Journal of Community Medicine & Public Health
Jeffrey JK, et al. J Community Med Public Health 6: 265.
www.doi.org/10.29011/2577-2228.100265
www.gavinpublishers.com

OPEN ACCESS

GAVIN PUBLISHERS

Research Article

Organizational Trauma-Informed Readiness, Burnout and Secondary Traumatic Stress among Head Start Staff and Educators during COVID-19

Jessica K Jeffrey[1*], Portia Jackson Preston[2], Delia Sanchez[3], Ariella Herman[4]

[1]Associate Professor, Department of Psychiatry and Biobehavioral Sciences, Semel Institute of Neuroscience and Human Behavior, University of California, Los Angeles, Los Angeles, CA, USA

[2]Assistant Professor, Department of Public Health, California State University, Fullerton, Fullerton, CA, USA

[3]Program Manager, Empowered to Exhale, Long Beach, CA, USA

[4]Research Director, Health Care Institute, University of California, Los Angeles, Anderson School of Management, USA

[*]**Corresponding author:** Jessica K Jeffrey, University of California, Los Angeles, Los Angeles, CA, USA

Citation: Jeffrey JK, Preston PJ, Sanchez D, Herman A (2022) Organizational Trauma-Informed Readiness, Burnout and Secondary Traumatic Stress among Head Start Staff and Educators during COVID-19. J Community Med Public Health 6: 265. DOI: 10.29011/2577-2228.100265

Received Date: 17 October, 2022; **Accepted Date:** 01 November, 2022; **Published Date:** 07 November, 2022

Abstract

The stressors experienced by Head Start staff and educators during the COVID-19 pandemic may increase their risk for burnout and secondary trauma. During the transition from in-person to online work, research has shown this population experienced increased stressors, accompanied by a decrease in wellbeing promoting activities, and an increase in mental health symptoms. The aim of this study was to explore the levels of burnout and secondary trauma symptoms among Head Start staff and educators during the COVID-19 pandemic, and the level at which their agencies are prepared to address exposure to trauma [JJK1] from clients. Participants completed a survey assessing their levels of adverse childhood experiences, compassion satisfaction, burnout, secondary traumatic stress (STS), and preparedness to address secondary trauma exposures. An ANOVA analysis showed that while indirect and direct roles both reported higher levels of burnout and STS compared to the overall population, indirect roles had slightly higher levels of STS and burnout compared to direct roles. The results of this study show the need for Head Start agencies to address and introduce trauma and resilience-informed care practices with early childhood education.

Keywords: Trauma-informed; Burnout; Secondary traumatic stress; Head start; Early childhood education

Introduction

Head Start early childhood education programs provide low-income children with a variety of educational and social services to support healthy growth and promote school readiness. Early childhood educators guide children's early educational experiences through their interactions with children and partnership with their parents. While baseline workplace stress is high among early childhood educators, the COVID-19 pandemic has further exacerbated levels of workplace and personal stress for Head Start educators and staff, putting them at risk for developing adverse health outcomes [1]. During the pandemic, low-income families experienced more food and housing insecurity due to job instability [2-4], and higher rates of COVID-19 infection and mortality [5]. These stressors and experiences within Head Start families

may influence relationships with early childhood educators and their wellbeing. Recent research indicates early childhood educators experience high levels of workplace stress, burnout, and Secondary Traumatic Stress (STS) [6-8]. High workplace stress has been associated with adverse mental health outcomes, such as depression, in early childhood educators [9,10].

Head Start educators and staff may be at particular risk for adverse mental health outcomes, given higher rates of risk factors, such as exposure to Adverse Childhood Experiences (ACEs), experienced among Head Start staff [9]. ACEs refer to exposure to potentially traumatic events, such as household dysfunction, abuse (physical, sexual, emotional), and neglect (physical, emotional) that occurs before age 18 [11]. Trauma occurs when experiences exceed a person's ability to cope. ACEs have lasting effects on health and wellbeing throughout the life span; this is important to note given that more than half (61%) of United States adults have reported at least one ACE, and one in six adults reported four or more ACEs [12]. Adults who experience ACEs may experience alterations in neural stress-regulatory circuits that increase stress sensitivity, placing them at increased risk for negative mental and physical health outcomes as adults, such as depression and obesity [13]. These symptoms, rooted in exposure to ACEs, may adversely affect the wellbeing of early childhood educators and staff. This may influence interactions with the children and families they serve [14], as may the social and emotional competence of these educators and their working environment [15]. In addition to experiencing ACEs themselves, Head Start educators and staff may be exposed to potentially traumatic events and situations as part of their work with Head Start children and families.

Compassion fatigue, thought to be an inevitable cost of caregiving [16], refers to the cumulative toll that results from working with traumatized individuals as part of everyday work [17,18]. Compassion fatigue is a state of exhaustion and dysfunction that occurs as a result of deep caregiver empathy resulting in manifesting trauma symptomatology, similar to that of the populations one serves [16]. The symptoms of compassion fatigue include an extreme state of tension, spanning psychological and physiological domains. For instance, symptoms of compassion fatigue may include anger and irritability, reduced empathy, headache, fatigue, and disrupted sleep. Symptoms of compassion fatigue may also include impairment in decision-making and reduced ability to care for those being served [18]. Ultimately, compassion fatigue may lead to increased work absenteeism, psychological injury claims, reduced work productivity, and turnover [18]. Compassion fatigue also influences job satisfaction and performance; importantly, this can impact one's relationship with the population served. However, research among human service professionals found that relationships within the workplace [19] and higher levels of compassion satisfaction [20] may reduce levels of compassion fatigue.

Compassion fatigue is conceptualized as consisting of a convergence of burnout and secondary traumatic stress [18]. Burnout is a phenomenon resulting from chronic stress due to work-related factors, and consists of three dimensions: emotional exhaustion, depersonalization, and lack of personal accomplishment [21]. Burnout increases when, being unable to reach a goal, an individual experiences feelings of frustration, lower morale, a loss of control, and inputting more effort into this goal [22]. Specific symptoms of burnout may include negative work-related attitudes, cynicism, and apathy [23]. Those experiencing burnout may feel overwhelmed and unsatisfied at work. Research in early childhood teachers has shown burnout contributes to lower rates of productivity, as well as higher work absenteeism and job turnover [24].

Secondary traumatic stress, the second component of compassion fatigue, may develop in individuals who work with clients who have been exposed to trauma. Symptoms of STS are similar to post-traumatic stress disorder [16] and may include intrusive thoughts, avoidance thinking or talking about a trauma, negative cognitions and mood, and changes in arousal and reactivity. According to Stamm, individuals who experience symptoms of STS are overwhelmed by the trauma incurred by those they serve, and unable to stop thinking about those they serve. Burnout and STS are related but distinct concepts. STS encompasses fear, which is not addressed by burnout [25]. Also, burnout focuses on factors related to how work is organized or delivered, rather than the emotional impact of serving others. STS is often discussed in conjunction with vicarious trauma, which is an altering in one's perception of the world as a result of engaging with individuals who have experienced trauma on a regular basis [26]. STS and vicarious traumatization have been associated with adverse physical health symptoms (e.g., high blood pressure, obesity, diabetes) [27] and mental health outcomes, such as anxiety and depression [28].

Compassion satisfaction, which refers to the positive aspects associated with one's role as a caregiver, may protect against the effects of workplace stress [25]. According to Stamm, compassion satisfaction may be thought of as the pleasure one derives from being a caregiver [25]. This construct describes the sense of meaning and purpose in the role. Compassion satisfaction is negatively correlated with burnout and secondary traumatic stress, and clinicians with higher levels of compassion satisfaction are more resilient [29]. Research conducted on early childhood home visitors found these educators experienced high levels of compassion satisfaction compared to the general population [28]. It was hypothesized that higher levels of compassion satisfaction may have buffered the effects of stressful events for these educators.

A study among a sample of healthcare employees during the beginning of the COVID-19 pandemic found that this population

was experiencing moderate levels of compassion satisfaction and low levels of burnout and secondary traumatic stress [23]. However, there is a gap in the literature that shows the levels of professional quality of life and rates of ACEs among early childhood educators. There is also limited data on how these factors have impacted this population during the COVID-19 pandemic. Due to the increased stress that early childhood education teachers and staff are under during the COVID-19 pandemic [1], an understanding of the prevalence of such as compassion fatigue, burnout, and secondary traumatic stress, and potential protective factors such as compassion satisfaction, is important for supporting this population and ultimately, the children and families they serve.

In order to better support the communities they serve, Bartlett and Smith recommend early childhood educators and support staff complete trauma and resilience-informed care (TRIC) training [14]. Trauma and resilience-informed systems within organizations help promote employee wellbeing [30], and Menschner et al. have created trauma-informed principles to help organization readiness [31]. The readiness of an organization to create awareness, address, and support staff with trauma is critical for preventing the negative outcomes associated with these phenomena [27], however, this is understudied in the Head Start context. Given that better wellbeing among early childhood educators has shown to increase positivity in the classroom, enhancing both children and educator experiences [32], this research aims to address this gap in the literature. The aim of this study is to 1) explore adverse childhood experiences in Head Start educators and staff, 2) ascertain the levels of compassion satisfaction, burnout, and STS in Head Start educators and staff during the pandemic, and 3) explore the levels of readiness within organizations to address burnout and trauma, in a nationwide sample of Head Start educators and staff.

Methods

Settings

This study focused on data collected in spring 2021 from a nationwide sample of agencies with Early Head Start and/or Head Start programs. Institutional review board approval was obtained prior to the study's start. The sample consists of 3,313 staff from 40 agencies selected to participate in the inaugural UCLA Trauma Informed Care Institute, selected based on letters of intent and efforts to ensure all 12 Head Start regions (spanning the United States) were represented. An anonymous online SurveyMonkey survey was circulated via email to participating agencies, who then forwarded it to their staff.

Adverse Childhood Experiences Scale (ACEs)

The Adverse Childhood Experiences Scale (ACEs) measures experiences of abuse (physical, emotional, sexual), neglect (physical, emotional), and household dysfunction (mental illness, incarcerated relative, mother treated violently, substance abuse, divorce) before the age of 18 [9]. The respondents indicate either yes or no, and the total score is used in the analysis. ACEs has been used in the adult population [9,11].

Professional Quality of Life (Pro-QOL)

The Professional Quality of Life Scale (ProQOL-5) was used to assess compassion satisfaction and compassion fatigue (burnout and STS) in relation to an individual's occupation [25]. This scale measures these factors on a Likert scale from 1 (Never) to 5 (Very Often). Extensive previous research has been done using the ProQOL-5 to establish validity, although there are some concerns that the reliability and validity for measures of STS and burnout can be improved [33,34].

Vicarious Trauma Informed Organizational Assessment (VT-ORG)

The Vicarious Trauma Informed Organization Assessment (VT-ORG) was used to assess organizational preparedness to address the effects of being exposed to the trauma of clients [35]. Vicarious trauma and STS are both associated with the trauma from exposure to trauma of others that these individuals experience. Previous studies have indicated strong reliability (Cronbach's alpha of .98) with the following results for subscales: leadership and mission (α=0.93), management and supervision (α=0.96), employee empowerment and teamwork (α=0.95), training and professional development (α=0.88), and staff health and wellness (α=0.93).

Trauma-Informed Organizational Assessment

The trauma-informed organizational assessment was used to assess the organization's readiness to address trauma. This assessment is separated into three parts: 1) Training & Education, 2) Adapting Policies, and 3) The Secondary Traumatic Stress-Informed Organization Assessment (STSIOA), with response options of Not at all, Rarely/Somewhat, and Mostly/Completely. This instrument is useful for understanding practices within an agency but is not used for comparison across agencies.

This assessment was completed by one staff member at each agency. Having learned from our prior experiences with Head Start agencies that staff response rates were maximized when surveys are written at an appropriate literacy level, we chose to adapt questions from several surveys, with the goal of assessing their agency's level of preparation to engage in trauma-informed practices. Parts one (Training & Education) and two (Adapting Policies) included questions from the staff development and adapting policies sections of the Agency Self-Assessment for Trauma-Informed Care, created from the National Center on Family Homelessness Trauma-Informed Organizational Self-Assessment [36,37]. One question was added: "the agency has a system in place to develop/sustain common trauma-informed objectives and SMART goals,"

referring to goals that are specific, measurable, attainable, realistic, and timely. For part three, select questions from the Secondary Traumatic Stress-Informed Organization Assessment (STS-IOA) (Sprang et al. 2014) were adapted to fit Head Start grantees. This assessment has shown very good reliability of α=.977 [38] and has been used to address organizational readiness in child welfare organizations [39].

Demographics

Respondents were asked to report demographic information consisting of individual and organizational characteristics. Individual characteristics included role/position, age, and the number of years they have been working for Head Start. In order to decrease the likelihood that smaller agencies could disaggregate data about staff, information on gender, race, and ethnicity were not collected. Organizational characteristics were submitted by one representative from each agency, and included services provided (Early Head Start, Head Start, or both), organization type, setting (urban, rural, or mixed), agency region, number of children served, and number of staff employed.

Data Analysis

Frequencies were reported for each measure, representing a baseline data collection for this population. One-way ANOVA tests were performed for compassion satisfaction, burnout, and STS scores across 14 different roles in direct and indirect categories.

Results

Demographics

The majority of participants were age 30 or older (57.4%) Nearly one half of the sample were teachers (46.5%) and have been with Head Start for 5 years or less (49.6%). Full demographics are provided in Table 1.

		Percentage	Sample (N=3313)
Age Group	Under 20 years	5.53%	3313
	20-29 years	13.23%	
	30-39 years	23.87%	
	40-49 years	23.35%	
	50-59 years	22.33%	
	60 and above	11.69%	
Number of years with Head Start	Less than 1 year	8.55%	
	1-2 years	18.22%	
	3-5 years	22.87%	
	6-10 years	17.01%	
	11-15 years	11.69%	
	16-20 years	8.97%	
	Over 20 years	12.69%	
Agencies per Region	1	2.50%	40
	2	12.50%	
	3	7.50%	
	4	5.00%	
	5	7.50%	
	6	2.50%	

	7	7.50%	
	8	7.50%	
	9	25.00%	
	10	20.00%	
	11	2.50%	

Table 1: Head Start Staff Demographics.

Adverse Childhood Experiences (ACEs)

The results from the ACEs scale (n=453) show that the three in four Head Start Staff (77%) have experienced at least one adverse childhood experience (ACE), and one in three Head Start staff (35%) have experienced four or more ACEs (Figure 1).

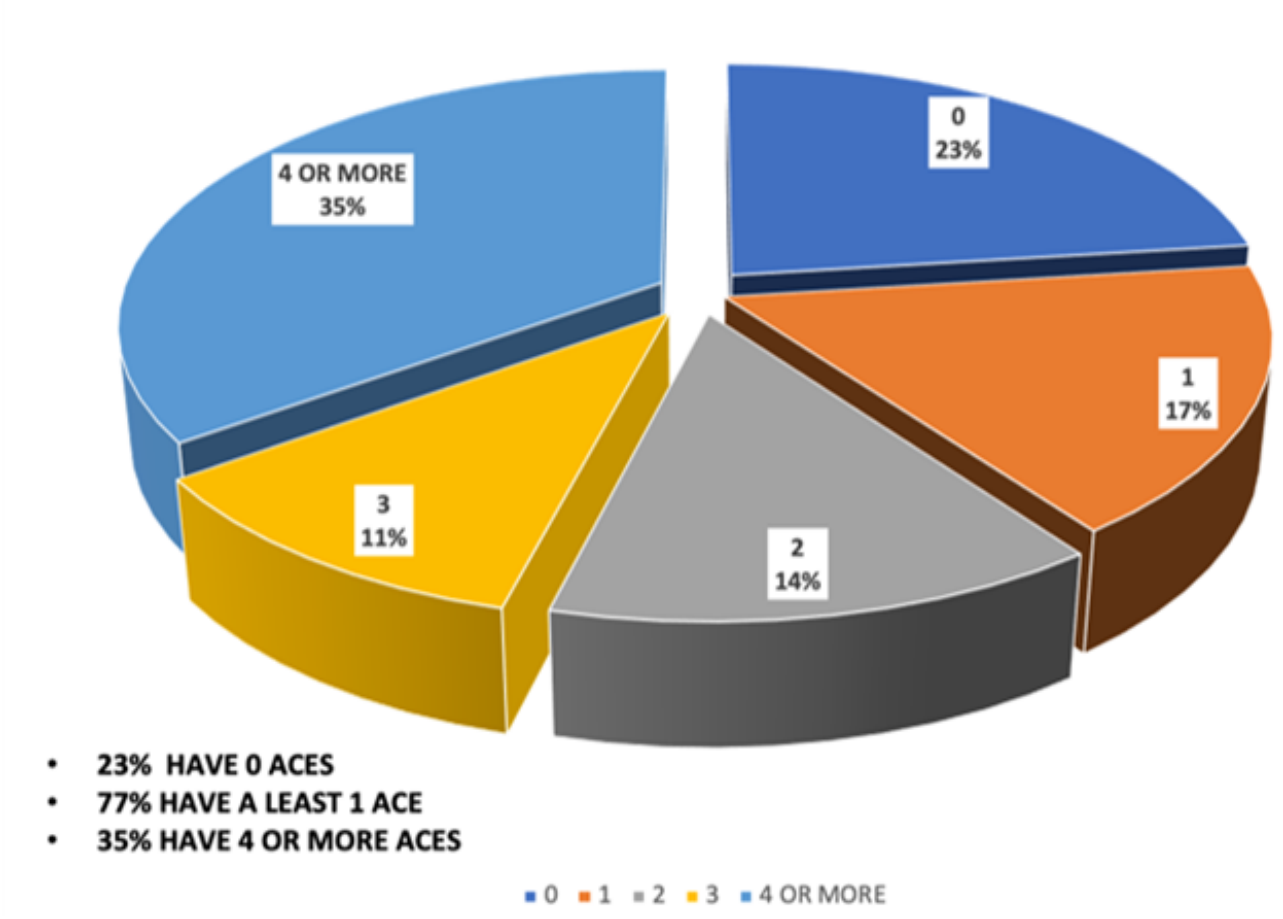

Figure 1: Number of ACES for Head Start Sample.

Professional Quality of Life (Pro-QOL)

Table 2 depicts results of the one-way ANOVA tests for compassion satisfaction, burnout, and STS scores across roles in direct and indirect categories.

Role	CS (Compassion Satisfaction)			BO (Burnout)			STS (Secondary Traumatic Stress)		
	N	Mean (SD)	P value	N	Mean (SD)	P value	N	Mean (SD)	P value
Direct Role	**2,406**	**41.15 (5.30)**	**0.468**	**2,106**	**21.04 (5.40)**	**0.005** **	**2,106**	**20.89 (5.78)**	**0.006** **
Home Visitor	193	41.18 (5.28)	0.297	193	20.62 (5.34)	0.287	193	21.05 (6.11)	0.476
Bus Driver	37	42.05 (4.39)	0.269	37	18.03 (4.87)	**0.000** ***	37	18.54 (6.12)	**0.021** *
Family Services Manager/Coordinator/Advocate	275	41.60 (5.49)	0.096	275	21.28 (5.33)	0.388	275	20.93 (5.05)	0.620
Teacher/Teacher's Aide/Assistant/Educator	1,411	41.14 (5.27)	0.683	1,411	21.13 (5.38)	0.280	1,411	21.00 (5.80)	**0.037** *
Indirect Role	**648**	**40.94 (5.39)**	**0.468**	**398**	**21.87 (5.32)**	**0.005** **	**398**	**21.77 (6.62)**	**0.006** **
Center Director/Assistant Director	148	41.31 (5.23)	0.614	148	22.07 (5.32)	**0.014** *	148	22.63 (6.02)	**0.000** ***
Executive Director/Director	53	40.96 (4.99)	0.852	53	23.06 (5.37)	**0.005** **	53	22.91 (7.93)	**0.007** **
Office Assistant/Secretary/Clerk	107	40.69 (5.94)	0.421	107	20.34 (5.09)	0.179	107	19.77 (5.95)	0.076
Education Content Manager/Coordinator	90	40.60 (5.13)	0.367	90	22.69 (5.00)	**0.003** **	90	22.09 (6.95)	**0.030** *
Health Manager/Coordinator/Specialist	67	40.10 (5.18)	0.121	67	22.19 (6.06)	0.069	67	22.19 (5.86)	0.541
Mental Health Content Manager/Coordinator	25	41.72 (4.60)	0.555	25	21.88 (5.17)	0.418	25	22.84 (7.92)	0.076
Nutrition/Food Services Content Manager/Coordinator	67	39.25 (5.05)	**0.004** **	67	20.90 (5.13)	0.849	67	20.01 (5.47)	0.296
Custodian	25	40.28 (6.34)	0.439	25	18.84 (4.96)	**0.041** *	25	16.52 (4.30)	**0.000** ***
Transportation Manager	6	40.17 (4.49)	0.667	6	15.67 (2.62)	**0.014** *	6	17.67 (6.00)	0.198
Other[1]	**550**	**41.01 (5.21)**	**0.688**	**550**	**20.31 (5.05)**	**0.001** ***	**550**	**19.54 (5.55)**	**0.000** ***
All Roles	3,054	41.10 (5.30)		3,054	21.02 (5.34)		3,054	20.76 (5.89)	

Note: The referent population is the sample mean. ProQOL scores range from 10 to 44, with the following cutpoints: Low (10-22), Moderate (23-41), High (42-44). Other1: One more or more of the following were true: participants had a combination of listed direct and indirect roles, a role not listed here, or did not disclose their role, potentially due to a fear of being identified based on small agency size. *Significant at the p<0.05 level; **Significant at the p<0.01 level; ***Significant at the p<0.001 level.

Table 2: Role Relationships with ProQOL.

Compassion satisfaction

The comparison of direct and indirect roles showed there is no significant difference in compassion satisfaction levels. Participants in nutrition, food services, content management and coordinators had significantly lower compassion satisfaction scores (39.25 (SD=5.05), p=0.004) compared to the sample mean.

Burnout

Higher mean levels of burnout were reported among executive directors and directors (23.06 (SD=5.37), p=0.005), education content managers and coordinators (22.69 (SD=5.00), p=0.003), and center directors and assistant directors (22.07 (SD=5.32), p=0.014) compared to the sample mean.

On the contrary, significantly lower levels of burnout were reported in bus drivers (18.03 (SD=4.87), p<0.000) and other roles (20.31(SD=5.05), p<0.001), and in transportation managers (15.67 (SD=2.62), p=0.014) and custodians (18.84 (SD=4.96), p=0.041) compared to the sample mean.

Secondary Traumatic Stress (STS)

When comparing indirect roles and direct roles, there was a significant difference in burnout and STS compared to the sample mean. Indirect roles (21.87 (SD=5.32), p<0.005) had a slightly higher level of burnout than direct roles (21.04 (SD=5.40), p<0.005). Indirect roles (21.77 (SD=6.62), p=0.006) also had a slightly significant level of STS than direct roles (20.89 (SD=5.78), p=0.006).

Significantly higher levels of STS were reported in center directors and assistant directors (p<0.000, 22.63 (SD=6.02)), executive directors and directors (22.91 (SD=7.93), p=0.007), education content managers and coordinators (22.09 (SD=6.95), p=0.030), and teachers, teacher's aides, assistants, and educators (21.00 (SD=5.80), p=0.037).

Significant lower levels of STS were found in custodians (p<0.000, 16.5 2(4.30)), other roles (19.54 (SD=5.55), p<0.000), and in bus drivers (p=0.021, 18.54 (SD=6.12)), compared to the sample mean.

Vicarious Trauma Informed Organization Assessment (VT-IOA)

Participants reported the frequency that their agency focuses on the different areas of organizational readiness to address vicarious trauma: leadership and mission; management and supervision; employee empowerment and work environment; training and professional development; and staff health and wellness. The average scores for staff health and wellness were lower than all other areas. The individual statements for this area are depicted in Table 3.

Area of Organizational Health	Mean
Leadership and Mission	4.15
Management and Supervision	3.78
Employee Empowerment and Work Environment	3.93
Training and Professional Development	4.03
Staff Health and Wellness	3.68*
1. My organization offers services that support individual staff members (e.g., employee assistance program, mental health providers, etc.).	4.07
2. My organization provides opportunities for peers to support one another.	3.91
3. My organization conducts exit interviews that include questions related to trauma and the organization's response.	3.58
4. Differentiation between work and non-work hours is recognized and respected.	4.02
5. My organization's policies support mental health and wellness.	3.84
6. My organization's policies support physical health and wellness.	3.42*
7. My organization provides wellness activities (e.g., a fitness program, mindfulness/meditation, yoga, gym access).	3.31*
8. My organization encourages wellness activities (e.g., a fitness program, mindfulness/meditation, yoga, gym access).	3.41*
Note: *is used to label areas and subareas that need attention from the organization.	

Table 3: Vicarious Trauma Informed Organization Readiness.

Trauma-Informed Organization Assessment (T-IOA)

The trauma-informed organization assessment was completed by one person at each agency. The majority of respondents disagree or responded rarely/somewhat to several critical items in this assessment, as shown below in Table 4.

PART I: Training & Education	
Staff at all levels of the program receive training and education on the following topics:	Do Not Agree
Cultural differences in how people understand and respond to trauma	62%
Part of supervision time is used to help staff members understand their own stress reactions	51%

How working with trauma survivors impacts staff	50%
PART II. Adapting Policies	
Creating Written Policies	Do Not Agree
The agency has a written statement that includes a commitment to understanding trauma and engaging in trauma-sensitive practices.	69%
Written policies are established based on an understanding of the impact of trauma on staff.	65%
The agency has a system in place to develop/sustain common trauma informed objectives and SMART goals.	61%
PART III: The Secondary Traumatic Stress-Informed Organization Assessment (STS-IOA)	
The organization promotes resilience-building activities that enhance the following:	Rarely/Somewhat
a. Basic knowledge about STS	68%
b. Monitoring the impact of STS on professional wellbeing	68%
How STS-informed are organizational policies?	
a. The organization has defined practices addressing the psychological safety of staff	54%
b. The organization's strategic plan addresses ways to enhance staff resiliency	56%
How STS-informed are other routine organizational practices?	
a. The organization provides formal trainings on ways to enhance psychological safety	54%
b. The organization offers activities (besides trainings) that promote resilience to STS	56%
How well does the organization evaluate and monitor STS policies and practices?	
a. The organization assesses the level of STS in the workplace	59%
b. The organization responds to what it learns through evaluation, monitoring and/or feedback in ways that promote safety and resilience	62%

Table 4: Trauma-Informed Organizational Readiness.

Discussion

There is a dearth of scholarship about early childhood educators' professional quality of life during the COVID-19 pandemic, although it is known that stress levels of early childhood educators increased drastically during the COVID-19 pandemic [1]. This paper expands upon previous research by further exploring employee professional quality of life and Head Start Centers' organizational readiness to respond to stress and trauma in a national sample of Head Start educators and staff. The results of this study show the need for Head Start agencies to implement trauma and resilience-informed care practices within their agencies.

Adverse Childhood Experiences

This scale was originally sent to organizations as part of the survey to be administered to their staff. However, it was removed after two days because organizations became concerned that staff who previously experienced trauma may be triggered by the questions posed in the survey. For those who completed the ACEs scale, results revealed respondents were more likely to have one ACE (77% versus 61% in a national sample) and three times more likely to report they had experienced four or more ACEs [12]. Specifically, participants experienced higher rates of physical, emotional, and sexual abuse, and physical and emotional neglect compared to the national sample. Rates of household dysfunction (e.g. mental illness, incarcerated relative, mother treated violently, substance abuse, divorce) were also higher than the general population sample. These results are similar to previous reports of increased ACEs in Head Start staff. Whitaker, Dearth-Wesley, and Gooze found that among Head Start staff who had experienced 3 or more ACEs, 23% reported poor wellbeing [9]. This may lead to increased risk of negative health outcomes [13].

Professional Quality of Life

Head Start educators reported higher levels of compassion satisfaction (M=42) as compared to the average of a sample of healthcare employees also surveyed during the early months of the pandemic (M=40.85) [23]. This finding is consistent with previous research, which demonstrated that early childhood home visitors experienced high levels of compassion satisfaction compared to the general population [28]. The high levels of compassion satisfaction expressed by Head Start educators and staff in both direct and indirect roles may be due to the meaning staff derive from serving the Head Start community. Research has shown that human service professionals often find multiple personal rewards related to their work, such as the opportunity to build relationships, alleviate suffering, and develop resilience [19]. Notably, some Head Start employees may have a personal mission to devote themselves to the community, as they may be previous Head Start graduates or parents themselves [40].

Compassion satisfaction serves to buffer against the challenges of professional caregiving. It may be a major contributor to being able to handle daily job-related stressors, burnout, and secondary traumatic stress [20,29]. High levels of compassion satisfaction are likely a strong motivator for continued commitment to the Head Start community [41]. High rates of compassion satisfaction among staff may permeate through the organization to benefit colleagues and the families served, but cannot be expected to fully mitigate the stressors faced by these populations.

Although the average burnout score for this population fell in the moderate range, it was a much higher score (M=38) compared to the average burnout score for a sample of healthcare employees (M=22.27) [23]. This finding is eye opening considering the stressors placed upon healthcare employees during this time. Of note, Head Start executive directors and directors, education content managers and coordinators, and center directors and assistant directors reported higher rates of burnout as compared to the sample mean.

Increased rates of burnout among staff with indirect roles are likely multifactorial in nature. Head Start staff in leadership positions generally bore the responsibility for enacting and enforcing new organizational guidelines and policies related to COVID-19 (mask and vaccine mandates). They also had to quickly adapt curriculum and family services in response to these new policies. These adaptations occurred in an environment in which new information about the pandemic, and subsequent Head Start policies were constantly changing. Additionally, families with lower incomes have less access to technology, which may impact ability to access online educational opportunities and resources [42], thus leading to increased stress for Head Start educators and staff working to provide remote learning and services. In addition to possibly experiencing personal stress and challenges within their own families related to the pandemic, Head Start executive directors and directors, and center directors and assistant directors may have also been concerned for, and working to manage, their staffs' stress and burnout. This may have in turn impacted their own levels of burnout [1]. Levels of burnout should be of concern given its associations with negative attitudes towards one's role [23], and higher rates of absenteeism and turnover, as well as lower rates of productivity [24].

The average score of STS in this population fell within the moderate level (M=24), compared to low levels of STS in a sample of healthcare employees (M=21.54) [23]. These scores are consistent with findings in similar studies, in which early childhood educators also reported higher levels of STS [6-8]. Importantly, the pandemic has disproportionately impacted families of lower socioeconomic status, those families served by Head Start. Economically disadvantaged children and families may experience increased exposure to the virus due to less opportunity for parents

in essential worker occupations to work from home during the pandemic. Families with lower socioeconomic status also faced disproportionately greater instability in work conditions and income, impacting food and housing security during the pandemic [2-4]. Furthermore, these families often have less access to health services to screen for the virus and manage infection [2]. Overall, economically vulnerable families experienced a higher incidence of infection and mortality from the virus, as compared with more economically advantaged families [5]. These factors increase the risk for stress and trauma in families, which in turn may increase the risk for stress and adverse mental health outcomes in Head Start educators and employees who are directly exposed to the struggles faced by the children and families they serve [10].

Trauma-Informed Organization Readiness

Trauma and resilience informed systems place an emphasis on the health and wellbeing of individuals who make up the system, and not incurring further harm to that population [30]. Fundamental to trauma and resilience-informed organizations are a shared mission and foundational principles. Both the vicarious trauma-informed organizational assessment and trauma-informed organizational assessment revealed that the majority of respondents felt they did not receive appropriate training for navigating stress and engaging with traumatized individuals. Additionally, participants indicated there is a lack of current organization policies focusing on the effects of trauma on staff and wellness among staff, in addition to the lack of organization participation in developing and implementing trauma-informed objectives and SMART goals for the organization. They also reported a lack of implementation of activities focused on building resilience and addressing STS in Head Start educators and staff. These results, and the high prevalence of ACEs in early childhood educators suggest a logical next step that would be to implement a trauma and resilience-informed framework within Head Start agencies. Bartlett and Smith recommend that organizations implement this type of training in order to prevent the negative health outcomes from trauma exposure [14,27]. Additionally, SAMHSA has developed and disseminated five core trauma-informed principles to guide system transformation and approach to providing services: family/child empowerment; choice; collaboration in treatment and services planning; safety; and trustworthiness [31]. Head Start agencies may consider adopting this framework.

Limitations

Research on professional quality of life, wellbeing, and organization readiness in Head Start staff is limited. A strength of this study is that it sheds light on professional quality of life among a national sample of Head Start staff (n=3313) and organizations' preparedness to address secondary and vicarious trauma in the early months of the pandemic. One limitation of this study is the short duration of the ACEs survey, as collection was paused in response to agency requests to avoid potential triggers for respondents in the early days of the pandemic. In this case, being responsive to the needs of our study population was paramount. A second limitation is the potential for bias due to self-report. Those who chose to participate in the survey may also have been more motivated to discuss these topics than the general population, and their views may not accurately reflect those of staff who did not participate due to disinterest, discomfort, fear of disclosure, lack of time, or other barriers. An additional limitation is that participants were recruited from agencies who have previously participated in Health Care Institute programming and submitted a letter of interest, which means that experiences of agencies that have not participated in the institute are not accurately reflected. In attempts to protect their identity, some individuals did not disclose their agency role. In consideration of the small size of some reporting agencies, race and other demographic factors were not collected (in efforts to protect participants from potential disaggregation). Further research should explore how experiences vary among this population by race, ethnicity, gender, and other factors.

Implications

The results of this study have implications for policy and practice in early childhood education programs. Burnout and STS have been previously positively associated with adverse health outcomes [27,28], while compassion satisfaction has shown to possibly serve as a buffer against stressful situations [28]. The wellbeing of early childhood educators and the working environment affect the stability of child and teacher/adult relationships [8,14,15]. For example, early childhood educators who are mentally and physically healthier are better able to effectively perform job tasks and provide quality care and education to children, as well as effectively deal with the stress of the job [9]. Employees who consider themselves healthy have less absenteeism, are more present in their interactions with children, and model positive behavior in the classroom [32]. A focus on Head Start employee wellbeing, with goals to bolster compassion satisfaction and prevent burnout and STS, will positively impact not only staff, but children and families. Trauma-informed care training is critical for raising awareness within individuals and organizations to create and maintain a healthy workforce in order to best serve Head Start communities.

Conclusion

The UCLA Health Care Institute conducted this large study of professional quality of life and organizational readiness among Head Start staff throughout the United States in the early months of the pandemic to better understand the extent to which individuals were experiencing compassion satisfaction, burnout, and secondary traumatic stress. Agencies were also surveyed to

assess organizational readiness to effectively respond to these factors. The findings of this study indicate that overall, both direct and indirect roles are experiencing significantly high levels of burnout and STS. However, compassion satisfaction may serve as a protective factor against burnout and STS [43].

Future research will continue to explore professional quality of life and evaluate organizational readiness in Head Start programs in order to achieve a better understanding of the steps that have been taken and their impact. In the year since this data was collected, a trauma-informed care institute was developed to respond to the needs of this population as identified by this study. Two cohorts of Head Start agencies have completed workshops three weeks in duration to educate them on stress management and trauma-informed approaches at the individual and organizational level. Our future research will publish one-year follow-up data to determine the institute's impact, acknowledging that the pandemic may be affecting the population differently during this time.

Acknowledgement

We would like to thank the participants who took part in this study and our research team for all of their hard work during these difficult times of the COVID-19 pandemic.

References

1. Jeffrey J, Szeftel Z, Herman A (2020) Supporting Head Start Employee Well-Being During the COVID-19 Pandemic. JAACAP Connect 17-21.
2. Patel JA, Nielsen FBH, Badiani AA, Assi S, Unadkat VA, et al. (2020) Poverty, inequality and COVID-19: the forgotten vulnerable. Public Health 183: 110-111.
3. Morales DX, Morales SA, Beltran TF (2021) Food Insecurity in Households with Children Amid the COVID-19 Pandemic: Evidence from the Household Pulse Survey. Social Currents 8: 314-325.
4. Sharma SV, Chuang RJ, Rushing M, Naylor B, Ranjit N, et al. (2020) Social determinants of health–related needs during COVID-19 among low-income households with children. Prev Chronic Dis 17: 200322.
5. Karmakar M, Lantz PM, Tipirneni R (2021) Association of social and demographic factors with COVID-19 incidence and death rates in the US. JAMA Netw Open 4: e2036462.
6. Miller JA, Bogatova T (2009) Quality improvements in the early care and education workforce: Outcomes and impact of the TEACH Early Childhood Project. Eval Program Plann 32: 257-277.
7. Wells MB (2015) Predicting preschool teacher retention and turnover in newly hired Head Start teachers across the first half of the school year. Early Childhood Research Quarterly 30: 152-159.
8. Totenhagen CJ, Hawkins SA, Casper DM, Bosch LA, Hawkey KR, et al. (2016) Retaining early childhood education workers: A review of the empirical literature. Journal of Research in Childhood Education 30: 585-599.
9. Whitaker RC, Dearth-Wesley T, Gooze RA, Becker BD, Gallagher KC, et al. (2014) Adverse childhood experiences, dispositional mindfulness, and adult health. Prev Med 67: 147-153.
10. Lessard LM, Wilkins K, Rose-Malm J, Mazzocchi MC (2020) The health status of the early care and education workforce in the USA: A scoping review of the evidence and current practice. Public Health Rev 41: 2.
11. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, et al. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. Am J Prev Med 14: 245-258.
12. Center for Disease Control and Prevention (2019) Adverse Childhood Experiences (ACEs), Preventing early trauma to improve adult health.
13. Herzog JI, Schmahl C (2018) Adverse childhood experiences and the consequences on neurobiological, psychosocial, and somatic conditions across the lifespan. Front Psychiatry 9: 420.
14. Bartlett JD, Smith S (2019) The role of early care and education in addressing early childhood trauma. Am J Commun Psychol 64: 359-372.
15. Jennings PA, Greenberg MT (2009) The prosocial classroom: Teacher social and emotional competence in relation to student and classroom outcomes. Review of Educational Research 79: 491-525.
16. Figley CR (1995) Compassion fatigue: Toward a new understanding of the costs of caring. In: B. H. Stamm (Ed.), Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators (pp. 3-28). The Sidran Press.
17. Geoffrion S, Lamothe J, Morizot J, Giguère CE (2019) Construct validity of the professional quality of life (ProQoL) scale in a sample of child protection workers. J Trauma Stress 32: 566-576.
18. Cocker F, Joss N (2016) Compassion fatigue among healthcare, emergency and community service workers: A systematic review. Int J Environ Res Public Health 13: 618.
19. Rohan E, Bausch J (2009) Climbing Everest: Oncology work as an expedition in caring. J Psychosoc Oncol 27: 84-118.
20. Harr CR, Brice TS, Riley K, Moore B (2014) The impact of compassion fatigue and compassion satisfaction on social work students. Journal of the Society for Social Work and Research 5: 233-251.
21. Maslach C, Jackson SE, Leiter M (1997) The Maslach burnout inventory. Palo Alto, CA: Consulting Psychologists Press.
22. Valent P (2002) Diagnosis and treatment of helper stresses, traumas, and illnesses. Treating compassion fatigue 1: 17-38.
23. Dwyer ML, Alt M, Brooks JV, Katz H, Poje AB (2021) Burnout and compassion satisfaction: Survey findings of healthcare employee wellness during COVID-19 pandemic using ProQOL. Kans J Med 14: 121-127.
24. Jeon L, Wells MB (2018) An organizational-level analysis of early childhood teachers' job attitudes: Workplace satisfaction affects early head start and head start teacher turnover. Child & Youth Care Forum 47: 563-581.
25. Stamm B (2010) The concise manual for the professional quality of life scale.
26. McCann IL, Pearlman LA (1990) Vicarious traumatization: A framework for understanding the psychological effects of working with victims. J Trauma Stress 3: 131-149.
27. O'Malley M, Robinson YA, Hydon S, Caringi J, Hu M (2019) Organizational resilience: Reducing the impact of secondary trauma on front line human services staff. SAMHSA ReCAST Issue Brief.

28. West AL, Aparicio EM, Berlin LJ, Harden BJ (2017) Implementing an attachment□based parenting intervention within home□based early head start: home□visitors' perceptions and experiences. Infant Ment Health J 38: 514-522.

29. Burnett Jr HJ, Wahl K (2015) The compassion fatigue and resilience connection: A survey of resilience, compassion fatigue, burnout, and compassion satisfaction among trauma responders. Compassion Fatigue and Resilience Connection.

30. Kimberg L, Wheeler M (2019) Trauma and trauma-informed care. In Trauma-informed healthcare approaches, pp: 25-56. Springer, Cham.

31. Menschner C, Maul A (2016) Key ingredients for successful trauma-informed care implementation. Trenton: Center for Health Care Strategies, Inc.

32. Mattke S, Liu H, Caloyeras J, Huang CY, Van Busum KR, et al. (2013) Workplace wellness programs study: Final Report. Rand Health Q 3: 7.

33. Heritage B, Rees CS, Hegney DG (2018) The ProQOL-21: A revised version of the Professional Quality of Life (ProQOL) scale based on Rasch analysis. PLoS One 13: e0193478.

34. Hemsworth D, Baregheh A, Aoun S, Kazanjian A (2018) A critical enquiry into the psychometric properties of the professional quality of life scale (ProQol-5) instrument. Appl Nurs Res 39: 81-88.

35. Hallinan S, Shiyko MP, Volpe R, Molnar BE (2019) Reliability and validity of the vicarious trauma organizational readiness guide (VT□ ORG). Am J Commun Psychol 64: 481-493.

36. Harris M, Fallot R (2009) Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol.

37. Guarino K, Soares P, Konnath K, Clervil R, Bassuk E (2009) Trauma-Informed Organizational Toolkit. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation.

38. Sprang G, Ross L, Miller BC, Blackshear K, Ascienzo S (2017) Psychometric properties of the Secondary Traumatic Stress–Informed Organizational Assessment. Traumatology 23: 165-171.

39. Brend DM, Sprang G (2020) Trauma-informed care in child welfare: An imperative for residential childcare workers. International Journal of Child and Adolescent Resilience 7: 154-165.

40. Holyoke Chicopee Springfield HEAD START (2021) "Success Stories!" HCS HeadStart Inc.

41. Stamm BH (1995) Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators. The Sidran Press.

42. Cha P, Niu G (2022) The Digital Divide Has Narrowed but Still Affects California's Children. Public Policy Institute of California.

43. Sprang G, Ross L, Blackshear K, Miller B, Vrable C, et al. (2014) The secondary traumatic stress-informed organization assessment (STSI-OA) tool. University of Kentucky Center on Trauma and Children.