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Infant-toddler teachers' early adversity, current wellbeing, and engaged support of early learning☆

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ABSTRACT

The purpose of this study was to examine the psychological wellbeing of infant-toddler child care teachers in a mid-Atlantic city (n = 160; 69% African American, 98% women) and to explore associations with teaching intentions and quality. Using survey measures and classroom observations, we tested associations between teachers' adverse childhood experiences (ACEs), depressive symptoms, work-related wellbeing (i.e., perceived organizational functioning and workload), intentions to continue teaching, and teaching quality. We found that infant-toddler teachers experienced similar levels of ACEs to Early Childhood Education (ECE) teachers in other studies. However, rates of depressive symptoms were relatively high in this sample (27% scored in the clinical range). Both ACEs and depressive symptoms were associated with teachers' work-related wellbeing. Notably, individual-level ACEs (e.g., household dysfunction and abuse) were associated with depressive symptoms and organizational wellbeing, whereas community ACEs (e.g., neighborhood safety) were not. Organizational wellbeing was significantly and positively associated with the number of years that infant-toddler teachers intended to continue working at their child care centers. Multilevel regression models indicated that community-level ACEs and current depressive symptoms were significantly associated with teachers' engaged support for toddlers' learning. When knowledge of child development was added to the model, depressive symptoms were no longer uniquely associated with engaged support for learning. However, community-level ACEs remained a significant correlate. These findings show that infant and toddler teachers may need more resources to support their psychological wellbeing so that they can support children in the classroom.

1. Introduction

Over 11 million children under age 3 attend weekly child care in the United States (Center for Economic Development, 2019). Early care and education (ECE) teachers play an essential role in the U.S. economy, caring for children so that parents can work outside their homes and preparing children with the academic and social skills they need to thrive in school and in the workforce (Center for Economic Development, 2019). However, ECE teachers are severely underpaid and under-supported. They often earn low wages, have low levels of education, lack job-related insurance benefits, and are frequently enrolled in public support programs like Medicaid (Gould, 2015; U.S. Bureau of Labor Statistics, 2021).

In addition, the individuals who seek employment in the ECE field are often from populations that already experience greater stress and fewer economic opportunities than the general public. For example, almost all ECE teachers are women; and compared with workers in other professions, a greater proportion of ECE teachers are African American and Hispanic (Gould, 2015; Lessard, Wilkins, Rose-Malm, & Mazzocchi, 2020). ECE teachers also have higher levels of trauma and depressive symptoms and lower wellbeing than elementary school teachers (Hubel et al., 2020; Lessard et al., 2020; Whitaker et al., 2014).

As a result of the psychological and contextual challenges that face the ECE workforce, there is burgeoning research on ECE teacher wellbeing (e.g., Madill, Halle, Gebhart, & Shuey, 2018; Smith & Lawrence, 2019). Kwon, Malek, Horm, and Castle (2020) define teacher wellbeing as a multifaceted phenomenon that includes various aspects of physical, psychological, and professional wellbeing. Low levels of teacher wellbeing pose signif-

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icant challenges for the ECE field and the children they serve. ECE teacher wellbeing is a consistent predictor of teachers' intentions to stay in the child care workforce, the quality of their teaching, and their ability to benefit from professional development programs (Grant, Jeon, & Buettner, 2019; Hubel et al., 2020; Jeon, Kwon, & Choi, 2018; Kwon et al., 2020). Currently, ECE teachers are leaving the field in record numbers due to the poor wages and the lingering effects of the Covid-19 pandemic (Bassok, Markowitz, Bellows, & Sadowski, 2021).

This is a particular problem for ECE programs that serve infants and toddlers. A recent study of ECE teachers in Louisiana found that almost half (49%) of ECE teachers in toddler classrooms leave their jobs each year, whereas only 31% of preschool and 26% of elementary school teachers turnover (Bassok et al., 2021). Teachers in infant and toddler programs may be at particular risk for low levels of wellbeing because they are often viewed as babysitters who lack other professional skills (Kim & Reifel, 2010). As such, they enter the workforce with a lack of knowledge of infant and toddler pedagogy, and receive lower levels of pay, professional development, and professional recognition than preschool or school-age teachers (Gloeckler & La Paro, 2015; Kwon, Horm, & Amirault, 2021b). Despite evidence on the unique challenges facing the infant–toddler workforce, empirical attention to the wellbeing of this population is limited.

Low teacher wellbeing is a threat to ECE quality. Teachers with low wellbeing are less able to provide the warm, responsive, and engaging interactions that children need to develop foundational social-emotional and cognitive skills (Mashburn et al., 2008). Teachers who report low levels of wellbeing, past trauma, and depressive symptoms may have difficulty responding to young children in ways necessary to enhance their development. For example, experiences of past trauma are associated with lower quality socio-emotional classroom climates (Hubel et al., 2020). Additionally, depressive symptoms and burnout are associated with lower overall child care quality (Jeon, Buettner, & Snyder, 2014). Child care quality is associated with children's immediate and long-term social and academic outcomes (Vandell, Belsky, Burchinal, Steinberg, & Vandergrift, 2010; Yazejian et al., 2017). Further, Kwon et al. (2020) argue that low teacher wellbeing may have a particularly detrimental impact on the quality of care provided to infants and toddlers due to these children's intense need for sensitive and stable care, and their unique vulnerability to poor quality of care.

2. Theoretical background

Consistent with their definition of teacher wellbeing, Kwon, Ford, and Salvatore (2022) have proffered a conceptualization of "whole" teacher wellbeing that crosses physical, psychological, and professional domains. Physical wellbeing pertains to general physical health, work-related injuries, and the prevalence of physical health challenges such as ergonomic pain, obesity, and cardiorespiratory fitness. Their conceptualization of psychological wellbeing includes teachers' experiences of depression, stress, and adverse childhood experiences (ACEs). Finally, professional wellbeing relates to teachers' work commitment, self-efficacy, job-retention, and relationships with the children they serve. In a study empirically testing this conceptual framework, Kwon et al. (2021a) documented higher levels of professional wellbeing (i.e., work commitment, self-efficacy) among ECE teachers, but noted that many reported lower levels of psychological (e.g., perceived stress, depressive symptoms) and physical (e.g., ergonomic pain) wellbeing.

Teachers' wellbeing exerts a strong influence on their effectiveness in the classroom (Hall-Kenyon, Bullough, MacKay, & Marshall, 2014; Kwon et al., 2020). Thus, it is important to understand what factors contribute to or detract from teachers' wellbeing. In the Kwon et al. (2020; 2021a; 2022) conceptualization, factors related to the work environment and workplace supports are identified as major influences on teacher wellbeing. Such factors include work climate, compensation, benefits, the availability of breaks, job demands, and the physical environment. Additionally, the authors of this conceptual framework posit that the key elements of a high-quality early care and education workforce are teacher wellbeing, teacher stability, highly qualified teachers, and the resultant high-quality care that children experience. Although not relevant for the current study, this conceptual model further suggests that this high quality ECE workforce leads to positive child and family outcomes, as well as benefits for other staff, the child care settings, and the larger labor economy.

In the next section, we review existing research on the psychological and work-related factors that contribute to ECE teacher wellbeing, with a focus on infant and toddler teachers. We also describe research linking psychological and work-related factors with teacher and student outcomes.

3. Psychological elements of ECE teacher wellbeing

3.1. Adverse childhood experiences

Adverse childhood experiences (ACEs) include a range of events, prior to age 18, such as sexual and physical abuse, neglect, poverty, family conflict and caregiver psychopathology (Felitti et al., 1998). Early adversities increase lifetime risk for negative psychological and health outcomes by setting the stage for chronic stress and relational difficulties (Lampert et al., 2016). Individuals who experience maltreatment, separation from a caregiver, and general household dysfunction during childhood may suffer mental and physical consequences later in life. Experiences like child abuse and neglect are particularly potent because they may disrupt early attachment relationships with caregivers, making it difficult for individuals to form trusting and affectionate bonds with others, both in childhood and adulthood (Cicchetti & Doyle, 2016). These early traumatic experiences are linked to myriad negative psychosocial and health outcomes in adulthood (Chartier, Walker, & Naimark, 2010; Lansford et al., 2002).

Recently, community ACEs were added to the traditional scale of childhood adversities. Community ACEs include witnessing violence, perceived experiences of discrimination, feeling unsafe around or mistrusting of neighbors, being bullied, and living in foster care (Cronholm et al., 2015). Studies suggest that, on average, parents living in neighborhoods with high rates of crime and poverty use more punitive caregiving practices and benefit less from social support (e.g., Ceballo & McLoyd, 2002). Community-level adversities such as witnessing violence and experiencing discrimination are psychologically harmful. They are also thought to compound the effects of individual ACEs through increased stress and likelihood of exposure to such experiences (Karatekin & Hill, 2019). Further, individuals who grow up in communities with high levels of poverty, food insecurity, domestic violence, crime, and other social injustices, are more likely to experience personal adversity and toxic stress (Ellis & Dietz, 2017). Community-level adversities are also associated with mental and physical health problems in adulthood such as depressive symptoms and cardiovascular illness (Wade et al., 2016). Research shows that individuals exposed to 4 or more childhood adversities are at high risk for negative psychosocial and health outcomes (Anda et al., 2006; Chang, Jiang, Mkandarwire, & Shen, 2019).

Recent research shows that, in addition to their work-related stress, infant and toddler child care teachers are more likely to have experienced childhood adversities than the average U.S. worker (Hubel et al., 2020; Lessard et al., 2020; Whitaker et al.,

2014). Recent studies of ACEs among early educators show that between 22% and 24% have experienced high levels (e.g., 4 or more exposures) of childhood adversity (Hubel et al., 2020; Whitaker et al., 2014). In a study of Early Head Start (i.e., infant-toddler) teachers, Kwon et al. (2021a) reported that nearly a quarter experienced 4 or more ACEs.

3.2. Depression

Depression is a psychological condition which includes feelings of sadness, irritability, restlessness, emptiness, and difficulty concentrating (American Psychiatric Association, 2013). Recent studies estimate that approximately 24% to 33% of child care and Head Start teachers experience clinical levels of depression, whereas only 18% of the general population meets the clinical criteria (Linnan et al., 2017; Roberts, Gallagher, Daro, Iruka, & Sarver, 2019; Whitaker, Dearth-Wesley, & Gooze, 2015). Further, in their examination of infant-toddler teachers, Kwon et al. (2020) documented that approximately one third reported feeling stressed and 19% reported feeling depressed.

Mental health challenges such as depression affect teachers' ability to contend with stress and emotions in the classroom and are consistently associated with caregiving quality (Hamre & Pianta, 2004; Hubel et al., 2020; Kwon, Jeon, Jeon, & Castle, 2019; La Paro et al., 2009; Sandilos et al., 2015). Teacher depressive symptoms are a major problem in early childhood education, as they are associated with lower emotional support, lower cognitive stimulation, and poorer classroom quality (Hamre & Pianta, 2004; La Paro et al., 2009; Sandilos et al., 2015).

4. Work-related elements of ECE teacher wellbeing

Teachers' perceptions of work-related wellbeing (e.g., job satisfaction, stress, relationships with other staff, and perceived support) are important contributors to overall wellbeing, teaching quality, and occupational commitment (Klassen & Chiu, 2011; McMullen, Lee, McCormick, & Choi, 2020; Nislin et al., 2016; Rentzou, 2012). Teachers are most effective when they feel supported by their organizations, have positive interactions with staff and children, and feel their needs are met. Nislin et al. (2016) found that the quality of early childhood educators' relationships with other staff was the most salient predictor of their overall wellbeing. Having negative or strained working relationships is associated with burnout and other forms of stress, which may reduce the quality of ECE teaching (Rentzou, 2012).

Child care teachers typically report high job demands and long work hours (Linnan et al., 2017). Workload and job demands are also important work-related predictors of general wellbeing. Teachers are most effective when they feel they have enough time and resources to do their jobs well. For example, Whitaker et al. (2015) found that Head Start teachers' job demands were associated with their stress and depressive symptoms. In their study of ECE teacher wellbeing, Kwon et al. (2022) documented several issues with teachers' working conditions, including low wages, poor benefits, and compromised physical environments. The physical job demands were particularly acute for infant-toddler teachers because of the need to pick up children and physically assist the children with a variety of developmental tasks.

5. Consequences of low teacher wellbeing

5.1. Wellbeing and intentions to continue teaching

Teacher wellbeing is a consistent predictor of teachers' intentions to keep working at their current centers and to continue in the child care profession (Grant et al., 2019). Teacher turnover is a major problem in early childhood education. Approximately 27% of early childhood teachers and up to 49% of infant-toddler teachers leave their centers or the field each year (Bassok et al., 2021; National Survey of Early Care and Education Project Team, 2013). When one teacher quits, other teachers and administrators must shoulder their work and direct resources towards training a replacement, which may increase workplace stress and reduce wellbeing among other teachers at the center. High levels of stress, exhaustion, and relationship issues with other staff are considered key contributors to teachers' decisions to quit (Bullough, Hall-Kenyon, & MacKay, 2012). In a qualitative study of retention of infant-toddler teachers, Kwon et al. (2020) documented that teachers' intention to leave was related to: (1) the stressful nature of their work; (2) a negative work environment; (3) the need to change their career trajectories; (4) pay and benefits; and (5) personal reasons such as moving and spending time at home with children. These teachers identified many negative effects of teacher turnover but suggested that the impacts were worse for infants and toddlers due to their developmental need for attachment that derives from trusting, consistent caregiving relationships, and routines.

5.2. Wellbeing and child care quality

5.2.1. Adverse childhood experiences

Several studies have demonstrated a link between teachers' past trauma and child care quality (Hamre & Pianta, 2004; Hubel et al., 2020; Jeon et al., 2014). Although few studies have examined ACEs in relation to quality of care, the studies that do exist show that ACEs are associated with lower quality classroom interactions. Hubel et al. (2020) examined associations between early childhood teachers' scores on the individual ACEs scale and classroom social-emotional climate. Using multilevel modeling to estimate the relations between ACEs and classroom social-emotional climate scores, they showed that teachers who reported a higher number of ACEs had lower quality classroom social-emotional climates, controlling for class size.

5.2.2. Depression

Depression appears to be a consistent predictor of lower social-emotional support and sensitivity (Hamre & Pianta, 2004; Jeon et al., 2014; Kwon et al., 2019). For example, Jeon et al. (2014) examined associations between teacher depression, global child care quality, and 3-year-olds' behavior problems using data from the Fragile Families and Child Wellbeing Study. They found that teachers' depressive symptoms contributed to both global environmental child-care quality and child behavior problems, controlling for the type of child care setting. Path analyses indicated that the association between teacher depression and child behavior problems was partially mediated by child-care quality. Similarly, Hamre and Pianta (2004) found that family and center-based child care providers' self-reported depression was significantly and negatively associated with sensitivity and positive verbal interactions and positively associated with withdrawn and intrusive classroom interactions, controlling for caregiver's age and education. Depressed teachers' reduced sensitivity and responsiveness may also have negative consequences for children's social-emotional development. For example, Roberts, LoCasale-Crouch, Hamre, and DeCoster (2016) found that children in Head Start classrooms with more depressed teachers exhibited significantly lower growth in social-emotional skills across the school year.

Although several studies have explored relations between depressive symptoms and social-emotional aspects of classroom quality, few studies have documented relations between depressive

symptoms and other aspects of classroom quality. To the authors' knowledge, only one study has examined the association between depression and instructional quality in ECE classrooms. Sandilos et al. (2015) investigated associations between Head Start teachers' self-reported depressive symptoms and their scores on a classroom observation of emotional support, instructional support, and classroom organization. They found significant associations between depressive symptoms and classroom organization and instructional support. The authors posited that depressive symptoms might be associated with instructional aspects of teaching because depressive symptoms reduce teachers' energy and motivation. This is logical, as teaching in early childhood takes an enormous amount of energy and enthusiasm, and lethargy and hopelessness are hallmark features of depression. Although this study is helpful in elucidating the relation between depressive symptoms and instruction in teachers of preschool-age children, research is needed to determine whether depressive symptoms affect teachers' support for early learning in infant and toddler classrooms.

5.2.3. Work-related wellbeing

Infant and toddler child care teachers often face work-related stressors such as child behavior problems, long work hours, insufficient professional support, and limited control over their working conditions (Berlin, Shdaimah, Goodman, & Slopen, 2020). High job demands are associated with negative outcomes such as intentions to quit and low-quality parent-provider relationships (Berlin et al., 2020; Kwon et al., 2020; McMullen et al., 2020). Higher job demands are also associated with greater conflict in teacher-child relationships in Head Start classrooms (Whitaker et al., 2015). Teachers who report high levels of connectedness with other staff, better supervisor support, and more control over their work report lower stress and provide higher quality care and are less likely to leave their jobs (Cassidy, King, Wang, Lower, & Kintner-Duffy, 2017; McMullen et al., 2020). In a rare study of toddler teachers, Cassidy et al. (2017) found that professional wellbeing (i.e., autonomy in the work environment, fairness of salary) was related to classroom practices, specifically emotional support.

6. The current study

Although several studies have examined the relations between elementary school teacher wellbeing and classroom quality, ECE and child care teachers remain understudied, especially those in infant-toddler classrooms. In addition, previous research has mostly focused on current working conditions and depression symptoms as indicators of wellbeing. Very few studies have considered teachers' ACEs in relation to current wellbeing and teaching quality (e.g., Hamre & Pianta, 2004; Hubel et al., 2020). Those that have examined ACEs have not linked those experiences with current depressive symptoms, classroom quality, or teachers' intentions to stay in their current roles (Hubel et al., 2020). Further, there is some research that suggests that teachers in the Early Head Start setting may experience elevated physical and psychological demands due to the challenges of serving young children and families from backgrounds of higher adversity (Kwon et al., 2022).

Thus, the overarching goal of the current study was to examine associations between psychological and work-related wellbeing and to understand how wellbeing related to teachers' intentions to continue teaching and quality of classroom practice. We had 4 aims: (1) to describe the psychological wellbeing of infant-toddler child care teachers participating in an Early Head Start partnership in low-income urban centers in a mid-Atlantic city; (2) to determine whether past trauma (i.e., ACEs) were associated with teachers' current depressive symptoms and work-related wellbeing; (3) to examine associations between teachers' ACEs, depressive symptoms, work-related wellbeing, and intentions to continue working at their current child care centers; and (4) to investigate whether ACEs, depressive symptoms, or work-related wellbeing were associated with the quality of teachers' classroom interactions.

We hypothesized that: (1) teachers' levels of individual ACEs, community ACEs, and depressive symptoms would be higher than those found in typical adult populations and similar to those found in low-income parents; (2) teachers' individual and community ACEs would be positively associated with depressive symptom scores and negatively associated with work-related wellbeing; (3) teachers' ACEs and depressive symptoms would be negatively associated with work-related wellbeing, which in turn, would be positively related to intentions to continue teaching; and (4) teachers' individual and community ACEs and depressive symptoms would be negatively associated with the quality of emotional and behavioral support and engaged support for learning in infant-toddler classrooms.

Table 1
Demographics.

Variable	*n*	%
Gender (Female)	157	98
Age Range ($n = 158$)		
18–21	4	3
22–27	27	17
28–32	34	22
33–37	25	16
38–42	19	12
43–47	11	7
48–52	10	6
53–57	12	8
58–62	10	6
63 and older	6	4
Race/Ethnicity ($n = 158$)		
African American/African/Caribbean	119	75
Asian	5	3
Caucasian/White	4	2
Latinx	13	8
Other	17	11
Language Spoken at Home ($n = 159$)		
English	132	83
Spanish	19	12
Amharic/Ethiopian	4	3
Other	4	3
Highest Level of Education ($n = 155$)		
High School Diploma or GED	49	32
Some College/Technical School/Associate Degree	75	48
Bachelor's/Master's Degree	31	20
Child Development Associate or State Equivalent Certificate (Yes)		
Yes	113	71

7. Method

7.1. Participants

Participants included 160 infant-toddler teachers from 18 child care centers in an urban area (see Table 1). Approximately 52% ($n = 83$) of the sample were lead teachers, 43% ($n = 69$) were teacher assistants, 4% ($n = 7$) were teacher aides, and 1% ($n = 1$) held other positions in the classroom. The majority self-identified as African American (69%; $n = 109$) women (98%; $n = 157$) who spoke English at home (83%; $n = 132$). Participants' level of education varied with 32% ($n = 49$) having only a high school diploma or GED and 16% ($n = 25$) having a Bachelor's degree. Most teachers (71%; $n = 113$) had Child Development Associate credentials. The teachers in this study were drawn from child care centers participating in an Early Head Start - Child Care Partnership (EHS-CCP). EHS-CCPs are collaborations between EHS programs and community-

based child care providers. They are intended to expand access to high-quality early learning programs and comprehensive services for low-income infants and toddlers and their families. EHS-CCP funding covers the costs of materials, resources, and professional development needed for child care partners to meet EHS requirements and EHS grantees support and guide partnership centers. Thus, the teachers in this study likely received more professional development and support than typical infant-toddler teachers in community child care centers.

Most families at these centers (81%) had incomes below $40,000 per year, which is considered low-income for families in the Washington, D.C. area. Additionally, the EHS-CCP initiative was designed to address the needs of families from low-income backgrounds and requires that a percentage of the families served meet criteria for low-income designation, such as receipt of child care subsidies through the Child Care and Development Fund (Administration for Children and Families, n.d.).

7.2. Measures

7.2.1. Adverse childhood experiences

Teachers were asked about their childhood exposure to adversity using the Philadelphia version of the Adverse Childhood Experiences (ACEs) scale (The Research and Evaluation Group at PHMS, 2013). The ACEs measure asks teachers to report on childhood experiences with individual and community-level adversities. Individual ACE questions included 15 items related to psychological, physical, and sexual abuse, neglect, and household dysfunction. Community ACEs included 6 items relating to witnessing violence, experiencing discrimination, perceived lack of neighborhood safety and/or mistrust of neighbors, being bullied, and living in foster care. ACEs questions were scored according to guidelines by Wade et al. (2016). Responses were dichotomized into exposure (1 = *Yes) vs no exposure* (0 = *No;* see Table 3) to examine the prevalence of ACEs within the sample. The dichotomous variables were then used to create 14 ACE categories that examined different individual types of childhood adversity (1 = *Some Adversity*, 0 = *No Adversity*). Finally, to examine the co-occurring nature of ACEs, a total score was created by summing exposure to any of the 14 items with scores ranging from 0 to 14. For descriptive purposes, participants were grouped according to their individual and community ACE risk level (Individual Risk Categories: 0 ACEs, 1–3 ACEs, and 4+ ACEs; Community Risk Categories: 0 ACEs, 1–2 ACEs, and 3+ ACEs) based on cut-off scores used in past studies (Anda et al., 2006; Wade et al., 2016). In the current sample, the overall scale and individual ACEs scale had good internal consistency, Cronbach's α = .87 and .88, respectively. Internal consistency was lower for the community/expanded scales (.58), but still acceptable given the small number of items.

7.2.2. Depression

The Center for Epidemiologic Studies Depression Scale (CES-D) is a brief, widely used self-report scale designed to measure depressive symptoms in the general population (Radloff, 1977). The CES-D was used in this study to measure the frequency (0 = *rarely or never* to 3 = *most or all of the time*) of teachers' depressive symptoms (20 items; e.g., "You felt you could not shake off the blues, even with the help of your family and friends."). For descriptive purposes, participants were categorized as having "clinical" or "nonclinical" levels of depressive symptoms based on their CES-D total score (scores of 16 or more = clinical). The internal consistency in the current sample was also good (Cronbach's α =.88).

7.2.3. Organizational functioning and workload wellbeing

Teachers reported on how positively or negatively (1 = *negatively* to 4 = *neither positively nor negatively* to 7 = *positively*) they viewed each aspect of their workload (5 items; e.g., "Fitting everything into the allotted time") and organization (6 items; e.g., "Relations with directors at my child development center") using the Teacher Wellbeing Scale (TWBS; Collie, Shapka, Perry, & Martin, 2015). We modified the measure for this study by changing "school" to "child development center" and by removing items that did not apply to infants and toddlers (Item 1 related to marking work, and the subscale on teachers' views of their interactions with their students). Internal consistency for the adapted scale was excellent (Cronbach's α = .93).

7.2.4. Intentions to continue teaching

The number of years teachers planned to keep teaching was measured with 1 teacher-reported survey item, "How many more years do you plan to work at your child development center?" (1 = *Less than a year*, 2 = *1–2 years*, 3 = *3–4 years*, 4 = *5–10 years*, 5 = *10+ years*).

7.2.5. Quality of classroom interactions

Using the Classroom Assessment Scoring System (CLASS) for Toddler classrooms (La Paro, Hamre, & Pianta, 2012), trained and certified research assistants observed and assessed the effectiveness of teacher-child interactions (1 = *low* to 7 = *high*) in child development centers and homes. The CLASS has good internal reliability with dimensions being significantly associated with one another in the expected ways (e.g., positive climate is negatively related to negative climate and positively related to teacher sensitivity). The CLASS also exhibits good construct validity and is related to other measures of the quality of early educational settings (La Paro et al., 2012). The CLASS has 2 overarching domains, which are composed of several underlying dimensions. The Emotional and Behavioral Support domain is composed of 5 dimensions: Positive Climate, Negative Climate, Teacher Sensitivity, Regard for Child Perspectives, and Behavior Guidance. In our sample, the reliability among these dimensions was good (Cronbach's α = .83; 5 dimensions). The second domain, Engaged Support for Learning, includes 3 dimensions: Facilitation of Learning and Development, Quality of Feedback, and Language Modeling. The reliability among those dimensions was excellent (Cronbach's α = .90; 3 dimensions).

7.2.6. Teacher's knowledge of infants and toddlers

Teachers reported their knowledge of children's emotional (14 items), cognitive (7 items) physical (4 items), and social development (8 items) using a modified version of the Knowledge of Child Development Inventory (KCDI; Larsen & McCreary Juhasz, 1986). For example, 1 question about social development asked, "In dealing with anger in their toddlers, parents can best help their children to develop self-control by… a) giving choices within firm limits, b) giving plenty of opportunities for expressing anger, c) ignoring angry outbursts, d) punishing lightly but consistently after each outburst." Questions were scored for accuracy and teachers received 1 point per correct answer. The original measure demonstrated high internal consistency (α = .93; Larsen & McCreary Juhasz, 1986). In the current study internal consistency was acceptable (α = .69; 33 items).

7.3. Procedure

The university's Institutional Review Board (IRB) approved this study. All participants completed consent forms prior to participation. Teachers completed surveys online through Qualtrics during the Spring of 2019. They were given the option to complete the survey on their own device or on an iPad with the guidance of a research assistant. Teachers had the option to skip any questions they did not want to answer. For their participation, they received a small monetary gift and a free catered lunch at their child

care centers. CLASS observations were conducted shortly after the surveys (also in the Spring of 2019). Certified infant and toddler CLASS observers completed observations across 2 days. The same observer conducted all 4 cycles of observation. To ensure comparability across classrooms, observations were conducted only in the morning and during routine activities (never during special events or outdoor play).

7.4. Analyses

Data were analyzed using the Statistical Package for the Social Sciences (SPSS, v.26) (IBM, 2019) and Stata Version 16.0 (StataCorp, 2019). First, we used descriptive statistics and Pearson correlations to examine the prevalence of ACEs, depressive symptoms, and other indicators of wellbeing (see Table 2). Because the focus of this paper is on teacher wellbeing, we conducted bivariate analyses to examine if differences exist between sociodemographic characteristics and outcomes of interest based on teacher role; however, no statistically significant differences were found. Ordinary least square and hierarchical regression analyses were performed to determine the associations between teacher wellbeing variables and teachers' intentions to continue teaching. Teachers' race/ethnicity, role, highest level of education, center, and knowledge of child development were entered as covariates in all initial regression models. For correlation and multiple regression analyses, we included dummy variables representing each child care center. To preserve statistical power, non-significant covariates (race/ethnicity, role, education, teacher role) were removed.

To determine the associations between teacher wellbeing and CLASS scores, we estimated several multilevel (MLM) regression models. We opted to use multilevel models as opposed to traditional regression techniques to examine the associations between teacher wellbeing and CLASS scores for 4 specific reasons: (1) the values of our intraclass correlations (≥.10; Lee, 2000; Robson & Pevalin, 2016) were indicative of the need for MLM as opposed to traditional regression analyses; (2) traditional regression analysis treats the unit of analysis as independent observations and, as such, does not recognize nested (hierarchical) structures within the data, which leads to an underestimation of standard errors of regression coefficients. This is problematic because it may lead to an overestimation of statistical significance; (3) multilevel modeling allows for examination of center-level residuals whereas traditional regression analysis does not; and (4) traditional linear regression models utilize a fixed effects model. In fixed effects models the effects of group-level independent variables are confounded and not able to be separated due to observed and unobserved characteristics. However, multilevel analysis allows for use of a random effects model where the effects of all variables can be estimated (Rabe-Hesketh & Skrondal, 2012; Sage Publications, 2020).

Teachers were nested within child care centers. Interaction terms were developed to measure the association of teacher's wellbeing (i.e., depressive symptoms and ACEs) with quality of classroom interactions. To detect evidence of random intercepts for the level 2 variable - teachers, we first ran a null model for each classroom quality outcome (i.e., toddler emotional and behavioral support, and toddler engaged support for learning) without covariates (Robson & Pevalin, 2016). To evaluate intraclass correlations (ICCs), we followed guidance from Lee (2000) and Robson and Pevalin (2016) indicating that ICCs of 0.10 or higher denote non-trivial variance. Random intercept models were then generated without covariates, followed by models with covariates (i.e., knowledge of child development) using quality of classroom interaction and educational centers. Non-significant results are not presented but are available upon request.

Table 2
Descriptive statistics and correlations for study variables.

Variable	*n*	*M*	*SD*	1	2	3	4	5	6	7	8	9	10	11	12
1. Individual ACEs	152	1.30	2.01	1											
2. Community ACEs	153	1.07	1.09	.541**	1										
3. Depressive Symptoms(CES-D)	153	13.87	8.76	.223**	.254**	1									
4. Organizational Wellbeing	124	5.54	1.3	-.211*	-.116	-.373**	1								
5. Workload Wellbeing	123	5.49	1.2	-.127	-.129	-.412**	.837**	1							
6. Emotional and Behavioral Support for Toddlers	50	4.08	0.59	-.124	-.225	-.351*	-.180	-.249	1						
7. Engaged Support for Learning for Toddlers	50	3.43	0.89	-.052	-.314*	-.435**	-.095	-.196	.792**	1					
8. Number of Years Teacher Intends to Stay at Center	158	3.23	1.23	-.052	.038	-.160*	.276**	.204*	-.020	-0.05	1				
9. Knowledge of Child Development	143	24.09	3.63	.066	.029	-.151	.067	.008	.278	.168	.011	1			
10. Race/Ethnicity - Black or African American	160	0.68	0.47	.111	.196*	.078	-.088	-.134	-.165	-.301*	.127	-.116	1		
11. Education - Some College or Technical Degree	155	0.48	0.50	.092	.069	-.172*	-.059	-.047	.225	.157	.086	.045	.036	1	
12. Education - Bachelor's Degree or Higher	155	0.20	0.40	-.067	-.112	.046	.003	-.033	.034	.124	-.139	.276**	-.205*	-.484**	1

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

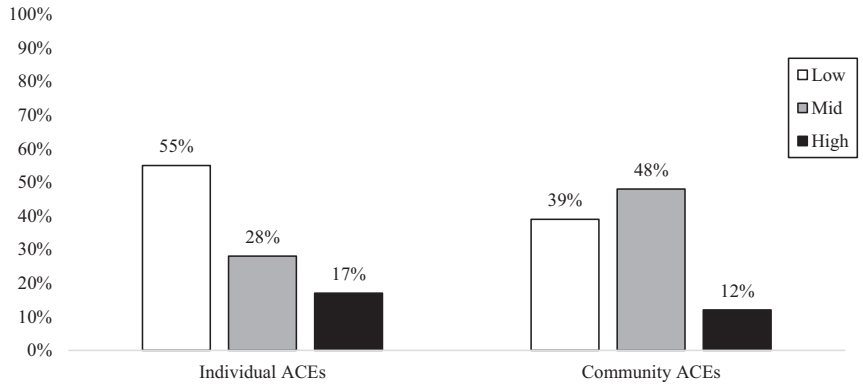

Fig. 1. Adverse childhood experiences among infant-toddler child care teachers.
Note. Individual ACE scores ranged from 0 to 9. Risk categories were defined as follows: 0 = Low, 1-3 = Mid, and 4 or More = High. Community ACE scores ranged from 0-5. Risk categories were defined as follows 0 = Low, 1-2 = Mid, and 3 or More = High.

Table 3
Adverse childhood experiences: individual scale.

Domain	*n*	*%*	*Items*
Household Substance Abuse	34	22	Did you live with anyone who was a problem drinker or alcoholic? (**Yes** or No) Did you live with anyone who used illegal street drugs or who abused prescription medications? (**Yes** or No)
Emotional Abuse	28	19	While you were growing up how often did a parent, stepparent, or another adult living in your home swear at you, insult you, or put you down? (**More than once**, once, never) While you were growing up how often did a parent, stepparent, or another adult living in your home act in a way that made you afraid that you would be physically hurt? (**More than once**, once, never)
Physical Abuse	27	18	While you were growing up did a parent, stepparent, or another adult living in your home push, grab, shove, or slap you? (**More than once**, once, never) While you were growing up did a parent, stepparent, or another adult living in your home hit you so hard that you had marks or were injured? (**More than once**, once, never)
Domestic Violence	26	17	How often, if ever, did you see or hear in your home a parent, stepparent, or another adult who was helping to raise you being slapped, kicked, punched, or beaten up? (**Many times, a few times**, once, never) How often, if ever, did you see or hear in your home a parent, step parent, or another adult who was helping to raise you being hit or cut with an object, such as a stick, cane, bottle, club, knife or gun? (**Many times, a few times**, once, never)
Sexual Abuse	20	13	During the first 18 years of life, did an adult or older relative, family friend, or stranger who was at least 5 years older than yourself ever touch or fondle you in a sexual way or have you touch their body in a sexual way? (**Yes** or No) Attempt to have or actually have any type of sexual intercourse, oral, anal or vaginal with you? (**Yes** or No)
Household Mental Illness	20	13	While you were growing up, did you live with anyone who was depressed or mentally ill? (**Yes** or No) Did you live with anyone who was suicidal? (**Yes** or No)
Incarcerated Care Provider	19	13	Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility? (**Yes** or No)
Physical Neglect	14	9	Your family sometimes cut the size of meals or skipped meals because there was not enough money in the budget for food. (**Very often true, often true**, sometimes true, rarely true, never true)
Emotional Neglect	10	7	There was someone in your life who helped you feel important or special. (Very often true, often true, sometimes true, **rarely true, never true**)

Note. Bolded response options represent responses coded as 1 = "Yes" for exposure to ACEs.

8. Results

All key outcome variables were approximately normally distributed. Associations between key variables were in keeping with our hypotheses. See Table 2 for descriptive statistics and Pearson correlations.

8.1. Psychological wellbeing of infant-toddler child care teachers

8.1.1. Infant-Toddler teacher's adverse childhood experiences & depression

For individual ACEs, 45% of teachers reported 1 or more and 17% experienced 4 or more. For community ACEs, 60% had experienced 1 or more and 12% experienced 3 or more (see Fig. 1). Household substance abuse (22%), emotional abuse (19%), physical abuse (18%), and domestic violence (17%) were the most endorsed adversities (see Table 3). The most common community ACEs were lack of neighborhood safety (35%), witnessing violence (38%), and experiencing discrimination (19%; see Table 4). CES-D scores ranged from 0 to 48. Scores above 16 were considered indications of clinical levels of depressive symptoms. Approximately 27% of caregivers who provided valid surveys met clinical criteria for depression.

8.1.2. Associations between psychological and work-related wellbeing

The second research aim was to examine associations between teachers' ACEs, depressive symptoms, and work-related wellbeing. Descriptive analyses showed that levels of work-related wellbeing were generally lower for individuals with higher exposure to ACEs and greater depression symptoms. After controlling for child care centers, the number of individual ACEs that teachers experienced significantly related to their current depressive symptoms (β = .17, p = 0.033). Individual ACEs also were significantly and negatively associated with teachers' organizational wellbeing (β = -.22, p = 0.014), controlling for center; however, they were not significantly associated with workload wellbeing. Community ACEs were not significantly related to depressive symptoms, organizational wellbeing, or workload wellbeing. Depressive symptoms significantly and negatively related to teachers' perceptions of or-

Table 4
Adverse childhood experiences: Community scale.

Domain	*n*	*%*	*Items*
Witnessing Violence	58	38	How often, if ever, did you see or hear someone being beaten up, stabbed, or shot in real life? (**Many times, a few times**, once, never)
Lacked Neighborhood Safety	53	35	Did you feel safe in your neighborhood? (All of the time, most of the time, **some of the time, none of the time**) Did you feel people in your neighborhood looked out for each other, stood up for each other, and could be trusted? (All of the time, most, **some of the time, none of the time**
Felt Discrimination	29	19	While you were growing up…How often did you feel that you were treated badly or unfairly because of your race or ethnicity? (**Very often true, often true, sometimes true**, rarely true, never true)
Bullied	17	11	How often were you bullied by a peer or classmate? (**All of the time, most of the time**, some of the time, none of the time)
Living in Foster Care	6	4	Were you ever in foster care? (**Yes** or No)

Note. Bolded response options represent responses coded as 1 = "Yes" for exposure to ACEs.

ganizational (β = -.40, $p < 0.001$) and workload wellbeing (β = -.43, $p < 0.001$), controlling for center.

8.1.3. Psychological wellbeing, work-related wellbeing, and intentions to continue teaching

To test associations between teacher wellbeing and intentions to continue teaching at their current child care centers, we estimated 2 sets of hierarchical regression models. In Model 1, we regressed the number of years teachers planned to continue teaching on individual ACEs, community ACEs, depressive symptoms, and perceived organizational wellbeing. Community ACEs (β = .31, p = 0.003) and organizational wellbeing (β = .22, p = 0.026) significantly and positively related to the number of years teachers planned to continue teaching at their current centers, whereas depressive symptoms and individual ACEs were not significantly associated with this variable. In Model 2, we added teachers' knowledge of child development and dummy variables representing the 18 center sites as covariates. Even with the addition of covariates, community ACEs (β = .25, p = 0.014) and organizational wellbeing (β = .28, p = 0.005) contributed to unique variance in intentions to continue teaching. Due to multicollinearity between organizational and workload wellbeing, we repeated the same analyses with workload wellbeing instead of organizational wellbeing. Workload wellbeing significantly related to intentions to continue teaching in Model 1 (β = .20, p = 0.045) and Model 2, which included knowledge of child development and child care center covariates (β = .24, p = 0.016).

8.1.4. Psychological wellbeing, work-related wellbeing, and quality of classroom interactions

To determine the amount of variance in teaching quality that could be attributed to the nesting of teachers within educational centers, we estimated multilevel regression models with only outcome variables and subject grouping terms to produce intraclass correlation coefficients (ICCs). Due to limited sample size, we only included lead teachers from toddler classrooms in multi-level analyses. Key outcomes included: toddler emotional and behavioral support; and toddler engaged support for learning. After estimating null models, we added independent variables and covariates. The unstandardized regression coefficients (B) and p-values for each classroom quality outcome and measure of teacher wellbeing are presented below. Due to space limitations, only models with significant findings are shown below.

8.1.4.1. Emotional and behavioral support. Results indicated an ICC of 0.17, denoting that 17% of the variation in emotional and behavioral support could be attributed to the difference between classrooms. A between and within teacher variance of 0.24 and 0.53 respectively were indicated by the null model. Neither teachers' individual ACEs nor their community ACEs were associated with emotional and behavioral support in toddler classrooms, controlling for teachers' knowledge of child development. None of the teachers' work-related wellbeing variables were associated with emotional and behavioral support. In addition, teachers' depressive symptom scores were not significantly associated with classroom emotional/behavioral support.

8.1.4.2. Engaged support for learning. Approximately 8% of the variation in toddler engaged support for learning can be attributed to the difference between teachers (ICC = 0.08, see Table 5). A between and within teacher variance of 0.25 and 0.82, respectively, were indicated by the null model. Teachers' individual ACEs were not significantly associated with engaged support for learning in toddler classrooms, controlling for teachers' knowledge of child development. Teachers' community ACEs were significantly and negatively associated with engaged support for learning (B= -0.50, p = 0.001; see Table 5). This association remained significant even after controlling for teachers' knowledge of child development (B= -0.48, p = 0.001), which was not significantly associated with engaged support for learning. Depressive symptoms (B=-0.06; p = 0.045) were significantly and negatively associated with classroom engaged support for learning (see Table 6). However, when teachers' knowledge of child development was added to the model, teacher depressive symptoms were no longer significant. None of the teachers' work-related wellbeing variables were associated with engaged support for learning in toddler classrooms.

9. Discussion

The current study extends the literature on ECE teacher wellbeing by focusing on infant-toddler teachers serving families from low-income backgrounds, examining a broad range of factors related to teacher wellbeing, as well as addressing the link between teacher wellbeing and classroom practice. To our knowledge, this is the first study to examine the prevalence of both individual and community ACEs and their respective associations with classroom quality among infant-toddler teachers. On average, the teachers in this study reported exposure to one individual and one community ACE. Approximately 17% of teachers had high individual ACEs and 12% had high community ACEs. These percentages are comparable to those found in other early childhood teacher and urban samples (Cronholm et al., 2015; Hubel et al., 2020; Whitaker et al., 2015). About 27% of infant-toddler teachers met clinical criteria for depression (CES-D scores 16 or higher). This is similar to findings in other studies of early childhood teachers, but higher than those of general adult populations. For example, studies show that about 24% of ECE teachers score in the clinical depressive symptom range and 18% of the general population meets the clinical cutoff (Linnan et al., 2017; Roberts et al., 2019; Whitaker et al., 2015).

Table 5
Multilevel models: Community adverse childhood experiences (ACEs) and engaged support for toddlers' learning.

Parameter	Null model			Random intercept model without covariates			Random intercept model with covariates		
	B	*SE*	95% *CI*	*B*	*SE*	95% *CI*	*B*	*SE*	95% *CI*
Community ACEs									
Intercept	3.43***	0.18	3.08, 3.80	3.86***	0.17	3.53, 4.20	3.11***	0.95	1.24, 4.98
Community ACEs				-0.50***	0.14	-0.77, -0.21	-0.48***	0.14	-0.75, -0.21
Control Variables									
Knowledge of Child Dev.							0.03	0.03	-0.04, 0.10
Log Likelihood		-34.44		-31.37			-31.22		
Within Group Variance	0.82	0.13	0.60, 1.13	0.72	0.10	0.54, 0.96	0.72	0.11	0.53, 0.98
Between Group Variance	0.25	0.28	0.02, 2.30	0.29	0.24	0.05, 1.51	0.26	0.28	0.03, 2.07
N	27			27			27		
ICC	0.08	0.18	0.001, 0.91						

Note. ACEs= Adverse Childhood Experiences
$^{*}p < 0.05$, $^{**}p < 0.01$, $^{***}p < 0.001$.

Table 6
Multilevel models: Teacher depressive symptoms and engaged support for toddlers' learning.

Parameter	Null model			Random intercept model without covariates			Random intercept model with covariates		
	B	*SE*	95% *CI*	*B*	*SE*	95% *CI*	*B*	*SE*	95% *CI*
Depressive Symptoms									
Intercept	3.43***	0.18	3.08, 3.80	4.16***	0.34	3.49, 4.84	3.60***	1.26	1.12, 6.07
Depressive Symptoms				-0.06*	0.03	-0.12, -0.001	-0.06	0.03	-0.12, 0.003
Control Variables									
Knowledge of Child Dev.							0.02	0.03	-0.05, 0.09
Log Likelihood		-34.44			-30.52		-30.43		
Within Group Variance	0.82	0.13	0.60, 1.13	0.75	0.12	0.53, 1.04	0.74	0.12	0.54, 1.03
Between Group Variance	0.25	0.28	0.02, 2.30	<.001	<.001	<.001, <.001	<.001	<.001	<.001, <.001
N	27			27			27		
ICC	0.08	0.18	0.001, 0.91						

$^{*}p < 0.05$, $^{**}p < 0.01$, $^{***}p < 0.001$.

Depression is widely regarded as a negative indicator of wellbeing and workplace functioning. Thus, it is important to understand what types of adversity might relate to depressive symptoms. Our results showed that individual, but not community ACEs, were significantly associated with current depressive symptoms. Although, to our knowledge, no other studies have examined both individual and community ACEs among infant and toddler teachers, it is logical that events that directly impact individuals during childhood, such as household dysfunction, might have greater implications for later psychological wellbeing than more distal factors such as those occurring in the community (Ramirez & Paz Galupo, 2019). However, this is not to say that community ACEs are not important factors to consider. Studies suggest that community-level adversities (e.g., perceived experiences of racism, witnessing community violence, living in an unsafe neighborhood, being bullied, and being in foster care) may act as moderators, reducing the extent to which individuals benefit from social programs (Ceballo & McLoyd, 2002).

As expected, depressive symptoms were consistently and negatively associated with teachers' perceptions of their current work-related wellbeing. Other studies have found similar connections between depressive symptoms and work environments among ECE teachers (Jeon, Buettner, & Grant, 2018; Kwon et al., 2021a). For example, Jeon et al. (2018) found that the extent to which preschool teachers' relationships with directors and staff, their pay, and physical working conditions matched their ideal, was significantly related to depressive symptoms. Additionally, Kwon et al. (2021a) documented that psychological wellbeing (e.g., depressive symptoms) mediated the associations between working conditions and professional wellbeing among ECE teachers.

Although we cannot draw conclusions about the temporal nature of depressive symptoms in relation to workplace wellbeing, we interpret the associations between ACEs, depressive symptoms, and workplace wellbeing through the lens of cumulative stress theory (Lampert et al., 2016). Teachers with high levels of early adversity may be more likely to experience depressive symptoms which may be associated with less satisfaction with their relationships and work environments.

9.1. Infant-Toddler teacher wellbeing and intentions to continue teaching

Teacher turnover is a major problem in the early education field (Bassok et al., 2021). Therefore, it is important to understand what aspects of wellbeing might be associated with the number of years teachers plan to continue working at their current child care centers. In this study, organizational wellbeing significantly was significantly associated with the number of years that infant-toddler teachers planned to continue working at their current centers. This finding is consistent with the qualitative findings from Kwon et al. (2021a) that work climate, pay, and benefits are related to teachers' decisions to leave. Depressive symptoms were not significantly associated with the number of years teachers planned to continue working at their centers. These findings are in keeping with perspectives of teacher turnover, which emphasize the need to understand negative conditions at schools and child care centers that may motivate teachers to leave (McMullen et al., 2020). Our measure of organizational wellbeing probed for the extent to which teachers felt supported by child care directors and staff as well as the general functioning of the center. Thus, improving teachers' social and professional support may be one way to reduce turnover.

9.2. Infant-Toddler teacher wellbeing and classroom quality

One of the most interesting findings from the current study is that the number of community adversities teachers experienced during childhood were significantly and negatively associated with their engaged support for learning in toddler classrooms. This find-

ing may be indicative of the persistence of neighborhood economic status across the life course. Studies show that children who grow up in poor neighborhoods remain in those same neighborhoods as adults (Sharkey & Elwert, 2011). It may also be indicative of cumulative disadvantage. Neighborhoods with high rates of violence and crime, often have lower quality schools, and lower household incomes (Evans, 2004). The combination of stress associated with living in impoverished and dangerous environments and lower levels of educational opportunity may be negatively associated with adult social-emotional competence (Sharkey & Faber, 2014).

Unlike other studies (Hamre & Pianta, 2004; Hubel et al., 2020), we did not find a significant association between ACEs, depressive symptoms, and classroom emotional support. This could be because most teachers in our sample scored in the mid to high range on the emotional and behavioral support domain of the CLASS, whereas scores on engaged support for learning spanned from low to high and therefore had higher variance. Another possibility is that providing engaged support for learning may be more challenging for teachers who are experiencing depressive symptoms and the lingering effects of early traumatic experiences than providing emotional and behavioral support to young children (Sandilos et al., 2015).

Like other studies, we found that depressive symptoms were associated with teachers' quality of interactions in the classroom (Hamre & Pianta, 2004; Jeon et al., 2018). However, our findings showed that these associations were partly accounted for by teachers' knowledge of child development. When we estimated multilevel regression models controlling for teachers' knowledge of child development, depressive symptoms were no longer significantly associated with teachers' engaged support for learning in toddler classrooms. In other words, teachers with more child development knowledge were able to engage with toddlers despite their depressive symptoms.

Other studies have also shown that caregivers' knowledge of infant development may moderate the association between depressive symptoms and quality of care. For example, Zolotor, Burchinal, Skinner, and Rosenthal (2008) found that when low-income mothers with high levels of psychological symptoms had greater knowledge of infant development, they implemented more safety practices at home. However, for mothers with low psychological symptoms, knowledge of infant development had less of an association with safety practices. Although sample size limited our ability to test for moderation in the current study, our findings in combination with those of past studies suggest that increasing teachers' knowledge of child development may be one way to reduce the potential impact of teacher depressive symptoms on classroom instructional quality.

9.3. Implications & conclusion

The infant-toddler classroom is an important microsystem where socialization and interactions with nurturing caregivers and other adults (e.g., educators) can help to mediate the consequences of children's own early adversities (National Scientific Council on the Developing Child, 2005/2014). Furthermore, infant-toddler teachers can offer stable and safe spaces for children by exhibiting a level of responsiveness and warmth that makes children feel valued and respected. Such an early education experience supports all domains of development, thereby providing the foundation for the child's future educational experiences and accomplishments. Consequently, when infant-toddler teachers' own adversity and depressive symptoms are related to low quality care and education, 2 generations are at risk.

It should be noted that the teachers included in this study were part of an EHS-CCP, and therefore may have been receiving more professional development and support than teachers in typical community-based child care centers. There is an increasing amount of data documenting the adverse childhood experiences and depressive symptoms of those working in the ECE field (Hubel et al., 2020; Roberts et al., 2019; Whitaker et al., 2015). Therefore, a systems-level response that considers the epidemic of inequities (e.g., poverty, violence, abuse and neglect, racism) experienced by many providers/teachers seems necessary (Ellis & Deitz, 2017). The Building Community Resilience (BCR) model highlights the importance of considering the role of communities in intensifying or buffering trauma (Ellis & Deitz, 2017).

To combat the effects of community ACES, teachers need coordinated systems of support, including mental health resources and monetary support in order to secure safe housing and care for their own families (Hall-Kenyon et al., 2014). Head Start and EHS-CCP systems have the infrastructure to provide additional services and compensation to teachers that could enable them to better address issues related to psychological wellbeing. Just as family support services are provided to young children who are considered at-risk for ACEs and other hardships, teachers should be screened and referred for mental health services and provided with professional development that encourages psychological and physical wellbeing.

Currently, early childhood systems largely focus on compensation, professional development, and a career ladder for those in the field (Hubel et al., 2020). Although these factors are critical, they are insufficient when it comes to teachers' mental health and wellbeing. To support ECE teachers in providing the best care possible to children in their care, we need to respect and understand how their own life events are tied to their current teaching beliefs and practices. We must also provide professional development that is sensitive to the environments in which teachers work and live. For example, teachers/caregivers who have experienced abuse and neglect in childhood may experience re-traumatization or secondary traumatic stress when they observe children in their classrooms having traumatic experiences that mirror their own childhood events and may need additional support (Butler, Maguin, & Carello, 2018).

While there is no one curriculum that has validity in addressing these issues, there are a number of evidence-based approaches designed to addresses the mental health and wellbeing of ECE teachers, including relationship-based professional development (RBPD; Sabol & Pianta, 2012), mindfulness interventions (Cameron, Carroll, & Hamilton, 2018), and stress reduction programs (Sandilos, Goble, Rimm-Kaufman, & Pianta, 2018). Professional development models, such as RBPD, which involve group sharing and support along with reflective coaching practices, may be well suited for teachers who have experienced individual and community-level adversities. With the help of a trusted coach, teachers can become aware of the parts of their daily work that trigger stress and negative emotions and find ways to improve their practices. Mindfulness and stress reduction interventions can also help teachers learn to experience and regulate their emotions in healthier ways (Cameron et al., 2018).

Members of the Happy Teacher Project, a research collaborative that aims to understand the individual and systemic factors that promote or detract from teacher wellbeing, suggest that one way to improve teacher wellbeing could be to add indicators of teacher well-being to state early childhood education licensing and Quality Rating and Improvement Systems (Kwon et al., 2021b). This approach may be especially helpful for getting funding and political attention for system-wide improvements needed to help teachers and programs get more resources and support to fulfill their responsibilities to children and families. In sum, our data strongly suggest that both ECE systems and policymakers must invest in providing both professional and social support for the teachers who care for our youngest children.

CRediT authorship contribution statement

Cassandra Simons: Conceptualization, Methodology, Formal analysis, Investigation, Writing – original draft, Writing – review & editing, Visualization, Project administration. **Brenda Jones Harden:** Conceptualization, Investigation, Writing – review & editing, Supervision, Funding acquisition, Resources. **Kerry A. Lee:** Methodology, Formal analysis, Writing – review & editing. **Christy Tirrell-Corbin:** Writing – review & editing, Supervision, Funding acquisition, Resources.

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