Reducing Stress and Promoting Wellness Among Parents and Service Providers: A University-Community Collaboration

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ABSTRACT

Background: Chronic stress is linked to worse parenting outcomes, with potential downstream effects on child development. Existing interventions targeting stress among low-income parents struggle with engagement and retention, and family service providers often report high stress themselves.

Objectives: This study evaluated the feasibility, acceptability, and preliminary efficacy of a stress-reduction and wellness program, adapted and disseminated to parents and service providers through a novel university-community collaboration.

Methods: The program was delivered in multiple formats to parents and staff from three community-based programs serving families with young children. A mixed-methods approach was used to assess engagement, retention, satisfaction, and wellbeing outcomes.

Results: Results revealed high program satisfaction and pre-post improvements in parents' coping and mental health. Strengths, barriers, and avenues for improvement were identified.

Conclusions: This program shows promise for reducing stress among low-income parents and service providers. Ongoing collaboration to address barriers may improve accessibility and effectiveness of future iterations.

KEYWORDS: Community-Based Participatory Research, Health promotion, Program Evaluation, Socioeconomic Factors, Parents, Mental Health

Introduction

Exposure to stress is linked to worse health and lower wellbeing, including among parents of young children.[1-5] Parental stress predicts worse child outcomes, partly due to alterations in parenting behavior.[6-12] Importantly, low socioeconomic status (SES) is linked to elevated stressor exposure, including environmental adversity, financial strain, and heightened parenting stress.[13-14] Such findings highlight a need for targeted interventions to enhance resilience in low-SES families with young children. Unfortunately, existing stress-reduction programs struggle to engage and retain low-income parents, with dropout rates ranging from 20-80%.[15-20]

One strategy to enhance retention involves partnering with established community services for parents of young children.[21] For example, researchers found that integrating mental health services into early childhood education bolstered engagement by minimizing scheduling demands and capitalizing on existing relationships with providers.[22] Importantly, research suggests that community providers can effectively deliver evidence-based interventions in partnership with field experts leading training and implementation.[23-24] This presents a unique opportunity for cross-institutional collaborations bridging the gap in evidence-based programming for low-income families.[25] Furthermore, inviting direct service providers to participate in stress-reduction programs may prepare them to support targeted skills among parents they serve while simultaneously addressing their own stress levels.[26]

This article describes the implementation of "Reducing Stress and Improving Your Wellbeing," a stress-reduction and wellness program developed at the Health Care Institute (HCI) of the University of California at Los Angeles. This program (hereafter, the Wellness Program) was tailored and disseminated by William & Mary in partnership with three

community-based parenting programs: Early Head Start (EHS), Head Start (HS), and Circle of Parents. This jointly written manuscript describes the collaborative adaptation and implementation of the Wellness Program in multiple formats and settings. Community partners led recruitment and home-based delivery, and researchers led group-based delivery and program evaluation. Together, we assessed the feasibility, acceptability, and preliminary efficacy of the Wellness Program for reducing stress and enhancing coping skills among participating parents and service providers.

Methods

Building a Community Partnership

Local implementation of the Wellness Program emerged from intersecting university-community collaborations in southeast Virginia, centered around Williamsburg EHS. EHS provides family-centered services for low-SES pregnant women and children aged 0-3, including center-based childcare and home-visiting by trained Family Advocates (FAs). Williamsburg EHS has a longstanding partnership with HCI, which teaches EHS/HS agencies to implement successful parent-training programs focused on health promotion (e.g., obesity prevention). During the COVID-19 pandemic, HCI leadership recognized unmet needs to support effective coping among parents facing significant stress. HCI developed the Wellness Program, centered on promoting healthy coping and sustainable self-care, to help parents flourish during challenging times, and Williamsburg EHS pursued training in this model.

William & Mary joined the community-university partnership in fall 2021, when Katie Quigley, director of Williamsburg EHS, invited Professor Madelyn Labella to help disseminate and evaluate the Wellness Program as an adjunct to typical home-visiting services. Dr. Labella's lab subsequently collaborated with EHS to adapt the Wellness Program for local use and conduct

a pilot evaluation, including post-training feedback from staff and pre-/post-intervention assessments from parents. The partnership later expanded to include two additional community groups. Williamsburg-James City County HS provides high-quality preschool and wraparound services to enhance early development and school readiness among children aged 3-5. Circle of Parents (CoP) is a peer mentorship group offered through Child Development Resources to provide mutual support for parents of children aged 3-6. Together, EHS, HS, and CoP afforded opportunities to evaluate the Wellness Program in multiple formats for multiple audiences. The timeline of partnership development and project implementation is depicted in Figure 1.

Intervention Development and Pilot Evaluation

Consistent with their broader mission, HCI developed the Wellness Program to reduce stress and enhance wellbeing among families engaged in EHS/HS. Motivated by evidence that parental stress affects children through alterations in the parent-child relationship,[6-8] the program targets parents' wellbeing by promoting effective coping and sustainable self-care. Drawing from multiple mental health traditions, including mindfulness and cognitive-behavioral approaches, the program includes a workbook divided into four modules, each containing psychoeducation, discussion prompts, and self-reflection activities (Table 1).

In preparation for local implementation of the Wellness Program, Dr. Labella, Ms. Quigley, and two EHS FAs attended a two-day nation-wide training facilitated by HCI. The FAs found the materials helpful in managing their own stress and requested further training before beginning program delivery. Dr. Labella and her graduate students delivered the Wellness Program to all EHS FAs, which involved four weekly meetings by Zoom. Sessions included psychoeducation, self-reflection, and conversation about applying program principles to FAs' own lives, followed by a collaborative discussion about optimizing delivery for EHS parents. In

response to FAs' feedback, researchers developed one-page handouts to accompany each module (Table 1). Handouts provide a concrete takeaway for parents (especially those intimidated by a multi-page workbook) and offer supplemental support for positive action. Dr. Labella's lab collaborated with the William & Mary Hispanic Studies Department and a bilingual FA to ensure program materials were translated for use with Spanish-speaking families. The resulting materials were used for subsequent Wellness Program delivery.

After FAs began delivering the Wellness Program to parents as part of EHS home-visiting, leadership from two additional community groups (HS and CoP) learned of the program and expressed interest in disseminating it. The scope of the pilot evaluation was expanded to include staff and parents from HS and CoP. Ultimately, the current study aimed to evaluate the feasibility, acceptability, and preliminary benefits of the local adaptation of HCI's Wellness Program, delivered in multiple formats and settings: through home-visiting (EHS parents), online groups (EHS/HS staff, EHS/HS parents enrolled in center-based care), and an in-person parenting group (CoP) (Figure 1).

Participants

Participants were 41 parents engaged in early childhood services (EHS, HS, CoP) in the broader Williamsburg community, as well as 38 staff members from EHS (n = 11) and HS (n = 27). Parents' self-reported demographics (Table 2) reflect generally low SES. This pilot sample, though small, was considered adequate for assessing feasibility of procedures and exceeded a recommended minimum of 30.[27]

Procedure

Study procedures were approved by the Institutional Review Board at William & Mary. Participating EHS/HS staff provided informed consent and completed a post-intervention

feedback survey following receipt of the four-module program. FAs who delivered the program during home-visiting also completed a feedback survey and qualitative interview about feasibility and acceptability of the intervention for EHS families.

Participating parents completed informed consent and several pre-post measures of stress and wellbeing, either in English or Spanish. For families enrolled in EHS home-visiting, the Wellness Program was delivered by FAs during regularly scheduled home visits. Researchers suggested covering one module per visit, but FAs were encouraged to use their judgment regarding when and how to deliver material. For families receiving center-based care or participating in the CoP support group, the Wellness Program was delivered by Dr. Labella and graduate students, covering one module per session. Following program delivery, parents completed a post-intervention feedback survey and qualitative interview.

Staff and parents received gift cards for completing measures, and families received a child-friendly mindfulness book upon program completion.

Measures

Stress and Mental Health. Pre- and post-intervention, parents completed well-validated, widely used measures of stress (Perceived Stress Scale[28] and Parental Stress Scale[29]) and mental health (Patient Health Questionnaire, Depression[30] and Anxiety[31] Modules).

Coping and Self-efficacy. Pre- and post-intervention, parents were asked to list strategies they used to cope with stress. Coping strategies were tallied, excluding theoretically maladaptive strategies (e.g., substance use). Parents also completed the Shift-and-Persist Scale[32], a validated measure of adaptive coping in the context of low SES. Finally, parents reported on self-efficacy using the New General Self-Efficacy Scale[33].

Parent and Staff Feedback

Program Evaluation. Post-intervention, parents and staff completed a self-report survey about the feasibility and acceptability of the Wellness Program, developed for the current study. EHS FAs answered additional items specific to intervention delivery. Items were rated on a 5-point scale from 1-*Strongly disagree* to 5-*Strongly agree* (Table 4).

Parents additionally completed open-ended interviews reflecting on their experience, including favorite and least favorite aspects, perceived helpfulness, and suggestions for improvement. EHS FAs completed similar interviews regarding intervention delivery, with additional questions about workbooks and handouts, barriers to delivery, and alignment with EHS curriculum. Qualitative interviews were inductively coded by the first and second author, who independently identified codes (95.9% agreement). Discrepancies were resolved by consensus and codes were organized by theme.

Analytic plan

Engagement and retention were evaluated through stated interest in and completion of the Wellness Program, respectively. Preliminary efficacy was assessed using paired-samples t-tests examining pre-post changes in parental stress, mental health, coping, and self-efficacy. Feasibility and acceptability were assessed using feedback surveys and qualitative interviews completed by parents and staff.

Outcomes

Engagement and Retention

Home-based delivery

Initially, eight FAs were trained in the Wellness Program. Over time, half left EHS and three newcomers were trained in program delivery. FAs were encouraged to offer participation to all families on their caseloads and track their responses; however, some chose not to the offer the

program to families who were new to EHS, close to discharge, engaged with other mental health supports, or overwhelmed by current stressors. Program delivery was paused from September 2022-April 2023 as FAs worked to master a new child assessment tool, consistent with federal mandates. After resuming intervention delivery, 37 of 41 families were offered the program and 21 accepted. Those declining cited busyness, discomfort with research, lack of interest, or imminent transition to center-based care. Most (85%) of those who declined were Spanish-speaking.

From March 2022-June 2023, 37 parents gave permission for researchers to contact them. One parent mistakenly began the program before completing a pre-intervention assessment, six did not follow through on scheduled visits, and two were unresponsive to scheduling attempts. Twenty-eight (76% of those initially interested) provided pre-intervention data (six in Spanish). One withdrew due to lack of interest in program content, and four were discharged from EHS prior to program completion. Twenty-three parents (62% of those initially interested) completed the program and 21 provided post-intervention data (five in Spanish). Number of parents completing the program varied by FA (range: 0-6).

Group-based delivery

Four-session group-based versions of the Wellness Program were offered to 1) families enrolled in center-based care through EHS/HS, and 2) parents participating in the CoP peer support group. Group #1 was advertised through flyers, phone applications used for parent-teacher communication, and conversations with EHS/HS family support specialists. Despite concerted recruitment efforts, just eight parents expressed interest in the program, of whom three declined to speak to researchers and two were unresponsive to scheduling attempts. Three

attended the group intervention (offered by Zoom at parents' requests, with one participant routinely joining from work) and completed pre-post-intervention measures (one in Spanish).

Group #2 was offered by CoP facilitators to families in their drop-in parenting support group. Ten regular attendees expressed interest and provided pre-post-intervention data. Sessions were offered in person as part of regularly scheduled CoP meetings, while children attended a concurrent play group.

Preliminary Evidence of Benefits

Paired-samples t-tests were used to evaluate pre-post-intervention changes in stress and wellbeing (Table 3). Overall, scores reflected moderate decreases in anxiety and increases in coping strategies ($|d|s$ = 0.38-0.54). Nonsignificant effects in the expected direction were observed for parental stress, depressive symptoms, and self-efficacy ($|d|s$ = 0.20-0.30). Effects were comparable across delivery type; group-based delivery was also associated with substantial improvements in self-efficacy (d = 0.65).

Feasibility and Acceptability

Results from post-intervention feedback questionnaires reflected high satisfaction from staff and parents (Table 4); most reported that the program helped them try new coping strategies, develop a self-care plan, and feel more confident managing stress. 94.7% of staff and 96.9% of parents agreed or strongly agreed with the statement, "Overall I was satisfied with this program." Additionally, all EHS FAs delivering the Wellness Program agreed or strongly agreed with the statement, "Overall, I believe parents were satisfied with this program."

Parents' and EHS FAs' open-ended interviews were qualitatively coded for recurring themes. Overall, parents had positive feedback regarding the program and noted many strengths (Table 5). Families appreciated that topics were relevant to their lives, fit well into home visits,

opened new lines of communication, and taught them something new. All parents reported using program materials in their everyday lives, with several providing examples of using coping techniques during stressful parenting moments and/or to coach their children through strong emotions. Several parents commented on the child-friendly mindfulness book provided at the end of the program, with one stating, "I already memorized one of them for me and my daughter…now I say 'Okay, let's close our eyes real tight and open them real wide and blink them three times. And…it gets her focus off of whatever the issue is long enough to relax and calm down." All EHS parents recommended continuing to offer the Wellness Program as part of home visits.

When asked about barriers, three parents shared difficulty keeping track of materials and remembering strategies in the moment, and two noted discomfort with the research component. One CoP parent noted that she could not attend one session due to lack of childcare when playgroup was not in session. Additionally, one parent from the remote group wished the format was more "personal." When asked for improvement suggestions, six indicated wishing it was longer, three requested more concrete resources, and two recommended adding a section that "the whole family could do together."

Staff

FAs who delivered the program also shared positive feedback, stating it fit well into their existing home-visiting curriculum, opened new conversations with the families they served, and delivered valuable information (Table 6). All FAs felt that EHS should continue to use these materials, with one commenting, "I will continue offering to more families and I'm hoping that more families will be involved because it's gonna benefit a lot." Despite these strengths, most FAs acknowledged barriers to program delivery, including competing demands on visit time and

disruptions in the home environment. Two shared feelings of discomfort with difficult topics that emerged. Regarding improvement, FAs echoed parents' feedback for longer duration and additional concrete resources, and one suggested a peer mentorship component so those delivering the program could share experience and advice.

Lessons Learned

Overall, the pilot supports the feasibility, acceptability, and promise of the Wellness Program, while offering avenues for improvement of future iterations. Integrating the Wellness Program into existing services proved more effective than offering a stand-alone group; just three center-based families completed the intervention remotely, despite recruitment efforts from EHS/HS staff. In contrast, more than half of home-visiting families offered the program accepted it, with 62% going on to complete it. Engagement and retention were even higher for in-person delivery integrated into a parenting support group: 100% of regular CoP attendees accepted and completed the intervention. Successful completion of the in-person group was likely aided by free childcare and a low-distraction environment. Because CoP has no income requirements, parents from the in-person group may also have experienced less socioeconomic strain than EHS/HS parents, potentially facilitating program follow-through.

Results demonstrated significant pre-post improvements in parents' coping and mental health. Group-based delivery was additionally associated with enhanced self-efficacy, suggesting that normalizing feedback and support from peers may build parental confidence; this should be interpreted cautiously given the small sample size. Quantitative and qualitative feedback revealed high satisfaction among parents and staff.

Given high satisfaction and promising efficacy, barriers to access should be addressed. Beyond integrating the Wellness Program into existing parent groups, in-person delivery may be

facilitated by free childcare and transportation, and/or scheduling around drop-off and pick-up for center-based care. If in-person attendance is not feasible, scheduling Zoom sessions when participants are not working or actively parenting (e.g., after children's bedtimes) may help to enhance engagement. Families may also benefit from "whole-family" programming that incorporates partners and children. Parents reported appreciating the mindfulness book given at the end of the program, and its child-friendly activities may offer a promising framework for family programming.

Program participation was lower for Spanish-speaking families, perhaps reflecting differences in cultural values. The second author (who completed pre-post intervention measures and delivered the Zoom intervention in Spanish) observed that Hispanic parents seemed to resonate less with stress-centered language, sometimes denying any experience of stress. Two FAs serving Spanish-speaking families referenced the cultural relevance of program in their feedback. One noted, "I think that they were very interested on identifying, you know, have that conversation that maybe they had never had before, especially in this culture." The other reported that spending time talking about their stress and wellbeing was unusual for parents she worked with, in part because of "the culture where they tell you, just get over it, you know?" These observations highlight the salience of cultural norms in shaping program engagement. Reframing stress-centered language to focus on promoting health and coping with everyday challenges may make material more approachable. Focus groups with Hispanic families may support cultural relevance of future iterations.

Finally, home-based delivery may be enhanced by addressing staff challenges. Most FAs reported difficulty balancing program delivery with pre-existing home-visiting curriculum. Identifying optimal times to introduce the program, streamlining other responsibilities (while

remaining consistent with federal mandates), and providing additional resources to address work-related stress might bolster feasibility. Implementing a peer mentorship component, as one FA suggested, could provide positive examples of successful intervention delivery, increasing comfort offering the program broadly, alleviating anxiety around discussing challenging topics, and sharing best practices for introducing material. Overall, addressing identified barriers may enhance broad implementation.

Conclusion

The current pilot study evaluated the feasibility, acceptability, and preliminary benefits of a stress reduction program for families and staff involved in community parenting services. Initial results reveal high satisfaction among program completers, as well as preliminary benefits for parental coping and mental health. Program delivery was particularly successful when incorporated into an existing in-person parenting group. Given promising results and positive feedback, future iterations should replicate this pilot study in larger samples and address identified barriers to enhance accessibility. This pilot study represents an important advancement in a developing community-university partnership, laying a foundation for future research and practice focused on wellness among families and service providers.

References

1. Hammen CL. Stress and depression: old questions, new approaches. Curr Opin Psychol. 2015;4:80-85.
2. Daviu N, et al. Neurobiological links between stress and anxiety. Neurobiol Stress. 2019;11:100191.
3. Steptoe A, Kivimäki M. Stress and cardiovascular disease. Nat Rev Cardiol. 2012;9(6):360-370.
4. Tosevski DL, Pejovic Milovancevic M. Stressful life events and physical health. Curr Opin Psychiatry. 2006;19(2):184-189.
5. Chronic Stress Puts Your Health at Risk. Mayo Clinic, Mayo Foundation for Medical Education and Research, 1 Aug. 2023. Available at: www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/stress/art-20046037.
6. Creasey G, Reese M. Mothers' and fathers' perceptions of parenting hassles: Associations with psychological symptoms, nonparenting hassles, and child behavior problems. J Appl Dev Psychol. 1996;17(3):393-406.
7. Deater-Deckard K. Parenting stress. Yale University Press; 2008.
8. Cherry KE, Gerstein ED, Ciciolla L. Parenting stress and children's behavior: Transactional models during Early Head Start. J Fam Psychol. 2019;33(8):916.
9. Deater-Deckard K, Panneton R. Unearthing the developmental and intergenerational dynamics of stress in parent and child functioning. Parental Stress and Early Child Development: Adaptive and Maladaptive Outcomes. 2017:1-11.

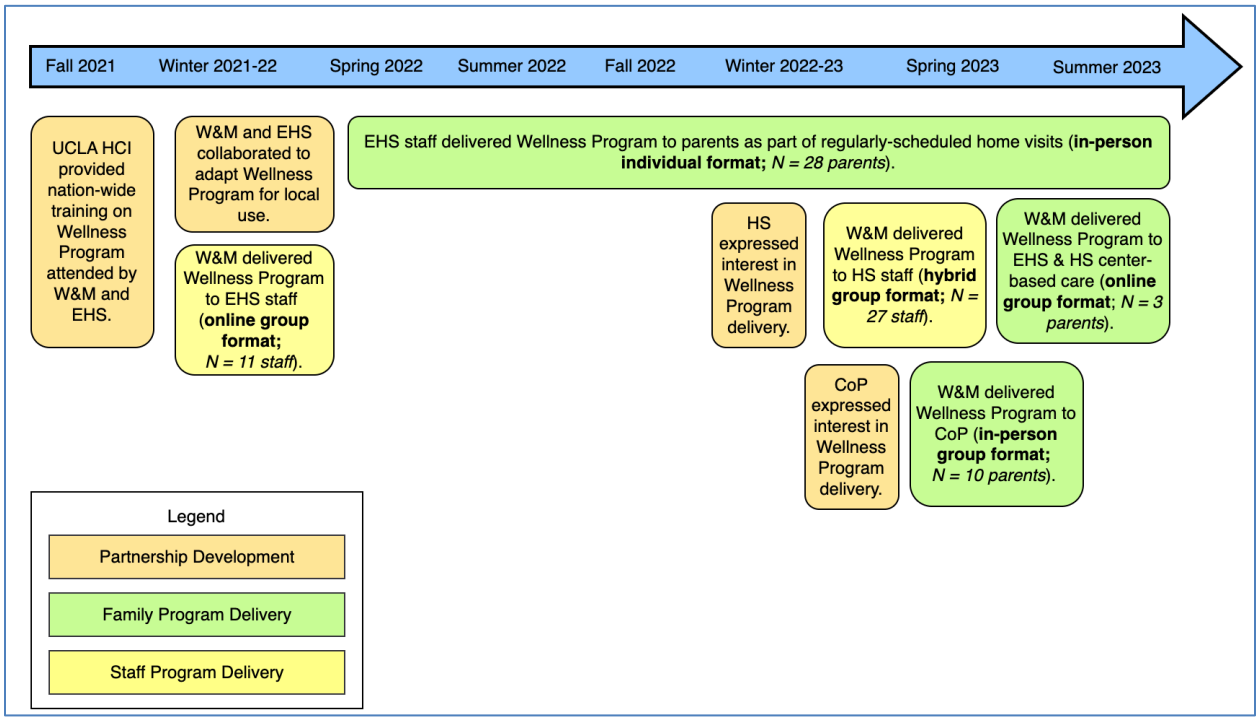
10. Guajardo NR, Snyder G, Petersen R. Relationships among parenting practices, parental stress, child behaviour, and children's social-cognitive development. Infant Child Dev. 2009;18(1):37-60.
11. Huth-Bocks AC, Hughes HM. Parenting stress, parenting behavior, and children's adjustment in families experiencing intimate partner violence. J Fam Violence. 2008;23:243-251.
12. Jackson AP, Choi J. Parenting stress, harsh parenting, and children's behavior. J Fam Med Community Health. 2018;5(3):10.
13. Shonkoff JP, Boyce WT, McEwen BS. Neuroscience, molecular biology, and the childhood roots of health disparities: building a new framework for health promotion and disease prevention. JAMA. 2009;301(21):2252-2259.
14. U.S. Department of Health and Human Services. The health and well-being of children: A portrait of states and the nation, 2011–2012. 2014.
15. Diehl K. A program for improving health and stress management for adolescents from low-income families: Integrating behavioral coping skills, nutrition education and yoga. J Adolesc Health. 2014;54(2)
16. Roth B, Robbins D. Mindfulness-based stress reduction and health-related quality of life: Findings from a bilingual inner-city patient population. Psychosom Med. 2004;66(1):113-123.
17. Urizar GG Jr, et al. Destined for greatness: a family-based stress management intervention for African-American mothers and their children. Soc Sci Med. 2021;280:114058.

18. Gopalan G, et al. Engaging families into child mental health treatment: Updates and special considerations. J Can Acad Child Adolesc Psychiatry. 2010;19(3):182.
19. Ingoldsby EM, et al. Quasi-experimental pilot study of intervention to increase participant retention and completed home visits in the nurse–family partnership. Prev Sci. 2013;14:525-534.
20. Masi MV, Miller RB, Olson MM. Differences in dropout rates among individual, couple, and family therapy clients. Contemp Fam Ther. 2003;25:63-75.
21. Skouteris H, et al. Early childhood education and health working in partnership: The critical role early childhood educators can play in childhood obesity prevention. Early Child Dev Care. 2017;187(8):1239-1243.
22. Gross DA, et al. Using Day Care Centers for Recruiting and Retaining Low-Income Families in a Prevention Trial: Contextual Challenges. The 2004 National State of the Science Conference. 2004.
23. Snell-Johns J, Mendez JL, Smith BH. Evidence-based solutions for overcoming access barriers, decreasing attrition, and promoting change with underserved families. J Fam Psychol. 2004;18(1):19.
24. Shonkoff JP, et al. An integrated scientific framework for child survival and early childhood development. Pediatrics. 2012;129(2)
25. Woods-Jaeger BA, et al. Development, feasibility, and refinement of a toxic stress prevention research program. J Child Fam Stud. 2018;27:3531-3543.
26. Alitz PJ, Geary S, Birriel PC, et al. Work-Related Stressors Among Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Home Visitors: A Qualitative Study

[published correction appears in Matern Child Health J. 2018 Oct;22(Suppl 1):121. doi: 10.1007/s10995-018-2622-y]. Matern Child Health J. 2018;22(Suppl 1):62-69.

27. Teresi, J. A., Yu, X., Stewart, A. L., & Hays, R. D. (2022). Guidelines for designing and evaluating feasibility pilot studies. Medical care, 60(1), 95-103.
28. Cohen S, Kamarck T, Mermelstein R. A global measure of perceived stress. J Health Soc Behav. 1983;24(4):385-396.
29. Berry JO, Jones WH. The parental stress scale: Initial psychometric evidence. J Soc Pers Relat. 1995;12(3):463-472.
30. Kroenke K, Spitzer RL, Williams JB. Patient Health Questionnaire-9 (PHQ-9). APA PsycTests. 1999;10.
31. Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006;166(10):1092-1097.
32. Chen E, McLean KC, Miller GE. Shift-and-persist strategies: Associations with socioeconomic status and the regulation of inflammation among adolescents and their parents. Psychosom Med. 2015;77(4):371-382.
33. Chen G, Gully SM, Eden D. Validation of a new general self-efficacy scale. Organ Res Methods. 2001;4(1):62-83.

Figure 1. *Community-University Partnership Development and Wellness Program Delivery.*



Note. UCLA HCI = University of California Los Angeles Health Care Institute. W&M = The College of William and Mary. EHS = Early Head Start. HS = Head Start. CoP = Circle of Parents.

Tables

Table 1. *Description of UCLA's "Reducing Stress and Improving Your Wellbeing" Program Modules.*

Module	**Description**	**Take-Home Materials**
Module 1.	This module introduces common causes and symptoms of stress, with the goal of normalizing stressful experiences, building self-compassion, and identifying opportunities for coping.	Handout (identifying and responding to stress)
Module 2.	This module demonstrates ways that thoughts, emotions, and behaviors can reinforce each other, with particular emphasis on recognizing unhelpful negative thoughts triggered by stress.	Handout (identifying and challenging negative thoughts)
Module 3.	This module introduces a variety of stress management techniques, including mindfulness practice, regulated breathing, progressive muscle relaxation, and guided imagery.	Handout (stress management techniques) List of free mindfulness resources
Module 4.	This module guides participants through developing their own "wellness plan" by setting concrete goals to enhance wellbeing in domains they wish to prioritize. Participants also develop a plan to engage in specific coping strategies in response to specific emotions (e.g., "When I feel frustrated, I will take a walk").	Personalized Wellness Plan Handout (coping with emotions) *Breathe Like a Bear* child-friendly mindfulness book

Table 2. *Participant Demographics*

Characteristic	Value	
	n	%
Parent Demographics		
Gender		
Female	36	87.8
Male	4	9.8
Non-Binary	1	2.4
Race/Ethnicity		
Black/African American	9	22.0
White (non-Hispanic)	10	24.4
Hispanic/Latinx	12	29.3
Asian	4	9.8
Multiracial	6	14.6
Education		
Less than high school	5	12.2
High school degree or equivalent	8	19.5
Some college	11	26.8
Associate degree	8	19.5
Bachelor's Degree	5	12.2
Graduate degree	4	9.8
Household Income		
Less than $10,000	12	29.3
$10,001-$20,000	8	19.5
$20,001-$30,000	4	9.8
$30,000-$40,000	4	9.8
$40,001-$50,000	6	14.6
$50,001-$60,000	2	4.9
More than $60,000	3	7.3

Note. Parental age (*Mean* = 32.80, *Standard Deviation* = 10.31).

Table 3. *Paired-Samples T-Tests Evaluating Intervention Effects on Parental Stress and Wellbeing*

Measure	Mean (SD) Pre	Mean (SD) post	*N*	*t*	*p*	Cohen's *d*
Perceived Stress	18.42 (6.22)	18.64 (5.85)	33	0.16	0.87	0.03
Home Visitor	18.90 (6.24)	18.29 (6.64)	21	-0.44	0.66	-0.10
Parent Group	17.58 (6.37)	19.25 (4.33)	12	0.61	0.55	0.18
Parental Stress	38.97 (7.11)	37.38 (2.09)	34	-1.27	0.21	-0.22
Home Visitor	37.86 (6.84)	35.71 (8.73)	21	-1.24	0.23	-0.27
Parent Group	40.77 (7.44)	40.08 (5.88)	13	-0.39	0.70	0.11
Depression Symptoms	6.74 (6.29)	5.41 (5.07)	34	-1.73	0.09	-0.30
Home Visitor	8.00 (6.91)	6.71 (5.70)	21	-1.36	0.19	-0.30
Parent Group	4.69 (4.68)	3.31 (2.95)	13	-1.04	0.32	-0.29
Anxiety Symptoms	13.73 (6.46)	12.30 (5.17)	33	-2.15	0.04*	-0.38
Home Visitor	14.57 (7.27)	12.95 (5.92)	21	-1.81	0.09	-0.40
Parent Group	12.25 (4.65)	11.17 (3.43)	12	-1.11	0.30	-0.32
Self-Efficacy	4.07 (0.64)	4.18 (0.55)	33	1.17	0.25	0.20
Home Visitor	4.27 (0.55)	13.29 (2.70)	21	0.36	0.72	0.08
Parent Group	3.73 (0.66)	3.94 (0.65)	12	2.25	0.05*	0.65
Shift & Persist	27.65 (3.99)	27.94 (3.72)	34	0.54	0.59	0.09
Home Visitor	27.14 (4.14)	27.95 (4.13)	21	1.19	0.25	0.26
Parent Group	28.46 (3.76)	27.92 (3.09)	13	-0.61	0.56	-0.17
Coping strategy count	2.09 (1.83)	2.97 (1.88)	33	3.08	<0.01**	0.54
Home Visitor	1.90 (1.83)	2.70 (1.38)	20	2.27	0.02*	0.51
Parent Group	2.38 (1.85)	3.38 (2.47)	13	2.03	0.07	0.56

Note: Perceived Stress, Perceived Stress Scale; Parental Stress, Parental Stress Scale; Depression Symptoms, Patient Health Questionnaire, Depression Module; Anxiety Symptoms, Patient Health Questionnaire, Anxiety Module; Self-Efficacy, General Self-Efficacy Scale; Shift & Persist, Shift-and-Persist Scale.

Table 4. *Program Satisfaction Reported by Parents and Staff*

Question	**Staff % Strongly Agree or Agree**	**Parent % Strongly Agree or Agree**
Program Specific Questions		
1. This program helped me to identify my own sources and symptoms of stress.	81.6	96.9
2. Because of this program, I tried new ways to manage stress.	84.2	96.9
3. This program helped me to cope more effectively with stress.	81.6	87.5
4. Because of this program, I made a plan to improve my health and well-being	92.1	84.4
5. After completing this program, I feel more confident in my ability to manage stress.	78.9	84.4
6. After completing this program, I feel a greater sense of well-being	81.6	93.8
7. Overall, I was satisfied with this program.	94.7	96.9
Delivery Specific Questions (n = 7 FAs)		
1. This program helped the parents I work with to identify their own sources and symptoms of stress.	100.0	--
2. Because of this program, parents tried new ways to manage stress.	100.0	--
3. This program helped parents to cope more effectively with stress.	85.7	--
4. Because of this program, parents made plans to improve their health and wellbeing.	100.0	--
5. After completing this program, parents felt more confident in their ability to manage stress.	100.0	--
6. After completing this program, parents felt a greater sense of well-being.	85.7	--
7. This program addressed issues that were important to the parents I work with.	100.0	--
8. This program aligned well with other materials we use in EHS.	100.0	--
9. Parents felt uncomfortable with the material in this program.	0.0	--
10. This program was difficult to fit into home visits.	14.3	--
11. This program was helpful for the families I work with.	100.0	--
12. I encountered a lot of barriers to completing this program.	28.6	--
13. This program was difficult for me to deliver.	0.0	--

14. The four-session training program prepared me well to deliver this program.	100.0	--
15. I felt confident sharing this material with parents	100.0	--
16. Because of this program, I had more conversations with parents about their stress and well-being.	85.7	--
17. This program gave me new ideas to help parents improve their well-being.	100.0	--
18. Because of this program, I felt more confident helping parents manage stress.	85.7	--
19. Overall, I believe parents were satisfied with this program.	100.0	--
20. Overall, I was satisfied with this program.	100.0	--

Note. Staff $N = 38$; Parent $N = 32$.

Table 5. *Qualitative Feedback Provided by Parents.*

Themes Codes	Definition	Number of Transcripts with Code ($N = 32$)	Example Quote
Strengths			
Feasibility	Parents express that the program was well-suited to their existing home visit schedule and did not add any undue burden or inconvenience	9	"I liked that it was set up in a way to kind of build into a schedule that was already established. That you came to the parents group that was already meeting, that we didn't have to find a way to get there, so to speak, or find a time to get there to participate. You came to us, and it made it really convenient and easy, which is a huge thing."
Communication & Relationship	Parents express approval or appreciation for the program's role in facilitating new and meaningful conversations, either with their family advocate or with other parents.	10	"It's been nice to be able to open up and doing it with someone who, you know, I'm comfortable with, that I'm building a relationship with, who not only cares about me but cares about the baby"
Concrete Resources	Parents express enjoyment or appreciation for the inclusion of physical handouts and materials as part of the program.	4	"I liked the discussions that it brought about, but I also thoroughly enjoyed the fact that there was a takeaway as well, like, you can physically take something back. That way I can revisit it, and, because, for me, I need the, like tangible reminders like this, hold something or see something. And, as a parent, I've, I've noticed that I need to put things around the house to remind me to appreciate the moment, or to breathe, or to, you know, just the little reminders. So to have that paperwork to take home is a reminder for me."

Educational	Parents express that they found the program to be educational or that they learned something new.	14	"We came up with strategies, you know, like what things stress me, what I can do to prevent the stress, and what things can I do going forward to manage my stress,"
Weaknesses			
Program Length	Parents express a preference for the program or its sessions to be longer	6	"I wish that the sessions had been a little bit longer. I felt like just like when we were kind of getting into the flow of having a good discussion, it was like, time to end it for that day."
Research Component	Parent express discomfort or unease with the research or interview aspects of the program	2	"I guess the thing that I liked the least was personally, my own connection issues with the first survey. But that didn't have anything to do with the program [laugh]. So, that was the only part. Like, the surveys took longer than I expected, but that was because I went to a park and I had no internet. So that, that was the only part that I think that I liked the least."
Barriers			
Implementing "in the moment"	Parents express difficulty in implementing the strategies provided by the program or using them effectively in real-time situations	3	"It's just when you get stressed, you forget all of, all of, all of what you have learned."
Feasibility	Parents identify specific barriers that hinder their ability to complete program sessions, including factors such as unavailable childcare, time	4	"One of the weeks, the barrier was that the childcare was not available for my children, so I had to try to zoom in and that definitely was not as valuable, I didn't feel as connected to the group."

	constraints, or distractions during sessions		
Suggestions for Improvement			
Program Structure	Parents suggest increasing the length of sessions or adding additional topics to the current program.	7	“It did really give me like, a longing for more, though, because once we ended at the four weeks, I was like, "Oh, I really would like to go another four weeks." That was the only thing that I was like, "I really feel like this could go a little longer."
Family Involvement	Parent suggest adding a section or activities aimed at involving family members and children in the program	2	“If there's the, uh, there's an ability to maybe do like a family thing on, in a section of it. I think that would do good, too. I think that'd be my only suggestion is, like, maybe put one section of it that it's for the family to sit together with.”
Concrete Takeaways	Parents suggest providing additional physical resources that can be used after completing the program.	5	“Other takeaways, I guess, to have more physical takeaways.”

Table 6. *Qualitative Feedback Provided by Early Head Start Family Advocates.*

Themes Codes	Definition	Number of Transcripts with Code (*N* = 7)	Example Quote
Strengths			
Feasibility	Family Advocates express that the program was well-suited to their existing home visit schedule and did not add any undue burden or inconvenience	4	"I just told 'em about the wellness program and asked them if they would like to explore the topic of improving their wellbeing and strategies for reducing their levels of stress, and they said yes. So, it was easy… around the middle or towards the end of the visit, I would reserve about 15 minutes with them to talk about their wellness and, um, the topic for the day.
Communication & Relationship	Family Advocates express approval or appreciation for the program's role in facilitating new and meaningful conversations, either with the families they serve or other advocates	3	"I just put a high emphasis on mental health, and I think there's like a huge mental load and stress on families, and moms, and parents and, um, it [the program] just kind of helps like ease into that conversation."
Concrete Resources	Family Advocates express enjoyment or appreciation that they were able to provide families with physical handouts and materials as part of the program	2	"It was nice to be able to give them something that they can use…. I like the apps, the resources for the different apps. I really, really like that."

Educational	Family Advocates express that the program was educational for families, and they were learning from it	7	"I saw the parents. They were engaged, and they were really interested. And when, even when I remind them now about some of the strategies, I feel like they are really interested, you know, to include it in their daily life"
Weaknesses			
Difficult Subjects	Family Advocates express discomfort or unease with the topics that emerged when working through materials	2	"Sometimes parents express, um, some, I guess levels of feeling kind of hopeless, or negative or, as though maybe there wasn't anything else that could, could help them or their situation. Those times were hard to kinda sit through until you got to a place where you could interject and come back to the wellness and wellbeing, you know."
Material Comprehension	Family Advocates express finding some of the material a bit confusing or difficult to explain	1	"I have to be honest, because at first I had to study it. I had to go through the whole material, I had to go through the book, the handouts, because, when I talk to the families about it, I wanna make sure that I introduce it in a way that's.. I don't scare the families you know, I don't wanna make them feel like, 'Okay, you know, this is way too much.'"
Barriers			
Home Environment	Family advocates express that distractions in the home environment made it difficult to deliver program materials	3	"The only thing is, children require attention. So you have to just learn how to patiently, get back to the conversation. But the children are first, so meeting their needs and making sure they're, uh, comfortable. Mom tries to have a

			conversation with someone, that's an ongoing challenge.”
Missed Visits	Family advocates express that parents cancelling visits made it difficult to deliver program materials	3	“And then battling like, cancelled visits, and then having to go back like two or three weeks and be like, "Hey, like, do you remember what we talked about?"”
Suggestions for Improvement			
Concrete Resources	Family Advocates suggest alterations to existing materials or the inclusion of additional physical resources for families	2	“If I could get the four handouts on half size sheets. Smaller papers or type things seem to work well for the families. And…maybe just having the tip sheets printed on nicer looking paper, like they could refer back to.”
Program Structure	Family Advocates suggest increasing the length of sessions or adding additional topics to the current program	2	“Maybe extending the second section, but other than that I think it was awesome. “
Supervision	Family Advocates suggest incorporating a peer check in or supervision component to program delivery	1	“I wish I would have that information on how the others were dealing with it. So I would get a, you know, we would all kind of like come back in the middle, see how it goes, what's working, what's not working earlier.”