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It Matters: Early Childhood Mental Health, Educator Stress, and Burnout

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Abstract
Early childhood educators (ECEs) face several workplace challenges, including young children's difficult behavior and mental health needs, workplace stress, low systemic support, and high levels of burnout. Both education and perceived confidence are often cited as important buffering factors, yet neither is well studied in the existing literature. The present study aimed to better understand and describe these factors. A survey, including both open and closed questions, was sent out to a large group of ECEs. Results were analyzed using descriptive statistics, T-tests, and the constant comparison method of qualitative coding. Findings suggest that the types of training ECEs have had is related to their comfort in recognizing and responding to young children's mental health and challenging behaviors. Both systemic changes and didactic needs were cited as necessary to further support ECEs.

Keywords Early childhood · Mental health · Educator stress · Educator burnout

Introduction

Early childhood educators (ECEs) care for young children in a variety of public (Universal Pre-Kindergarten, Head Start) and private (center-based, faith-based, home-based child care; Grist & Caudle, 2021) settings. Data suggest that approximately two million early childhood educators are responsible for watching about 10 million young children each day in the United States (Whitebook et al., 2018). Collectively this workforce is responsible for the welfare, learning, and development of young children while simultaneously allowing their parents to engage in other sectors of the economy, both of which are important societal functions. Despite the known importance of early childhood educators, this is a profession that is challenged with low levels of support and high levels of stress and associated burnout, exacerbated by the COVID-19 pandemic (Eadie et al., 2021; Souto-Manning & Melvin, 2022).

The early education system in the United States is fragmented and administered at the state level (Halfon et al., 2009), meaning that early education systems are less well supported and coordinated than in many economically comparable countries (Halfon et al., 2009). As a result, early education settings and ECE experiences vary widely depending on their workplace. For instance, Jeon et al. (2018) found that when home care providers had more support they had lower levels of stress, but also that professional support was harder to access for home care providers than ECEs in other settings. Additionally, there is some evidence that ECEs experience more stress than their K-12 counterparts, due to environments that are emotionally and financially challenging, limited resources, and a job that is often not highly regarded by society (Jeon et al., 2018, 2019).

Despite the variation in early care and education settings, certain patterns have been documented as systemic challenges that impact ECE experiences, and in turn the children in their care. For instance, high child–teacher ratios make it difficult for ECEs to provide optimal care and develop strong relationships with each child in the classroom (Albin-Clark et al., 2016; Burchinal et al., 2002). Stressful environments (Hindman & Bustamante, 2019; Jeon et al., 2019), high workloads (Farewell et al., 2021), low pay (Logan et al., 2020), and limited opportunities for advancement (Gomez et al., 2015) are amongst the systemic challenges that exist within early care and education settings. In addition, there is evidence that some ECEs of color experienced

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disproportionate levels of stress due to the Covid-19 Pandemic, further emphasizing the need to attend to teacher well-being (Souto-Manning & Melvin, 2022). Together the stressors that ECEs face have been linked to lower job satisfaction and high rates of professional turnover (Farewell et al., 2021). The challenges ECEs face in their work and workplace environments are multifaceted and impact the professionals themselves, the field, and the children for whom they care. Therefore, there are calls to support ECEs' wellbeing to positively impact workforce retention and child–educator relationships (Eadie et al., 2021).

Individual educator and child characteristics, such as teacher mental health needs (Kwon et al., 2019) or children with challenging behaviors (Jamil et al., 2021; Jeon et al., 2019; Rudasill & Rimm-Kaufman, 2009) also impact ECE wellbeing. Relatedly, teachers' perceptions and understanding of children's challenging behaviors impact relationship quality (Jamil et al., 2021; Rudasill & Rimm-Kaufman, 2009). For instance, Rudasill and Rimm-Kaufman (2009) looked at a sample of first grade students and teachers and found that child temperament, gender, frequency of child–teacher engagements, and teacher perceptions of child–teacher interactions all influenced the quality of the relationship. In research conducted by Jamil et al. (2021), a small sample of early childhood educators' perceptions of young children's challenging behavior was explored. They found that challenging behavior impacted teacher–child relationships but that this was influenced by the teacher's level of understanding and perceived malleability of the behaviors. This suggests that teachers' knowledge of young children's behavior has the potential to be highly impactful in subsequent actions and relationships.

Teacher training and educational background are also linked to the quality of early education settings. Bachelor's and associate degrees in early childhood education have been linked to higher levels of ECE knowledge and better classroom practices, with bachelor's degrees showing a greater benefit than associate degrees (Institute of Medicine and National Research Council, 2015; Whitebook, 2003) The quality of teacher–child relationships has also been connected to ECE training. Burchinal et al. (2002) examined teacher self-reports of training and educational experiences and found an association between higher levels of education and training and higher levels of sensitivity in their relationships with children. More specifically, ECEs with college training had higher quality classrooms than professionals with no training or other types of training.

Teacher Wellbeing and Supporting Young Children

Prior research has documented the bi-directional connection between teacher wellbeing and young children's challenges (Jeon et al., 2019). Research has suggested that working with children who have experienced trauma (Kwon et al., 2021) or who exhibit challenging behavior (Friedman-Krauss et al., 2014; Jamil et al., 2021; Zee & Koomen, 2016) appears to increase the level of stress and emotional burnout amongst ECEs (Logan et al., 2020). Not only is this important to consider when thinking about supporting and retaining ECEs, but this also directly impacts young children; when teachers experience high levels of stress they can attend less effectively to the children in their care (Zinsser et al., 2013). For instance, Kwon et al. (2019) looked at teacher psychological distress in a sample of Early Head Start teachers and found a relationship between teacher psychological stress and an increase in child behavioral problems and a lesser quality of teacher-provided emotional support.

Several studies have looked at different elements of teacher wellbeing and the impact on their teaching, classrooms, and the children in their care. Schreyer and Krause (2016) looked at a large sample of staff working in childcare centers in Germany and found a link between job satisfaction and staff's perceived level of stress, with greater satisfaction correlated with lower levels of stress. Another study looked at perceptions of professional support and level of stress amongst home childcare providers and the corresponding impact of providers' responsiveness to children's emotions. Findings suggest that both low levels of stress and higher levels of perceived professional support were associated with increased responsiveness to children's emotions (Jeon et al., 2018). Wong and Zhang (2014) examined school culture and the relationship between teacher job satisfaction and mental health. They found that teachers who had more positive perceptions of their school culture also had higher levels of reported job satisfaction and fewer mental health concerns.

ECE wellbeing is connected to several important outcomes, ranging from children's social-emotional gains (Roberts et al., 2016), the quality of teacher student relationships (Eadie et al., 2021), classroom environment (Jennings, 2015) teacher perceptions of children's behavior (Jamil et al., 2021; Kwon et al., 2019) and the stability and retention of the ECE workforce (Eadie et al., 2021). Furthermore, positive ECE and child relationships are associated with ECEs' workplace perceptions and emotional wellbeing by ECEs who are emotionally and mentally prepared (Cassidy et al., 2017; Jennings, 2015; Roberts et al., 2016). In turn, teacher mental health and poorer work environments both appear bi-directionally linked to ECE burnout and stress.

Burnout and Stress in Early Childhood Education Settings

Burnout and stress amongst ECEs are well documented (Whitebook & Sakai, 2004). Systemic concerns appear to play a large role in ECE burnout, with low pay, limited

resources, low educational qualifications, difficult classroom dynamics, and stressful environments often mentioned (Gomez et al., 2015; Logan et al., 2020). Difficulty managing children's behavior is also linked to ECE stress and burnout (Gomez et al., 2015; Jamil et al., 2021; Seo & Yuh, 2021). Farewell et al. (2021) surveyed ECE professionals employed in Head Start Centers and compared results to a representative sample across professions and found that ECEs' levels of perceived stress, depression, and staffing challenges are higher than the national average. Furthermore, they found that ECEs had fewer workplace resources to deal with their challenges.

Research has demonstrated that there are systemic and individual factors that can support ECEs and mitigate some of the challenges and stress that they face. Workplace environment, particularly the perceived level of social support, appears to be one of the biggest driving factors of ECE wellbeing (Kwon et al., 2021). For instance, there is evidence that having more resources, positive co-worker relationships, and supportive administration (Zinsser et al., 2015) lessens ECE stress and burnout. Unfortunately, the highly varied environments where ECEs are employed means that some educators have environments and opportunities that are supportive whereas others do not.

Both direct and indirect benefits are linked to teacher wellbeing. For instance, increasing ECE emotional availability promotes social emotional and cognitive development (Shirvanian & Michael, 2017). Health and mental health indicators also appear to contribute to stress and burnout among ECEs (Cassidy et al., 2017; Jennings, 2015; Roberts et al., 2016). Understanding how ECEs navigate child and systemic level challenges, how this contributes to their stress and burnout, and ECEs' additional needs is an important part of gaining a more complete understanding of ECE wellbeing.

Current Study

The present study aimed to learn about ECEs' preparedness to support young children's mental health, as well as learning about their perceptions of their own mental health, stress, and burnout. There have been calls for greater attention to mental health and mental health promotion in early education settings (Logan et al., 2020) and how ECEs' perceived ability to support young children's mental health relates to ECE stress and burnout. Additionally, although prior research has looked at factors related to educator stress and burnout, there are gaps in the current literature. For instance, much of the research on ECE burnout has focused on ECEs in specific types of educational environments (e.g., Head Start teachers) and the literature has called for research looking at stress and burnout amongst ECEs across settings (Farewell et al., 2021). This project aimed to further the existing research by addressing the following research questions: (1) What training and experiences have ECEs had related to addressing children's challenging behaviors and supporting children's mental health? (2) Do ECEs feel prepared to work with young children with challenging behaviors and mental health needs? (3) How confident are ECEs in recognizing and addressing their own mental health needs? (4) What factors do ECEs identify related to their mental health, stress, and burnout?

Methods

Sampling

The survey was sent out to registrants of a state-level Professional Development Information System (PDIS). PDIS is a state-level portal for professional development and education for early childhood professionals. At the time the survey was sent out the PDIS database included over 8000 individuals who had created a PDIS account. The first author of the study was given permission to use the PDIS database for survey dissemination. Prior to taking the survey respondents were informed that the survey was voluntary, responses were confidential, and the project was approved through the primary author's university Institutional Review Board.

Participants

The number of individuals who responded to the survey was 1419. Of this number, 1355 respondents self-identified as female (95%) and 1132 as White/Caucasian (79.8%). Next, 160 (11.3%) identified as Hispanic/Latinx and 32 respondents (2.3%) identified as Bi/Multi-Racial. Smaller percentages of respondents identified with other races or ethnicities (see Table 1). Although our sample was overwhelmingly female and White, this is consistent with the largely early childhood field (Whitebook et al., 2018). The present sample did represent a wide range of ECE roles and training backgrounds (e.g., general and special education).

The greatest number of respondents described their training background as early childhood education ($n = 1151$, 81.1%), followed by education ($n = 329$, 23.2%) and special education ($n = 165$, 11.6%). Smaller numbers of respondents endorsed other types of training backgrounds (see Table 1). In Colorado, where the present study took place, a variety of pathways and resources are available to obtain training in early childhood education, although these training backgrounds represent both those respondents with terminal degrees and those whose training did not include a terminal degree. Respondents identified a large variety of current positions, with the majority of respondents working

Table 1 Respondent demographic characteristics

	n	%
Gender		
Male	47	3.3
Female	1355	95.5
Non-binary/third gender	10	0.7
Prefer not to say	5	0.4
Other	2	0.1
Race/Ethnicity		
American Indian or Alaska Native	8	0.6
Asian	22	1.6
Black or African American	30	2.1
Bi/multi-racial	32	2.3
Hispanic/Latinx	160	11.3
White/Caucasian	1132	79.8
Native Hawaiian or other Pacific Islander	3	0.2
Other	32	2.3
Training background		
Early childhood education	1151	81.1
Education	329	23.2
Special education	165	11.6
School psychology	25	1.8
Social work	64	4.5
Professional counselor	19	1.3
Behavior specialist	43	3
Speech and language pathologist	30	2.1
Occupational therapist	7	0.5
Physical therapist	6	0.4
Other	285	20.1
Current position		
Early childhood educator	532	37.5
Homecare providers	106	7.5
Special education providers	56	3.9
Early education Aids, assistants, paraprofessionals	77	5.4
Directors, supervisors, managers	191	13.5
Nurses or school-based health providers	54	3.8
Student	15	1.1
Speech and language pathologist	16	1.1
Occupational therapist	4	0.3
Physical therapist	5	0.4
BCBA/RBT/behavior interventionist	10	0.7
Mental health provider	23	1.6
Retired/Unemployed	46	3.2
Kindergarten or elementary teacher	35	2.5
Consultant	6	0.4
Child find/early intervention	9	0.6
Other	234	16.5

as early education teachers ($n = 532$), but there were also home care providers ($n = 106$), special education providers (e.g., ECSEs, $n = 56$), early education aids, assistants, and paraprofessionals ($n = 77$), directors and supervisors ($n = 191$), and nurses or school-based health providers ($n = 51$). A smaller number of respondents identified their role as some other type of early childhood provider (e.g., speech and language pathologist, early childhood mental health consultant). Respondents had been in education for a mean of 14.21 years ($SD = 10.87$, Range 1–41 years), with a similar mean amount of time spent in early childhood education ($M = 12.49$, $SD = 10.49$, Range = 1–41).

Measures

The survey questions used in this project were part of a larger collaborative survey. Key stakeholders (e.g., state-level early childhood offices) and the study's first author began by determining what information they wanted to learn, and drafted questions. Specifically, the survey was developed to learn more about early childhood educators' perceptions related to the role of mental health in their work as well as to consider how this relates to their own mental health and job burnout. More specifically, the survey asked participants about their experiences, training background, confidence in recognizing and supporting young children's mental health, and their own needs related to training, stress, and burnout. Both quantitative, forced-choice, and qualitative open-narrative questions were included. After the initial questions were written, they were reviewed by experts in the field. Provided suggestions from experts in the field included changes to item wording to make the survey clearer and to ensure that applicable answer choices were represented. For instance, the word dysregulated was removed from one item, due to a reviewer suggesting that it might be interpreted variably by respondents.

The survey items utilized in the current study included seven demographic questions and eight survey questions. Six questions were closed-questions and two were open-ended questions. All of the included questions focused on child and educator mental health as well as related correlates. See the online resources for the included survey items.

Data Analytic Plan

Data were analyzed using both quantitative and qualitative methods. Quantitative analytics included descriptive statistics, frequency calculations, and T-tests for between-group comparisons. Prior to completing quantitative analyses data were cleaned and screened. Data met appropriate metrics and assumptions for analysis in most instances, including normality of distribution and homogeneity of variances. When variables violated Levene's Test for Equality of Variances, which happened in a few instances, equal variances were not assumed when interpreting results.

Qualitative analysis of responses to open-ended survey questions was conducted using constant comparative analysis, which has been used in similar mixed-method surveys (Glaser & Strauss, 1967; Vaughn & Turner, 2016). Given the large number of qualitative responses to the survey, a random 10% of responses to each qualitative question were analyzed, in accordance with the recommendations outlined by O'Connor and Joffe (2020). Individual responses to survey questions were analyzed by three researchers to determine initial Level I codes (Glaser & Strauss, 1967; Hutchinson, 1986). The researchers then met to compare Level I codes to determine if there were any redundancies indicating that a code should be removed or combined with a similar code (Glaser & Strauss, 1967).

Next, thematic analysis was conducted to move from Level I codes to Level II codes, or categories (Glaser & Strauss, 1967; Vaughn & Turner, 2016). To do this, initial Level I codes with similar content were mapped out and grouped together (Vaughn & Turner, 2016). For example, responses that mentioned "parent involvement" or "Covid restrictions" were grouped together. Each researcher completed this independently before meeting with the other researchers to discuss discrepancies. Initial interrater reliabilities were above 75% agreement, apart from two items. The raters discussed their ratings and worked towards consensus. Before moving on in the coding process the existing categories were examined to ensure that the category was definable and noting whether any categories were not robust. After this step, the research team again compared findings and discussed possible changes. Two items (Q10 IRR = 62.5%, Q20 IRR = 82.4%) did not reach the accepted level of at least 85% agreement (Miles et al., 2014) and the group discussed why these items were more discrepant than the others and worked to consensus. After creating categories, Level III codes were formed by analyzing Level II codes for overarching themes that emerged from Level II codes (Glaser & Strauss, 1967; Hutchinson, 1986). To enhance the clarity of each definition, an exemplar response for each code was also selected.

Data Integrity

Several data integrity checks were employed to ensure that findings are methodologically sound. First, the researchers aimed for adequate data through sampling a wide range of ECEs from different types of educational settings and with different training backgrounds. This was done by sending the survey out to a very large pool of individuals. Although the data does have some sampling limitations (see the "Limitations and Future Directions" section), it is adequate to address the research questions examined, since the sample size is large and represents a number of different perspectives. Specifically, this was determined based on a robust sample size, an expected level of heterogeneity within the sample, and quantitative variables with good distribution. Throughout the analytic process the constant comparison method allowed for triangulation, ensuring that both qualitative and quantitative findings corroborated and supported each other. During the qualitative coding process, an audit trail was maintained to allow for data checking and confirmation (Koch, 1994). Lastly, findings throughout the analytic process were grounded, ensuring that codes, categories, and themes were supported by concrete participant responses. As mentioned above, qualitative items were coded by multiple researchers and interrater reliability was established through iterative coding and interrater reliability checks (Leech & Onwuegbuzie, 2007.

Results

The quantitative and qualitative results are organized by the four research questions posed in this study: (1) What training and experiences have ECEs had related to addressing children's challenging behaviors and supporting children's mental health? (2) Do ECEs feel prepared to work with young children with challenging behaviors and mental health needs? (3) How confident are ECEs in recognizing and addressing their own mental health needs? (4) What factors do ECEs identify related to stress and burnout?

RQ #1: Training and Experience

Experience working with children with different types of behavioral and mental health needs varied across respondents and for different types of needs. Challenging behavior was the most frequent category that respondents had experienced ($n = 1324$, 93.3%), followed by young children with social challenges ($n = 1145$, 80.7%) and developmental disabilities ($n = 1103$, 77.7%). Most respondents also had experience working with children with trauma backgrounds ($n = 936$, 66%) and anxiety ($n = 893$, 62.9%). The least endorsed category was experience working with a young child with depression ($n = 393$, 27.7%).

Participants' formal preparedness to work with young children's mental health and behavioral needs was also highly variable. Almost half of the respondents had participated in professional development focused on young children's mental health ($n = 653$, 45.9%). Close to one-third of respondents had no training in young children's mental health ($n = 433$, 30.5%) and smaller numbers of participants had taken college courses on young children's mental health ($n = 327$, 23%), participated in consultation ($n = 219$, 15.4%) or had some other instruction focused on young children's mental health ($n = 123$, 8.7%). Notably, a subset of

respondents ($n = 219$, 15%) had taken mental health focused courses in college even if they were not trained as a mental health professional.

Qualitative responses to asking participants about their training needs related to young children's mental health yielded two themes (Table 2), *No Additional Training Needs* and *Additional Training Needs*, each with subcategories. Three Level II codes, or categories, emerged within the Additional Training Needs theme. First, were respondents who expressed the need for more *Training* on young children's mental health. For instance, Respondent 1167 said, "I am hopeful that this survey will highlight the need for more training. There is a great need." The second category that emerged was *Access to Resources*. For example, Respondent 1771 said:

> I would hope that part of your work considers how much is being asked of teachers. I would hope that there are efforts to create new systems to support the mental health needs of children as their sole goal, rather than adding this to everything else teachers are responsible for. We need trained mental health professionals to work either alongside us in school or independently to meet the needs of children, not teachers who have had a few workshops.

The third category that emerged is the *Importance of Mental Health*. For instance, Respondent 1119 said, "I think exposure and reminders about all of these topics are helpful to keep early childhood mental health at the forefront of people's minds is very important."

A series of T-tests (Table 3) examined the impact of mental health-focused education. Specifically, to ascertain whether having mental health training through either college or professional development impacted professionals' confidence in recognizing and responding to their own and children's mental health needs. Early childhood mental health training in college was associated with higher confidence in recognizing mental health needs in young children ($M = 2.96$, $SD = 0.66$) than those who did not have college level training ($M = 2.50$, $SD = 0.74$). This difference was statistically significant $t(591) = -10.81$ $p < .001$ and had a large effect size $d = .72$. ECEs who had mental health training in college also had a higher level of confidence in responding to mental health needs in young children ($M = 2.84$, $SD = 0.70$) as compared to those without college level training ($M = 2.37$, $SD = 0.73$). This difference was statistically significant ($t(559) = -10.72$, $p < .001$) and had a large effect size $d = .72$. Similarly, early childhood mental health training through professional development was associated with higher confidence in recognizing mental health needs in young children ($M = 2.75$, $SD = 0.70$) as compared to those without mental health focused professional development ($M = 2.48$, $SD = .0.75$). This difference was statistically significant ($t(1403) = -6.83$, $p < .001$) and had a large effect size $d = .73$. Professional development focused on mental health was also associated with higher confidence in recognizing mental health needs in young children ($M = 2.63$, $SD = 0.70$) as compared to those without such professional development ($M = 2.35$, $SD = 0.77$). This difference was statistically significant ($t(1403) = -6.83$, $p < .001$) and had a large effect size $d = .73$. Participating in professional development focused on mental health was also associated with statistically significant higher confidence ($t(1417) = -7.10$, $p < .001$) responding to mental health needs in young children ($M = 2.63$, $SD = 0.70$) when compared to those without this type of training ($M = 2.35$, $SD = 0.77$). The effect size of for this difference was also large, $d = 0.74$.

RQ #2 Preparedness

Early childhood educators reported that they are somewhat confident ($n = 588$, 41.4%) or confident ($n = 607$, 42.8%) in recognizing mental health needs in young children. Some respondents were very confident ($n = 157$, 11.1%) or not at all confident ($n = 67$, 4.7%) in recognizing mental health needs in young children. Generally, respondents who described their role as an educator were less sure of how to respond to young children's mental health needs, although the majority of respondents were somewhat confident ($n = 649$, 45.7%) or confident ($n = 548$, 38.6%), with smaller numbers of respondents either very confident ($n = 116$, 8.2%) or not at all confident ($n = 106$, 7.5%).

Group comparisons of confidence recognizing and responding to children's and one's own mental health were conducted to look at respondents trained as educators (early childhood educators, special educators, and general educators) or respondents trained as mental health professionals (school psychologists, social workers, and professional counselors). Having mental health related training was associated with higher levels of recognizing ($M = 2.96$, $SD = 0.75$) and responding ($M = 2.86$, $SD = 0.79$) to young children's mental health needs. The mean differences in recognizing ($t(121) = -5.08$, $p < .001$) and responding ($t(1357) = 5.42$, $p < .001$) were statistically significant and had large effect sizes, $d = .74$ and $d = .74$, respectively.

RQ #3 ECE Mental Health

Being trained in mental health and having taken mental health courses in college were both associated with higher levels of confidence recognizing and responding to one's own mental health needs. Individuals with mental health training were more likely to have confidence in recognizing ($M = 3.29$, $SD = 0.72$) and responding ($M = 3.09$, $SD = 0.80$) to their own mental health needs. Confidence recognizing ($t(1357) = 3.26$, $p < .001$) and responding ($t(1357) = 3.00$,

Table 2 Themes, categories, and exemplar quotes from qualitative coding

Theme	Category	Exemplar quotes
Question one		
Is there anything else we should know about your training needs related to young children's mental health?		
No additional training needs	No additional training needs	Respondent 1403 No, thank you. This is a very comprehensive survey
Additional training needs	Access to resources	Respondent 1771 I would hope that part of your work considers how much is being asked of teachers. I would hope that there are efforts to create new systems to support the mental health needs of children as their sole goal, rather than adding this to the everything else teachers are responsible for. We need trained mental health professionals to work either alongside us in school or independently to meet the needs of children, not teachers who have had a few workshops
	Training	Respondent 1167 I am hopeful that this survey will highlight the need for more training. There is a great need
	The importance of mental health	Respondent 1119 I think exposure and reminders about all of these topics are helpful to keep early childhood mental health at the forefront of people's minds is very important
Question two		
What supports do you believe would help you avoid personal and professional burnout?		
Relational and mental health support	Connection with others	Respondent 1308 Having support from professionals in the building to help with any concerns or problems you my encounter with your students
	Mental health resources	Respondent 1498 More mental health professionals in our schools that support children, families and staff
Systemic changes	Benefits & pay	Respondent 1515 I strongly believe that preventing personal & professional burnout begins at the highest level of an organization and must be a priority at all levels. I also believe that preventing burnout begins with providing incredibly well for an employee's basic needs. Employees must be supported financially to the highest level possible (solid pay, benefits, health care, retirement, etc.) and MUST have flexible and plentiful paid time off and be encouraged to apply that as needed. Plentiful, PAID parental leave (for both parents). Funding for professional development (and supported time away from everyday work duties to pursue it). These things are not luxuries; they are essential to providing employees with a balanced existence inside and outside of work
		Respondent 1607 Specifically, a well staffed school with people who actually want to work with children and are not just looking for a paycheck. Overall, I believe it's less the children and more the profession in general. We are underpaid, overworked, maxed out at ratio, and not taken as seriously as we should (we are literally helping human beings develop!)
	Supportive systems	Respondent 1175 SYSTEMS! The burnout rate is high. This is a system problem and not an educator problem. Self care and mental health support for staff needs to be regular and integrated into the day as part of the job, not another thing on our plate. I need help with setting boundaries and speaking up when I disagree and navigating conflict with administrators and teachers. It is draining to beat myself up when I hear comments that reflect implicit bias and a white supremacy culture and I don't have the skills to regulate myself and have courage to lean into the uncomfortable conversations. I'm not living into my values and it is painful
		Respondent 2247 More awareness from our own administration about the real challenges we face everyday
	Training	Respondent 1047 Administration training to recognize and support this in their staff

$p = .001$) to their own mental health needs were statistically significant as compared to those without mental health training. The associated effect sizes with recognizing ($d = .73$) and responding ($d = .77$) to one's own mental health were large. Individuals who had mental health training in college had higher confidence in recognizing their own mental health needs ($M = 3.18$, $SD = 0.67$) as compared to those without this type of training ($M = 3.03$, $SD = 0.75$). This difference was statistically significant ($t(1417) = -3.38$, $p < .001$) and had a large effect size $d = .73$. Mental health training in college was also associated with higher confidence in responding to one's own mental health needs ($M = 2.98$, $SD = 0.75$) as compared to those without this training ($M = 2.84$, $SD = 0.77$). This difference was statistically significant ($t(552) = -2.92$, $p = .002$) and had a large effect size $d = .77$. Mental health focused professional development was not statistically significantly associated with increased recognition or perceived competence responding to one's own mental health needs, although the effect sizes were still large, $d = .73$ and $d = .77$, respectively.

RQ #4: ECE Mental Health, Stress and Burnout

Two themes and five categories emerged from the qualitative responses asking participants about support that would help avoid personal and professional burnout (Table 2). The two themes that emerged focused on the need for relational connections and mental health supports and the need for systemic change. The shortcomings of early childhood systems are well documented elsewhere (see Hindman & Bustamante, 2019) and were replicated in the current findings, with respondents indicating the need for more systemic and resource supports. The second theme that emerged focused on the need for additional *Relational and Mental Health Support* in order to allow professional and personal wellbeing of ECEs. The two emerging categories were *Connection with Others* and *Mental Health Resources*. For instance, Respondent 1308 said "Having support from professionals in the building to help with any concerns or problems you may encounter with your students" or Respondent 1498 emphasized the need for "More mental health professionals in our schools that support children, families and staff."

Discussion

The present study aimed to learn about ECEs' training, experience, and preparedness to work with young children's challenging behaviors and mental health needs, as well as the role of personal mental health, stress, and burnout amongst ECEs. Overall findings indicate that most ECEs have some training and experience related to addressing young children's challenging behaviors and mental health needs. However, the type of training and range of experiences were variable. There were group-level differences based on professional training backgrounds and the types of learning the professional had participated in. Findings are discussed in detail below.

The first research question asked about the training and experiences ECEs had related to addressing challenging behaviors and supporting mental health. The need for additional training focused on young children's mental health is often mentioned in the literature (Askell-Williams & Cefai, 2014; Graham et al., 2011). Overall respondents had experience working with children with a range of behavioral and mental health needs, with externalizing concerns (e.g., behavior, social challenges) more frequently than internalizing concerns (e.g., depression, anxiety). Formal training focused on young children's mental health and challenging behavior was endorsed by most respondents, with professional development as the most common type of training. Colorado, where the present study took place, requires continuing education related to social-emotional development, which may be reflected in the data (Colorado Office of Early Childhood, 2022). However, a notable percentage of respondents said that they had not had any training focused on young children's mental health.

The second research question asked whether ECEs feel prepared to work with young children with challenging behaviors and mental health needs. Prior research has shown that supporting social emotional development and challenging behaviors is often an area where ECEs are less confident (Hemmeter et al., 2008). The current data reflected a lot of variation in comfort addressing children's mental health needs and challenging behavior, which is not surprising given the range of experiences and professional training in the sample. Although most respondents had some level of comfort addressing children's challenging behavior and mental health needs, a small, but noteworthy, group of respondents was not at all comfortable responding to young children's mental health needs. There were also some important group level patterns. Individuals with a mental health training background were much more comfortable recognizing and responding to mental health needs than individuals with an educational background. The types of training someone has had focused on mental health (e.g., college courses, professional development) also was influential, with both college level courses, and professional development sessions associated with increased comfort recognizing and responding to children's mental health needs.

Over time, there have been increased calls for higher educational attainment amongst ECEs, to align with evidence for best practices (Institute of Medicine and National Research Council, 2015; Whitebook et al., 2018). Yet, professional development, in the form of various types of on-the-job training is the most common type of formal learning for many

Table 3 T-tests by types of training

	College courses		No college courses		*t*(n)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Confidence recognizing mental health need in young children	2.96	.66	2.50	0.74	− 10.81(591)	< 0.001	0.72
Confidence responding to mental health needs in young children	2.84	0.70	2.37	0.73	− 10.72(559)	< 0.001	0.72
Confidence in recognizing their own mental health needs	3.18	.67	3.03	0.75	− 3.38(1417)	< 0.001	0.73
Confidence in responding to their own mental health needs	2.98	.75	2.84	0.77	− 2.92(552)	.002	0.77
	Professional development focused on mental health		No professional development focused on mental health		*t*(n)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Confidence recognizing mental health need in young children	2.75	0.70	2.48	0.75	− 6.83(1403)	< .001	0.73
Confidence responding to mental health needs in young children	2.63	0.70	2.35	0.77	− 7.10(1417)	< .001	0.74
Confidence in recognizing their own mental health needs	3.06	0.73	3.06	0.74	0.026(1417)	0.490	0.73
Confidence in responding to their own mental health needs	2.88	0.76	2.86	0.78	− 0.378	0.353	0.77
	Education training		Mental health training		*t*(n)	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Confidence recognizing mental health need in young children	2.58	0.74	2.96	0.75	5.08(121)	< .001	0.74
Confidence responding to mental health needs in young children	2.45	0.74	2.86	0.79	5.42(1357)	< .001	0.74
Confidence in recognizing their own mental health needs	3.04	0.73	3.29	0.72	3.26(1357)	< .001	0.73
Confidence in responding to their own mental health needs	2.85	0.76	3.09	0.80	3.00(1357)	.001	0.77

The variation in the value of n is due to whether Levene's Test for Equality of Variances was significant or not, which determined whether equal variances were or were not assumed

ECEs, making it an essential part of ECE training (Rucker et al., 2022). Professional development has been associated with ECEs' ability to support young children's development (Egert et al., 2018), with variation depending on the type, focus, and duration of the training provided (Brunsek et al., 2020). Present findings extend prior research related to both formal education and professional development, demonstrating that at the aggregate level (versus focusing on a specific training program or type of training) they can have a positive impact on ECEs work with young children.

Qualitative findings asking about participant training needs related to young children's mental health and challenging behavior were divided between respondents who wanted more mental health focused training and those who did not want additional training. Those who did want additional training focused on the need for more recognition and support related to young children's mental health. Responses discussed both didactic training as well as elevating the importance of mental health and access to resources so that the work does not fall solely on ECEs. Many of the responses asking for additional resources focused on the need for mental health professionals and specialists, both to support young children and ECEs.

Given the relationship between ECEs' own mental health and their ability to support young children (Zinsser et al., 2013), the present study aimed to learn how confident ECEs are in recognizing and addressing their own mental health needs. As previously mentioned, respondents who had participated in mental health-focused professional development or who had taken college-level mental health courses reported more confidence in recognizing and responding to young children's mental health needs. However, only the group of ECEs who had mental health focused training in college were more confident in recognizing and responding to their own mental health needs. Given that ECE mental health is associated with their ability to support the young children whom they work with (Zinsser et al., 2013) and related to their stress and burnout (Whitaker et al., 2015), this is important to consider. One possible reason for this finding is that college level courses can provide more in-depth information than professional development sessions. Therefore, ECEs who have had college level mental health focused courses may have learned more about topics related to their own mental health as well as that of young children.

Addressing ECEs' stress and burnout is an essential issue in early education, both to support the educators working

in these spaces (Whitebook & Sakai, 2004) and because of the impact that educator wellbeing has on young children in their care (Logan et al., 2020; Whitaker et al., 2015). The present study examined factors that ECEs related to their level of stress and burnout. Qualitative themes were either related to relational and mental health supports or systemic changes. Like prior research (National Research Council, 2015), respondents indicated that they need additional support with their own mental health and systems that recognize and support their work (Logan et al., 2020). Collegial workplace relationships (Eadie et al., 2021) and mental health coaching (Conners Edge et al., 2021), both of which are relationally based, have shown evidence of buffering ECEs against some of the stress that they experience.

Numerous studies have demonstrated the importance of positive mental health and supporting young children's mental health to support later academic and general success (Shonkoff & Phillips, 2000). Yet, often young children's mental health needs are not identified early, and young children frequently exhibit challenging behaviors, some of which are related to mental health needs, and are described by ECEs as their biggest challenge (Hemmeter et al., 2008). In turn, young children's challenging behaviors and mental health needs are linked to ECE stress and burnout (Whitaker et al., 2015). Given the high rate of turnover amongst ECEs (National Research Council, 2015), a better understanding of workforce challenges is vital. The current study adds to the existing literature by further describing the role of ECE training and perceptions related to mental health.

Limitations and Future Directions

Findings from the present study add to the existing literature in several ways, but they are not without their limitations. First, the current study sampled early childhood educators from a single state database, which presents a sampling bias, and it is not clear whether the results generalize to other contexts. In addition, the present research did not ask about certain demographic characteristics, such as respondent socioeconomic status or information about the child population they serve. Future research should continue to sample ECEs in various geographic locations who encompass a wide range of identities. The current sample was demographically homogeneous, although like the early childhood field as a whole in that respondents were overwhelmingly White and female-identifying (Whitebook et al., 2018) and may indicate a response bias. Nonetheless, it is important that future studies try to gather information from ECEs from other demographic groups to ensure representation in the research. Second, the use of self-reported stress has limitations as well. Although perception of stress (Schreyer & Krause, 2016) is important, objective physiological metrics (e.g. cortisol sampling) should also be considered in future research. Lastly, there were some limitations in what we were able to ask related to stress, burnout, and mental health, due to concerns about the sensitivity of these topics. Therefore, it is possible that asking more in-depth questions about ECEs experiences would have yielded different findings.

Conclusion

Early childhood educators encounter young children with behavioral challenges and mental health needs regularly in their work and their ability to respond effectively has lasting impacts on each individual child and on the collective functioning of our communities. Yet, the comfort ECEs have in recognizing and responding to these needs is inconsistent and influenced by their training. Given the importance of addressing these needs, both for the mental wellness and workplace satisfaction of ECEs and their ability to support the young children in their care, it is important that ECEs have competence in supporting young children's mental health and challenging behaviors. Furthermore, to continue to have an early childhood workforce, there must be mental health professionals available to support ECEs. Given the importance of early care and education for the youngest members of our community, addressing their needs and challenges, as well as those of the professionals working with them is essential. Ultimately, confronting the concerns that impact ECEs and the children in their care has far reaching impacts that are beneficial to society.

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Declarations

Conflict of interest We have no known conflict of interest to disclose.

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