the field by nature of the people they serve such as therapists or social workers at local mental health clinics, graduate students in clinical psychology and social work, and physicians.</p>
<p>What intervention-specific training is required to use this model?</p>	<p>Therapists receive training in clinical work with women exposed to IPV, including identifying and treating symptoms of traumatic stress, as well as ethical issues in working with at-risk populations. The training manual describes session topics, evidence for relevant issues, and example process notes.</p> <p>People who are experienced in working with women or have been exposed to violence can implement MEP quite well. When people first do the program, the recommendation is to have supervision after each session as many questions come up concerning the provision of additional services and handling and managing difficult situations that come up during the group.</p>
<p>In what settings can the intervention be delivered?</p>	<p>MEP is carried out in a community setting (shelter or center). The initial interview is carried out over the phone and the intake session is at a location of the woman's choosing. For safety reasons, community settings are selected for the group sessions.</p>
<p>Ongoing research regarding this intervention</p>	<p>MEP is currently being implemented in 28 different states in four countries (Sweden, Australia, Mexico, and Canada) with three currently published randomized control trials involving three separate samples: mothers of school aged children (Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007), mothers of preschool children (Howell et al., 2014), and Latina, Spanish speaking immigrant mothers (Galano, Grogan-Kaylor, Stein, Clark, & Graham-Bermann, 2016). As two trials involved samples of primarily Caucasian, African American, and biracial participants, and in light of a request for services, there was a shift towards collecting data from sample of Spanish</p>

	<p>speaking, Latina women.</p> <p>Currently, data on MEP is being collected in Alaska with a sample of Native American Alaskans and Alaskan residents. Overall, the translation of MEP for implementation in different countries and among different cultures has been successful (for example, the program has been successfully translated to Swedish). In the future, there may be a shift towards using more universal measures that are more user friendly and that will facilitate easier data sharing among community based researchers.</p>
Author's recommendations and reflections	<p>As this work is done in community settings and group sessions take place in shelters or other safe community spaces, special attention should be paid to implementation logistics. In particular, childcare provision, transportation, and access to service are extremely important when working within a community setting. The women who participate in the program are responsible for juggling the needs of their children with all their other day-to-day responsibilities and special efforts should be made to facilitate their program attendance. In some cases, this might mean providing childcare and reimbursing participants for gas money.</p> <p>Specific programs for violence are really needed, but it is not enough to just address trauma. Programs really have to take the whole woman and all of her needs into account and that's what [MEP] does."</p>
Citations – article of intervention	<p>Graham-Bermann, S., & Miller, L. E. (2013). Intervention to reduce traumatic stress following intimate partner violence: An efficacy trial of the moms' empowerment program (MEP). <i>Psychodynamic Psychiatry</i>, 41(2), 329-350. DOI: 10.1521/pdps.2013.41.2.329</p> <p>Miller, L. E., Howell, K. H., & Graham-Bermann, S. A. (2014). The effect of an evidence-based intervention on women's exposure to intimate partner violence. <i>American Journal of Orthopsychiatry</i>, 84(4), 321-328. DOI: 10.1037/h0099840</p>
Author contact information	<p>Sandra Graham-Bermann, Ph.D. Department of Psychology, University of Michigan 530 Church Street Ann Arbor, MI 48109-1043 Email: sandragb@umich.edu</p>