

IT TAKES A VILLAGE: EVALUATING THE FEASIBILITY AND ACCEPTABILITY OF A COMMUNITY-BASED PARENTING PROGRAM

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Abstract

Background: A community-academic partnership responded to a community-voiced need to address parenting challenges while living in poverty.

Purpose: To evaluate the feasibility and acceptability of a community-based intervention that included positive parenting strategies to build and support healthy families, and behavioral health promotion.

Design: Multi-method pilot study

Findings: Focus group participants (n=11) valued the program highly. There were no changes in participants' (n=36) Perceived Stress Scale scores after program completion ($p>0.05$, $d=0.063$).

Conclusions: Participants were highly engaged throughout the program and requested a longer duration of the intervention to continue to build social connectivity.

Keywords: Community Health Nursing; Community Partnership; Parenting Education; Collaboration; Social Capital; Health Promotion

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The National Center for Children in Poverty (2018) estimates that 15 million, or 21%, of children in the United States live in poverty. Although this estimate, based on the

Federal Poverty Level (FPL), significantly underestimates the income needed to meet daily needs. Taking that measure into consideration, 43% of children live in low-income households (National Center for Children in Poverty, 2018). The effects of poverty as experienced by children are extensive. Early childhood developmental researchers report that poverty is linked to lags in childhood brain development in the frontal and temporal lobes which are the structures correlated with school readiness skills (Hair et al., 2015; S. B. Johnson et al., 2016). Childhood stressors, including living in poverty, increase children's vulnerability to gene-environment interactions that modify behavior, development, and health across the lifespan (Cree et al., 2018; Shonkoff et al., 2012). In their youth, these children can present difficulties with attention, impulse control, regard for authority, and peer relationships (Mazza et al., 2016). As adults, they experience lower educational attainment and economic prosperity, poorer mental and physical health status, and shorter lifespans (Evans & Cassells, 2014; Flaherty et al., 2006).

There are two primary mechanisms by which poverty shapes childhood outcomes (Chaudry & Wimer, 2016). A pervasive lack of basic resources (such as nutrient-dense food, safe and consistent housing, and accessible health care), often referred to as "material resources," have been associated with worse mental, behavioral, and developmental outcomes in children (Chaudry & Wimer, 2016; Evans & Cassells, 2014; Hair et al., 2015; S. B. Johnson et al., 2016). Additionally, parental stress, due to lack of income to meet basic expenses and garner material resources, may reduce parents' ability to develop and maintain nurturing relationships with their children (Yoshikawa et al., 2012). These nurturing relationships are foundational to optimal mental, behavioral, and physical health development of children (Chaudry & Wimer, 2016; Hair et al., 2015; S. B. Johnson et al., 2016).

The Family Stress Model (K. J. Conger et al., 2000; R. D. Conger et al., 2002, 2010; Masarik & Conger, 2017) details how economic hardship leads to multiple family stressors which may create ineffective parenting practices resulting in physical, social-

emotional, and cognitive effects on youth. When combined with poverty, harsh parenting practices, identified as shouting, expressing annoyance/hostility, slapping/spanking, or scolding the child, create poor physical and behavioral health outcomes in children (Masarik & Conger, 2017; Shelleby, 2018). Further, children exposed to financial hardship and harsh parenting practices are more likely to suffer from physical and mental health challenges across their lifespan (R. D. Conger et al., 2002).

Health promotion programs that support many family structures living in poverty may assist individuals to become successful parents and increase their capacity for health, including behavioral health (Masarik & Conger, 2017; Morris et al., 2017). Group-based parenting programs that included components to strengthen parents' social support have been associated with statistically significant improvements in parental mental health (Barlow et al., 2012). Parents with greater psychosocial well-being, in turn, have a greater capacity to respond to children's physical and psychosocial needs (Council on Community Pediatrics, 2016). Therefore, there is considerable promise for interventions developed to foster parental mental health to also promote the physical, social-emotional, and cognitive health of youth, and thereby to bolster the health of future generations (Barlow et al., 2012).

The curriculum evaluated in this article aimed to promote individual, family, and community health and wellness among urban-dwelling adults. Community and academic partners developed the program to address recurrent community-voiced concerns about limited resources to address the challenges of parenting while living in poverty (City of Milwaukee Health Department, 2016).

The purpose of this pilot study was to determine the feasibility and acceptability of engaging community members in a multi-component program, delivered by an interprofessional team, to lessen the perceived stress of parents living in poverty and increased feelings of social connectivity.

MATERIALS AND METHODS

The total sample for the feasibility study was derived from three consecutive, non-overlapping community cohorts. For each cohort, the intervention and data collection procedures consisted of three phases:

- Phase I: Participants completed a baseline demographic survey and the Perceived Stress Scale (PSS) questionnaire (Cohen et al., 1983).
- Phase II: Participants attended the 8-session intervention and completed formative evaluations after each session.
- Phase III: Participants repeated the PSS (Cohen et al., 1983) after the eighth session.

In Phase IV, all participants were invited to attend a focus group to share their perceptions of the program and offer suggestions for improvements. The study team facilitated the post-intervention focus group. The following sections explicate the methodological details of the mixed-methods pilot study.

PARTNERSHIP STRUCTURE

This project was a collaboration among a faith-based community center, a college of nursing, and a behavioral health consultant, to develop a parenting intervention to increase the mental health and social capacity of community-dwelling adults. Integral to the project's success was the creation of an interdisciplinary and multi-sector team representing distinct areas of expertise and interests. Each member identified and served a distinct role in co-creating and delivering the program's content.

Faith-based Community Center

A concerned Capuchin brother, Brother Booker Ashe, opened a faith-based community center in response to the overwhelming needs of the African American community following the race riots in Milwaukee in 1966 (Capuchin Community Services, 2019). He used servant leadership principles to empower the community to harness their strengths to support each other during financial, emotional, spiritual, and interpersonal challenges. Their commitment to personal and community growth sustained the center.

Today the community center continues to be supported by the Capuchin friars of the Province of Saint Joseph, whose mission is to “feed the hungry, clothe the naked, help the spiritually infirm, and heal the sick” (Capuchin Community Services, 2019). There is an on-site food pantry that provides food for people who qualify financially for assistance, and a clothing closet that provides new and gently used clothing, with an area of small household goods for anyone who asks. Community center staff and volunteers offer community-based programs and free legal services (Capuchin Community Services, 2019).

University of Wisconsin-Milwaukee College of Nursing

Nearly 30 years ago, the University of Wisconsin-Milwaukee college of nursing partnered with the Capuchin Community Center to create an on-site nurse-led health clinic. In 1991, nursing faculty and students began providing health information, referrals to community resources, and nurse case management services, along with health promotion programs (House of Peace Community Nursing Center, n.d.).

Behavioral Health Consultant

A behavioral health consultant with 25 years of experience providing direct psychotherapy services across the lifespan, specializing in the treatment of significant trauma; adjustment, anxiety, and mood-related challenges; self-esteem and chronic and persistent mental health issues; eating disorders; and grief counseling; contributed significantly to the development and delivery of the program’s content. The consultant directed the Behavioral Health Department in a free clinic in the community center’s neighborhood, which provided free counseling services for community residents with behavioral health needs. The collaborative services expanded through the project. All participants were provided with the opportunity for free individual counseling services.

In 2016, leaders from the community center, community advisory board members, representatives from the college of nursing, and the behavioral health consultant

identified funding opportunities to address community-voiced needs. Their discussions culminated in a vision for community-based programs to support families and improve their holistic health by increasing self, family, and community sustainability. They envisioned a series of programs, beginning with addressing the challenges of parenting while living in poverty. They named the constellation of programs *Advancing the Village* after the African proverb, “It takes a village to raise a child.” This proverb aptly conveys that all people in the community share a collective responsibility to raise the village children.

PROCEDURE

Recruitment

Participants were recruited through flyers and word of mouth to patrons visiting the faith-based community organization, other community-based organizations, and churches, as well as announcements in free papers. The program offered incentives such as bus tickets, free on-site childcare during the sessions, and a meal at every session. To be eligible for the program, an individual needed to self-identify as a “parenting adult,” having an active role in mentoring and/or caregiving for youth, regardless whether those youth were biologically related to them and/or living within their household. We chose these broad eligibility criteria based on the premise of the program: *It takes a village to raise a child*. It is also consistent with historically African American cultural and family values of intergenerational kinship (non-blood relatives) and multigenerational families (Waites, 2009). The academic’s institutional review board approved and provided oversight for the study.

Intervention

The Village program included three components: (1) positive parenting strategies to build and support healthy families; (2) behavioral health support for parenting adults; and (3) health promotion information. An interprofessional team of nurses, a social worker, a psychologist, a community health worker, and undergraduate nursing and graduate family counseling students led the classes. The community-based

interprofessional team developed an eight-week curriculum designed to address the challenges of parenting while living in poverty. Semi-structured 90-minute classes held at the community center allowed content to be tailored to the expressed needs of the community members, which were elicited by the interprofessional team during each class.

To build a sense of social connectivity among the participants, the meal shared by participants was based on recipes from *Good and Cheap: Eat Well on \$4/Day* (Brown, 2015), a cookbook designed to help supplemental nutrition assistance program (SNAP) recipients maximize their nutrition (United States Department of Agriculture Food and Nutrition Service, 2019). While participants ate their meal, they watched the interprofessional team portray examples of community parenting in skits staged on a house porch, which was built for the program. The skits reflected a time when neighbors sat on porches and collectively watched and provided guidance to neighborhood children. The skits offered examples of positive parenting in the midst of multiple stressors such as raising small children while going to school and working, how to manage numerous financial demands on a low income, and navigating challenging interpersonal relationships. Participants debriefed after each skit, engaging in dialogic thinking by sharing their parenting experiences and strategies, and appreciating different viewpoints (Davis & Arend, 2012). The team intentionally threaded the dialogues through subsequent class content. The debriefing sessions and sharing a meal were included in the curriculum to provide an opportunity for the development of shared values and understandings, to build trust, and to foster community identity. As part of the last session, participants received a certificate of completion, a \$25 grocery store gift card, and the cookbook, *Good and Cheap: Eat Well on \$4/Day* (Brown, 2015). Figure 1 displays the session title, agenda, and facilitators of activities.

Figure 1. Program Agenda, Session Title, and Facilitator

Program Agenda	
Session Schedule	Facilitator
10:00- Opening Prayer- Peace Prayer of St. Francis of Assisi	Nurse
10:05- Mindfulness Exercise	Psychologist or graduate family counseling student
10:15- Class Topic	See topics and facilitators below
10:45- Weekly goal setting	Village team and Participants
11:00- Porch Skit with “Mom” sayings	Village team
11:10- “Feed Yo’ Self” (buffet food line); How we “feed” ourselves; “Take one, leave one”	Village team and Participants Participants wrote parenting advice and encouraging words on cards to share with other Participants
11:25- Closing Prayer	Participant led
11:30- Class Evaluation Form	Nurse
Session Topics	Facilitator
Welcome to the Village	DNP, FNP-BC, RN
Feed Yo’ Self - Coping with Stress	BSN, RN
When life gives you lemons	BSW
I can do this!	BSN, RN
Healthy Nutrition for Families	CHW and Undergraduate nursing students
Positive Parenting	CHW and Undergraduate nursing students
Mind-Body Connection	PhD, LPC, LCPC
Ain't I a Woman/Man?	BSW

Note. *DNP* = Doctor of Nursing Practice, *FNP-BC* = Board Certified Family Nurse Practitioner, *RN* = Registered Nurse, *BSN* = Bachelor of Nursing Science, *BSW* = Bachelor of Social Work, *CHW* = Community Health Worker, *LPC* = Licensed Professional Counselor, *LCPC* = Licensed Clinical Professional Counselor

MEASURES

Formative Class Evaluation

After each class, participants completed a seven-question formative class evaluation survey using a Likert-type scale of 1 (disagree) to 5 (agree). The formative evaluation was designed to ascertain the relevance of the session content to the participants and to provide evaluative feedback each week. The Village team used the class evaluations to monitor learning and adapt content to the expressed needs of the participants.

Perceived Stress Scale

The PSS (Cohen et al., 1983) was administered at the first and last sessions of the eight-week series to measure differences in perceived stress. If a participant did not attend the first or last session, they did not have the opportunity to complete the tool. The 10-item PSS was designed to indicate the degree to which respondents perceived their lives as stressful over the last month. Items include, “In the last month, how often have you felt you were unable to control the important things in your life?” and, “In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?” (Cohen et al., 1983). In the original study, the PSS indicated good internal consistency, with a Chronbach’s alpha of 0.84. Across multiple studies, the PSS 10-item Cronbach’s alpha ranged from 0.74 to 0.91 (Lee, 2012). The criterion validity of the PSS was strongly correlated in the predicted way with the Short form-36 mental health component of health status (Lee, 2012).

ANALYSIS

Quantitative

We analyzed data as a total group, using descriptive statistics to summarize demographic and formative session evaluation data and a paired-sample *t*-test to compare the pre- and post-intervention PSS (Cohen et al., 1983) scores.

Qualitative

All participants in *The Village* programs were invited to participate in a single focus group in May 2017 to share their experiences, to inform the development of other programs in the series. The focus group provided summative evaluation of the program. The data were gathered using a semi-structured discussion guide (Figure 2.) The focus group was recorded and professionally transcribed with identifiers removed.

Figure 2. Participant Focus Group Semi-Structured Discussion Guide

1. Please go around the room and state how you found out about *The Village* parenting classes.
2. Think back to when you first became involved with the program. What were your first impressions?
3. What part(s) of the class was/were most and least beneficial for you to be a better parent?
4. In what way is your life different because of your participation in the program?
5. Suppose that you were in charge and could make one change that would make the program better. What would you do?
6. Of all the things we discussed, what to you is the most important?
7. Have we missed anything you wanted to share today?

The data were managed using NVivo qualitative analysis software version 12. A qualitative thematic analysis approach was used to identify, analyze, and describe patterns in the data (Ritchie et al., 2013). In the first step, a line-by-line review of the transcripts identified patterns from the participant discussions. Preliminarily identified patterns were listed using direct quotes and paraphrasing common perceptions. The line-by-line review of the data continued to group the dialogue within the pattern to which it corresponded. The review of the transcripts and patterns continued iteratively to combine fragments, concepts, and experiences into representative themes. Discussions of the themes and supporting text continued among the authors until consensus was reached. Ultimately, six themes were identified (Ritchie et al., 2013).

RESULTS

Quantitative

Thirty-six participants engaged in the program. The majority of participants were Black/African American (86%) women (89%) ranging in age from 40 to 64 years old (75%). Mean household size was 2.7 people ($SD = 1.8$). Mean household income was \$10,383

($SD = \$8,736$), which is between 45% and 63% of the federal poverty level. Figure 3 displays additional participant characteristics.

Figure 3. Participant Characteristics (n=36)

Characteristic	N (%)
Gender	
Female	32 (89%)
Male	4 (11%)
Age	
13-19	0 (0%)
20-39	5 (14%)
40-64	27 (75%)
65+	4 (11%)
Race	
Black/African American	31 (86%)
White	2 (6%)
More than 1 race	2 (6%)
Native American	1 (3%)
Ethnicity	
Non-Hispanic	34 (94%)
Hispanic	2 (6%)
Household Size (n= 33)	$M = 2.7$ $SD = 1.8$
Household Income (n= 28)	$M = \$10,383$ $SD = \$8,736$

Participants completed a total of 130 formative class evaluations. Overall, participants reported that *The Village* program was highly valued. Over 95% of participants (N=36) “Agreed” (1=Disagree to 5=Agree) with the following statements: (1) I like the way the class was taught; (2) The presenter knew the information well; (3) The info increased my knowledge about the topic; (4) The class was organized and had helpful materials; (5) I can apply this information in my life; and (6) I can explain what I learned to others.

The PSS (Cohen et al., 1983) was administered at the first and last sessions. The average score on the PSS at the first session (n=26) aligned with a high level of psychosocial stress ($M=20.15$, $SD=6.93$). Of the participants who attended the eighth session (n=14), the average PSS score continued to reflect a high level of psychological stress ($M=19.71$, $SD=7.08$), $F(1, 13)=1.452$, $p > 0.05$, $d=0.063$.

Qualitative: Focus Group Themes

Eleven African American participants (nine women and two men) participated in the focus group. Participants' experiences with and recommendations for *The Village* program were grouped in six themes derived from direct quotes: Balance out my life; The village made me change my life; They're looking through the window; The village could help them; It's gonna be all right, and Help the whole village out.

Balance out My Life. Participants reported that the application of program content improved their ability to engage in self-care activities. Many reported the incorporation of behavioral health strategies to reduce stress and set boundaries that allowed for the application of techniques taught in class. When asked how their life was different because of participation in the program, a participant offered,

I was so overwhelmed when I came... The group really helped me balance out my life. I learned how to say no. When I'm going through stressful stages in my life, I remember what I was taught here, so I started meditating in the morning and just starting relaxing.

One participant who identified as a grandmother stated, "I tell everybody this today, 'Look, I'm taking care of me. I got to be for me.'"

The Village Made Me Change My Life. Participants indicated how *The Village* program content brought to light previously unrecognized perceptions, attitudes, and anger. One woman said, "I was a young parent and as I'm learning, and I was sitting here reading, I'm like, Oh, that's why I was so angry. Oh, oh, oh, oh." The insight led to further reflection and changed the way this participant communicated with others. She expanded, "I've changed my attitude, and I don't argue with nobody, and if people are mad at me I'm going to walk away. *The Village* made me change my life." Others discussed how their interpersonal communication changed by being more empathetic with others. One woman reflected on the program's teachings: "We learned how to think first and then say something uplifting to that person, because you never know

what a person is going through.”

They’re Looking through the Window. A clear theme emerged when participants were asked what they would change to improve the program. All participants recommended that *The Village* extend beyond the eight-week curriculum. They identified multiple reasons for a continuous program, but most frequent were the enduring need to connect with others and apply behavioral health skills taught in class. A woman stated, “We don’t have too many social outlets, and I think here is like a village, a family. I think that after the [*Village* is over], the people, they want to come back. They’re looking through the window.” A man shared, “I want to keep on getting this information so I can apply it to my everyday life and keep moving on...We should be able to come back as many times as it takes to stay on our feet.” A participant who was a single father summarized, “I need the groups. I need it to better me, to keep going.”

The Village program intentionally recruited adults who identified as having a mentoring or caregiving role for youth, but most participants were middle-aged or older adults. The community partner’s director hypothesized that afternoon sessions might attract younger parents, since they typically come to the community center after 1 pm. When the researchers asked the participants if there were other ideas they wanted to share, a lengthy discussion ensued about how future *Village* programs could recruit and retain younger parents. Participants also offered specific advice to younger parents.

The Village Could Help Them. Village participants offered the interprofessional team advice on how to recruit and retain younger parents.

The Village is only given one day a week? Okay, so, what about two times in that day, if it's possible? A morning group for people who can come in the morning, and then an afternoon group.

If you put out a survey to some of the younger parents here, who come through the food pantry, or whatever program, and then find out would they be willing to come, you'll know what their needs are.

Once you find out what their needs are, and then they know that you're gonna' provide some information of how to get the things that they need, whether it be clothes, or furniture, or a job, or how to get into school, you know, as long as you're giving them something like that, they'll come.

The focus group participants' comments validated the need for parenting programs for younger parents.

A lot of these young people have anger issues, and they're angry. I was thinking that *The Village* could help them. These are really important issues because that would end up helping them go on to being a better parent, a better person.

A grandmother offered that the non-judgmental approach and welcoming atmosphere of the class would benefit younger parents. She remarked,

These kids, they don't want to hear the screaming and the hollering and the put-downs. They want to hear some encouragement. That's what *The Village* might be able to help these kids with - all these young kids. When they find out that you're not pointing the finger or judgment, whatever, then they'll open up better.

A scene from a skit resonated with one grandmother. She expressed, "In the Porch [skit] the young lady would come with her baby, and she was so stressed out, and she didn't have a babysitter and stuff, and I'm like, Wow, that's my daughter right there."

It's Gonna Be All Right. A majority of participants described the advice they have shared or could share with younger parents. One grandmother shared how she would mentor a young mother:

If I see a young person with an issue ... I say, "You know, baby girl, come on now. It's gonna be all right. Come on now, let me give you some information that will help you out in the situation you're in, because someone helped me out." So, with me, I talk to some of the young ladies on the bus, and I just talk to them.

A grandmother suggested that young parents lack the financial skills to buy necessities with limited resources; she hypothetically questioned, "If you've got \$20, you've got to buy the baby some diapers, and you've got to buy some food, what do you do and stuff?" Another participant suggested, "Take the big old sack of Lil' Ray-Ray clothes, take it to the consignment, and then you get some clothes for him, do an even swap." An older female participant added, "They need someone just to keep guiding them and sit and listening to them, even if you don't agree with them." One participant summed up the value for younger parents with this reflection, "[*The Village*] teaches them positive things, keeps them away from the negative."

Help The Whole Village Out. As the focus group neared the end, participants across age groups and genders shared a holistic view of the benefits of *The Village* program. . A single father described the value of the program continuing: "It should be like broadening people, like motivating people and networking people with information that can help the whole Village out." They expressed how continued learning and application of the health promotion content would serve to better the community. "All kinds of things are out there, to help you stay healthy, so you can become a productive voice in the community." A concluding remark from a participant summarized the benefit and need of the program, "It takes a village, you know, like the concept of this group, and we've just been missing in that part, to share."

DISCUSSION

Advancing the Village, commonly referred to by participants as '*The Village*,' addressed the expressed needs of the community within a holistic framework in the development of classes for adults to support the physical, mental, social, economic, and spiritual

aspects of the participants' lives. The mixed-methods pilot study used to evaluate *The Village* community parenting curriculum supports the value of including multiple methods of inquiry to understand how the multi-component program influenced the perceived stress of parents living in poverty and feelings of social connectivity. The quantitative approach provided data using a standardized instrument and presented it in a succinct and economical way (Yilmaz, 2013). A shortcoming of this method is the a priori phenomenon of interest, perceived stress, may fail to provide an understanding of the participants' individual or personal experiences. A qualitative focus group provided the participants with the opportunity to describe their experiences beyond the phenomenon of perceived stress. By combining quantitative and qualitative methods, the study drew on the strengths and mitigated the weaknesses of each methodology (Creswell et al., 2011).

After completing the eight sessions, program participants' high level of perceived stress, as measured by the PSS (Cohen), remained heightened. The quantitative measure did not show change, but the qualitative data illuminated how the participants applied stress reduction techniques taught in class (e.g., meditation, guided imagery) to cope with life's stressors. The participants shared how their self-management behaviors changed as a result of the program, within the context of their low economic status. With these qualitative data, we learned that participants' coping, defined as the process of managing complex demands that place pressure on or overtake the resources of a person (Folkman & Moskowitz, 2000), with the effects of poverty did change. Without the qualitative data, the beneficial outcomes of *The Village* would have remained hidden.

The results from this pilot study also indicate that a program focused on wellness and self-care for the whole person has the potential for sustained benefits in the lives of parents and children. In line with recommendations of previous research (Holt et al., 2018; Liu et al., 2018), the results of the evaluation affirm the need for community-based programs that improve the social capital of community members. Social capital

is defined as resources accessed through networks and relationships, which are essential to individuals, families, and communities to achieve their objectives (Lin, 2002). The focus group data demonstrated that *The Village* participants valued the new relationships and connections the class afforded them. For some participants, *The Village* program was the first safe place to discuss long-standing feelings of anger and social isolation related to parenting with few economic resources. Offering the class in a trusted community-based setting with a co-located nurse-managed health center may further impact the health of this community's youth by connecting parents to health care and other resources which may be difficult to access due to the complexities of living in poverty (Cree et al., 2018).

Limitations

There are several limitations to this pilot study. The duration of the program may have limited the ability to detect the benefits (e.g., lower levels of perceived stress) of *The Village* content. *The Village* program was delivered within the most racially segregated metropolitan area in the United States, where racial and economic disparities represent a significant public health concern (City of Milwaukee Health Department, 2016; County Health Rankings & Roadmaps, 2019; Vila et al., 2007). Therefore, the experiences of *The Village* participants may not be representative of or generalizable to other communities. Furthermore, a low number of participants completed all eight sessions, despite employing recommended retention strategies (Robinson et al., 2011), community involvement, weekly reminders, monetary and non-monetary incentives, and free childcare.

Implications for Practice and Research

High levels of stress and poor mental health are closely linked with the pervasive effects of poverty (e.g., insecurity around food, housing, and finances). These adverse effects directly and deleteriously impact the psychosocial health of parents and children (J. G. Johnson et al., 1999). *The Village* established a framework for community-driven program development that addressed community-voiced needs and values. Although

participants reported applying stress reduction techniques demonstrated in class to real-life situations, they did not experience a reduction in perceived stress after eight weeks of the program, as measured by the PSS (Cohen et al., 1983). However, the data from the focus group suggests participants' knowledge, behavior, and attitudes changed after the program.

The quantitative and qualitative data underscore the need for continued social connection and mindfulness programming. Based on the results of this mixed-method pilot study, the academic and community organizations continue to provide programs that optimize community strengths and diminish the challenges faced by individuals and families. An exemplary new program is Coffee, Tea & Me - Affirmations for Change. The group meets on a weekly basis for consistency and is kept small (8 to 12 participants) to help facilitate a safe place to share reflections, experiences, and opinions. A registered nurse and a licensed behavioral counselor facilitate the group using cognitive behavioral therapy (CBT), to assist community members in reframing and changing their thoughts, to incorporate ways to effectively change various unwanted behaviors (Butler et al., 2006; Santiago et al., 2013). The topics discussed are selected by participant-voiced issues and challenges related to spiritual, emotional, intellectual, physical, social, environmental, and financial wellness.

Decades of research on families and parenting recognize the influence of poverty on parental stress and children's health (Masarik & Conger, 2017). The Family Stress Model substantiates that interventions that promote optimism among parents (Taylor et al., 2012), foster familial values (White et al., 2015), help parents deal with feelings of hostility and anger (Masarik et al., 2016), and galvanize neighborhood support (Krishnakumar et al., 2014) lead to healthy parenting practices. Partnerships among academic institutions, community organizations, and community members, such as the partnership that developed *The Village* program, can aptly respond to the community-voiced need for positive parenting programs. A key insight gleaned from this evaluation

was that *The Village* tapped a previously unrecognized value for structured social interaction and sharing among those interested in community parenting strategies.

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