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From the Clinics to the Classrooms: A Review of Teacher-Child Interaction Training in Primary, Secondary, and Tertiary Prevention Settings

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Without intervention, childhood behavioral problems, including aggression and noncompliance, are likely to continue over the lifespan and adversely affect a child's functioning across several domains. Based on the early emergence of functional impairment and the established negative trajectory of these difficulties, prevention and early intervention programs are critically important. Interventions for disruptive behavior disorders have primarily focused on parent training. However, given the limited access to evidence-based mental health care in many communities and the significant amount of time children spend in school, researchers and clinicians have explored creative ways to provide interventions in the school setting. Increasing attention has been given to prevention efforts. Discussed below are the results of preliminary studies investigating the effectiveness of teacher training in improving behavior management in the classroom. The teacher training is based on the established efficacy of Parent-Child Interaction Therapy (PCIT) for young children with disruptive behavior disorders and their families. This paper reviews the various teacher-child interaction training models that have been used in different settings (e.g., Head Start, general education) and includes discussion of adaptations for the classroom and for consideration in future study.

Left untreated, aggressive and defiant behaviors in early childhood often persist and escalate over time (Shaw, Lacourse, & Nagin, 2005). Indeed, disruptive behavior disorders (DBDs) in young children have been linked to a variety of future behavioral and emotional concerns (Loeber, Burke, & Pardini, 2009; Vitelli, 1997) and pervasive impairment across settings (Bradshaw, Schaeffer, Petras, & Lalongo, 2010; Campbell & Ewing, 1990). Early-onset behavior problems significantly increase the risk of involvement in the juvenile justice system (Cropsey, Weaver, & Dupre, 2008), school dropout (Arnold et al., 1999; Barbaresi, Katusic, Colligan, Weaver, & Jacobsen, 2007; Tramontina et al., 2001), drug abuse (Flory, Milich, Lynam, Leukefeld, & Clayton, 2003; Kellam, Ensminger, & Simon, 1980), depression (Mazza et al., 2009), and violent behavior (Broidy et al., 2003). Nevertheless, almost 80% of children and adolescents who require mental health care do not receive it (Kataoka, Zhang, & Wells, 2002). For the children and adolescents who access care, there are over 550 treatments being used (Kazdin, 2000), the vast majority of which have never been empirically supported through controlled or uncontrolled trials (Kazdin, 2008). Given the individual and societal implications of the DBD trajectory and that youth with serious behavioral and emotional concerns face significant barriers accessing cutting-edge treatments (Henggeler & Santos, 1997; Mojtabai et al., 2011), early prevention and intervention are critically important.

A multitude of empirically supported treatments (ESTs) have been developed to address DBDs early on and prevent related impairment from intensifying (Eyberg, Nelson, & Boggs, 2008). Many treatments involve training the child's caregivers in specific behavior management strategies (Eyberg et al., 2008). For disruptive behavior in the classroom, behavioral and cognitive-behavioral approaches are promising but less established (Wilson, Gottfredson, & Najaka, 2001). Given the high cost of health care (Sutherland, Fisher, & Skinner, 2009) and the barriers many families face to receive mental health care in their communities (Owens et al., 2002), schools provide an accessible setting for children to receive services. Accordingly, efforts recently have been made to adapt an existing evidence-based treatment for DBDs to the classroom setting.

PCIT: The Model and its Efficacy

Parent-Child Interaction Therapy (PCIT) is an EST for DBDs (Brestan & Eyberg, 1998) for children aged 2 to 6 years, 11 months with DBDs and their families. Through didactics, home practice, and live coaching,

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parents learn effective behavior management strategies while simultaneously improving their relationships with their children. In the first phase of treatment, the Child-Directed Interaction (CDI), parents learn positive attending skills aimed at increasing children's prosocial behaviors and decreasing inappropriate behaviors. In the second phase, the Parent-Directed Interaction (PDI), parents learn how to set limits in a predictable and consistent manner. Graduation from treatment is contingent upon parent mastery of pre-set skills, parent-reported confidence in using the skills, and improvement in symptoms of disruptive behavior to the typical range (Zisser & Eyberg, 2010).

PCIT results in multiple, positive outcomes for children and their parents. Child outcomes include significantly reduced disruptive behaviors and increased compliance. For some children, improvements in compliance also generalize to the school setting (Bagner, Boggs, & Eyberg, 2010; Funderburk et al., 1998; McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991). Following PCIT, parents demonstrate marked increases in positive verbalizations and decreases in critical statements. Furthermore, parents report fewer psychiatric symptoms, less personal distress, and improved parental locus-of-control (Schuhmann et al., 1998). Research indicates that the positive outcomes of PCIT are long-term, such that improvements in child behavior and parental self-efficacy are maintained as many as 6 years after treatment (Hood & Eyberg, 2003). Additionally, empirical data have supported the use of PCIT in several populations, including as a viable early intervention for child anxiety (Pincus, Eyberg, & Choate, 2005), depression (Lenze, Pautsch, & Luby, 2011), DBDs in children with mental retardation (Bagner & Eyberg, 2007), and for maltreating parents (Chaffin et al., 2004).

Behavior Management in the Classroom: A Chronic Concern

Given the efficacy of PCIT in improving a child's functioning at home, researchers began evaluating how similar strategies might be applied in the school setting (McIntosh, Rizza, & Bliss, 2000). Disruptive behaviors are a primary concern of early childhood educators (American Psychological Association, 2006; Martin, Linfoot, & Stephenson, 1999), and classroom discipline problems and student misbehaviors are among the factors most strongly associated with teacher burnout (Ozdemir, 2007). Teachers who experience this stress are at higher risk of leaving their jobs, and those teachers who experience burnout but remain in their positions tend to engage in negative behavior management practices that interfere with effective education (Hughes, 2001). Similar to the coercive interaction cycle commonly observed with children with DBDs and their parents (Patterson, 1982), negative interaction patterns are often replicated among disruptive students and their teachers (Sutherland & Oswald, 2005). For these reasons, there is a compelling need to support teachers in their behavior management efforts.

Existing classroom behavior management programs typically involve single or combined behavioral strategies, including group contingencies (Barrish, Saunders, & Wolf, 1969; Hulac & Benson, 2010), token economies (Anhalt, McNeil, & Bahl, 1998; Maggin, Chafouleas, Goddard, & Johnson, 2011), and differential reinforcement (Deitz, Repp, & Deitz, 1976; LeGray, Dufrene, Sterling-Turner, Olmi, & Bellone, 2010; Wheatley et al., 2009). Although many classroom-based programs exist (Simonsen, Fairbanks, Briesch, Myers, & Sugai, 2008), and Teacher-Child Interaction Training (TCIT) is based on similar behavioral principles as these programs, the teaching format is often didactic via lecture, handouts, role-play, modeling, review of videotape, and discussion of vignettes (e.g., Incredible Years-Teacher Program; Webster-Stratton, Reid, & Stoolmiller, 2008). Live coaching in PCIT, which sets this treatment apart from other parent training programs, is an active ingredient in the successful outcomes (Kaminski et al., 2008). In schools, live coaching of teachers has been associated with higher student achievement (Ross, 1992). Thus, it is hypothesized that live coaching plays an important role in training teachers in behavior management. Accordingly, TCIT is unique in that teachers receive live skills coding, performance feedback, and tailored coaching in their classrooms with students.

Important to any psychosocial intervention is consumer satisfaction and buy-in. TCIT has demonstrated high consumer satisfaction from teachers (Campbell, 2011; Stokes et al., 2011). When comparing TCIT skills to a different classroom management system, teachers reported more satisfaction with TCIT skills than the token economy they also learned to implement for managing classroom behavior (Filcheck et al., 2004). The emphasis on coding and coaching in TCIT places weight on teacher behavior as the catalyst for student change and empowers teachers with skills they can use year after year in managing their classrooms. TCIT's focus on live coding and coaching of teacher behavior underscores that the interaction between teacher and student is the primary focus of the intervention and the solution.

The Development of and Preliminary Support for TCIT

TCIT, adapted from PCIT, is an evolving, classroom-based teacher training protocol that aims to enhance teacher-student interactions and equip teachers with skills to manage their students' behavior. The primary target population for TCIT has ranged from teachers and students