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Promoting Interdisciplinary Practice:
An Interview with Steven R. Forness

Steven R. Forness is Distinguished Professor Emeritus of Psychiatry and Biobehavioral Sciences at UCLA. Since 1968 Dr. Forness has served in a number of roles at UCLA, including Chief of Educational Psychology in the Child Outpatient Department at the Neuropsychiatric Hospital, member of the Mental Retardation Research Center, Principal of the Neuropsychiatric Hospital School, and Director of the Mental Retardation and Developmental Disabilities Training Program. His research has primarily focused on early detection and eligibility of children with psychiatric disorders for special education services in public schools. He is co-author or co-editor of 10 books on children with learning or behavioral disorders, has published more than 200 journal articles on education and mental health topics, and has served on review boards of several professional journals.

In recognition of his contributions to the field, Dr. Forness has received the Wallin Award from the Council for Exceptional Children, the Distinguished Educator Alumni Award from University of Northern Colorado, Teacher Educator of the Year from the Teacher Education Division of CEC and Merrill Press, the Leadership Award from the Midwest Symposium for Leadership in Behavior Disorders, the Sidney Berman award on Learning Disorders from the American Academy of Child and Adolescent Psychiatry, and Best Article of the Year Award from the School Psychology Division of the American Psychological Association.

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Intervention: Could you tell us how you got into the field of the education of students with emotional/behavioral disorders?

Forness: Well, it was like just about everyone else who has been a pioneer; it wasn't planned and was mostly happenstance. I did my first year of college at the U.S. Naval Academy and I flunked out. So, I was a good candidate for special education right there. You flunk one subject at the Academy and you're gone, and I flunked chemistry. The only college in my home state that would accept me was the University of Northern Colorado, a teacher training college. So I went far afield of chemistry; since I had always liked English courses, I became an English major. Of course, I was at a teacher's college, so it was just easy enough to add education as a second major.

I was having so much fun in Greeley - it's a great place to go to school - that I ended up staying an extra year for my master's. I was intrigued by my undergraduate courses in psychology, so I got my master's in School Psychology. I taught high school in California for a couple of years, since teaching experience was a requirement to become a school psychologist. I realized through a number of experiences in teaching that school psychology was a bit too little and too late. Special education was where I felt I could probably do the most good. So, I went down to UCLA and I got my doctorate working under Frank Hewett and Barbara Keogh. I then was hired at the Neuropsychiatric Hospital, kind of as a fluke as well. That's how I got

started. It wasn't planned at all. I set out to be a naval aviator, as a matter of fact.

Intervention: I recently read an article that equates managing a classroom for kids with challenging behavior to being an air traffic controller.

Forness: It has an awful lot in common. Directing traffic.

Intervention: Beginning when you went to UCLA, first as a doctoral student, could you tell us about your career?

Forness: I actually went to UCLA initially thinking I might be in school psychology, even though I was also interested in special education. I really didn't know that much about it, but I took my very first special education course and, you know, I was hooked from then on. My first course was with Barbara Keogh, in learning disabilities. She was my mentor in that area, but the course I really loved was with Frank Hewett. When I graduated, Frank actually asked me if I wanted to take a position at the Neuropsychiatric Hospital where he had been the school principal. I wasn't terribly interested, so, after graduation, I went off and worked at a summer camp for kids. I realized at the end of that summer that I had my doctorate, had about \$600 in my pocket, but I really had no clue what I wanted to do with the rest of my life. So, I went back to Frank and he said, "Well, why don't you take this position at the Neuropsychiatric Hospital. It's on soft money, and we haven't been able to find anyone else to take it." With that auspicious beginning, I looked at it as a possible post-doctoral year or two; and,

as I tell my graduate students, it turned into about a 40-year post doctorate.

I had taken courses in mental retardation, learning disabilities and emotional disturbance, but I initially went to the Neuropsychiatric Hospital under the auspices of mental retardation because it was part of the University Affiliated Programs Interdisciplinary Training Program in Developmental Disabilities, which was funded by federal grants. Although I started out in mental retardation, it was really an interdisciplinary program where I found myself teaching psychiatrists, pediatricians, medical students, and our own doctoral students from special education as well as undergraduate practicum students from special education who came down and worked in the Neuropsychiatric Hospital.

A couple years later, I was asked to start a school psychology service in the outpatient department. So, at that point I moved more into learning disabilities, but I became more interested in the emotional disorders of those kids, because we were in the Department of Psychiatry. About 7 or 8 years after I started my career there, the school principal left, and I was asked to take on his job, with the assumption that I would give up the other two. But I couldn't give up the other two, so I did all three full-time jobs. That ended in 1992 when I had coronary bypass surgery, probably from the stress that finally caught up to me. I had actually three different simultaneous

career phases in the Neuropsychiatric Hospital, but each one involved kids with either primary or co-morbid emotional or behavioral disorders.

Intervention: Thinking back over your professional life, what events or policies, innovations, people, have had the most important influence?

Forness: Well, obviously Frank Hewett is one. He was my primary mentor. I gave a talk at the 50th anniversary of CCBD a couple months ago about the history of that organization. I realize that we had a wonderful history in those early years of CCBD, but it was Frank who was kind of the “marketing” person for the field. He had worked his way through a doctoral program by working at the learning disabilities school on campus that was run by the Psychology Department. He was then asked to open up the Neuropsychiatric Hospital School during his first year after graduation (by the way, the Neuropsychiatric Hospital also has its 50th anniversary this year as well). Back in those days, school consisted of the nursing staff taking 10 emotionally disturbed kids from the locked inpatient unit, walking them down the hall, and locking them in a room with Frank Hewett for two hours. Out of that desperation, he drew from the ideas of Dick Whelan, Norris Haring, Frank Wood, and others and made them into a kind of “educational package.” As we say in California, it’s all in the marketing. Frank actually added to this package his own expertise in teaching kids with learning disabilities. I was really stunned by how many different

components he was able to include and by the fact that he could put together a coherent program that teachers could take with them when they graduated. For years afterwards when I'd talk to teachers, I would ask them what kind of approach they used in their classroom and they would usually say, "Oh, I have a Hewett classroom."

Then he and I wrote an introductory textbook together which was based partly on the Madison School Plan he developed in the public schools. The Madison plan was a systematic approach to mainstreaming using four different levels of readiness for classroom functioning. While Frank was doing his research on the Madison plan, I was taking some of the same ideas and applying them to the inpatient hospital school where I was principal.

I also can't leave out Barbara Keogh, who gave me a good grounding in both learning disabilities and developmental psychology. Then, of course, there was Jim Simmons, who was chief of our inpatient service in child psychiatry. He was probably the only two-star general who was a child psychiatrist. He wasn't a two-star general then, but he was in the Army National Guard Medical Reserves. He'd been in the Battle of the Bulge, and after that went back to medical school, and later became our Chief of Service while also rising in the ranks of the National Guard. I loved the way he was committed to the interdisciplinary approach. In the hospital school, even our assistant teachers were encouraged to edit the reports of advanced child

psychiatry trainees as to what to leave in and what to take out of the discharge reports that they were going to give to the public schools. He made sure that each profession really listened to one another...that teachers listened to psychiatrists, psychiatrists listened to teachers, social workers listened to them both, etc. That interdisciplinary training program I mentioned earlier was pretty much the model for all of that.

Intervention: What do you think has had the greatest positive impact on the field of educating kids with emotional behavior disorders?

Forness: I would have to say, although I have not been a part of it, that positive behavior support (PBS) has been critical. I've always focused on early identification. Early on in my career, I did a series of classroom observation studies, but the first one was to use direct observation to predict Kindergartners' need for special education some three or four years later. In the last 10 years of my career, I also worked on Head Start as my primary research focus. I had always been interested in how our kids were identified for special education, which in some ways, was too little, too late. I think PBS was a major contribution in the area of developmental psychopathology and demonstrated how these children had problems long before we got them in special education. I think PBS alerted teachers to the need for screening in a systematic way so we could get these kids earlier.

Intervention: How can teacher trainers provide opportunities where team members can use that interdisciplinary model?

Forness: The interdisciplinary model? Well, I think it's absolutely critical in our field. You know, behavior disorders are simply the psychiatric disorders that occur in school, which is most of them. I've always been committed to looking *beneath the behavior* - even though it's almost kind of heresy in the field of behavior disorders to do so since we've embraced applied behavior analysis and behavior modification in which psychiatric diagnoses or other underlying causal issues were seen as largely irrelevant. If we don't look beneath the overt behavior, I think we're missing a big opportunity to more effectively respond and/or refer for additional help from psychiatrists, psychologists, and social workers and to bring the family into the treatment process. One thing that would be important for people who are training in PBS teams would be to have people who, even if they're not a regular part of their team, are people they can refer to...psychiatrists for medications, or school psychologists for cognitive behavioral therapy. This puts a little more of a mental health spin on the kinds of problems of kids we see. I advocate for doing the best we can first with our behavioral programs before we go to the other disciplines. But in many cases, when our kids become nonresponders to our programs, I think that there are often other people out there who can carry the ball, probably better than we can.

Intervention: If you were to design a master's program to work with kids with emotional behavior disorders, what components would it have?

Forness: That's something I've thought about a lot. We actually started a program for our special education doctoral students. What we did was develop an interdisciplinary core course in which we had lectures by people in each of the various disciplines, so you'd have lectures by social workers, psychiatrists, school psychologists, clinical psychologists, and even by parents. We also had pediatricians since they are the ones who give a lot of the psychiatric medications because we don't have that many child psychiatrists to go around. In our department of psychiatry, I was also part of an interdisciplinary core curriculum where we did the same thing. We had lectures each week by a professor from each of the disciplines. I think it would also be worthwhile to include students from other departments, to make it a university-wide, cross-departmental course for people working with kids, so that social workers, psychology interns, school psychology trainees could all participate. A different faculty member would get up each week and would say, "Here's what my profession is all about and what it can do for your clients. Here's how you refer, here's how we operate, and here are our research and controversial issues." Then, several times a semester, we would do a case study, have an actual kid come in and have the faculty demonstrate how they would do an interdisciplinary case conference. At some point more advanced

students might actually present the case the next time around. I think you can do this with lectures, but not as well as you can do it with lecture *and* demonstration. These experiences are real eye openers because students can really see what their disciplines can do and, more importantly, what other disciplines can do better. I spent close to 35 years weekly with our interdisciplinary team and was later the chair for that course or core curriculum. It was not only one of the most interesting courses, but we also got the best ratings, because students had never had a chance to see anything like that.

Intervention: During your career, what do you see as the most negative influences?

Forness: I haven't taken too kindly to full inclusion in some of its forms or to post-modernism. I think that these have set us back a bit. Full inclusion without many supports, assuming that teachers will just learn if we put the kids in their classrooms, just doesn't work. It might work in learning disabilities, because teachers are trained to teach reading and math and so forth, but they don't get that much training in the area of behavioral disorders. They certainly don't understand concepts of developmental psychopathology in order to alert them that what they're seeing as a disruptive behavior disorder might be something else entirely. That's something I spent probably the last 20 years of my career on – looking at the possibility of an underlying psychiatric disorder and how medication and cognitive behavioral interventions might work with various kinds of problems. There's a

fair amount of data out now showing that when you treat the depression, anxiety or ADHD underlying behavior disorders with psychiatric medications, then the disruptive behaviors improve. They may not entirely go away, but they certainly improve. I think we need to take advantage of that, particularly in our field. That's not to say you start with medication; but, when you begin to see that the intervention you've chosen isn't working, and you kind of tweak it and it still isn't working at the level you would expect, a little alarm might go off in your head, "Wait a minute! There might be more going on." You might then need to screen for psychiatric disorders, using teacher and/or parent rating scales.

Intervention: Are you saying that more of the same intervention, if it's not working, doesn't necessarily work better?

Forness: That's a great way to put it! I think that the issue of full inclusion highlights that general education teachers are not usually tuned into such a possibility.

And post-modernism - the view that everybody is so different, from different diverse and cultural backgrounds, that nothing in research can possibly generalize? We have to start somewhere. There's a quote from W. H. Auden that I can't remember exactly but it goes, "We may not know very much, but we do know something; and while we must always be prepared to change our minds, we must act as best we can in the light of what we know."

Intervention: What do you see in the future for education for children with emotional and behavior disorders?

Forness: There's a difference between where I see the future going and where I'd like to see the future going. I can do utopia first. I would like to see at least a couple of things. One would be the whole issue of manualized or packaged programs. That's brought home to me in a lot of the psychiatric medication studies where medications have been compared directly with behavioral and cognitive behavioral interventions that are carefully structured for success. It's also brought home to me looking back on Frank Hewett's career and the fact that his was really a manualized program. He developed a systematic package of different interventions with social, behavioral, cognitive, and academic components all integrated into a coherent whole. That package was basically something teachers could take with them. I think that's much easier than sending teachers out there with all of the component pieces that they have to assemble "on the run." Rather than to go out and construct a program in his or her classroom or for each kid from the ground up, I think it would be better for a teacher to have a package and then add or subtract from that package as needed.

Another hope for the future is for more interdisciplinary connections. I'd like to see that done a lot more, and particularly with psychopharmacology. Whether we like it or not, our kids are the most

obvious candidates for psychiatric medications because they are usually the most seriously involved. When you look at psychopharmacoepidemiologic studies, there are way more kids needing medication who do not receive it than there are kids who are being over-medicated. Also, if we don't know enough about psychopharmacology, a kid in our class could remain on the wrong medication or not get enough of the right medication. Some kids also outgrow the medication over time. There's a lot that we can do to work with the physician to make that child's life better, make his or her family's life better, and probably even to make *our* job easier. I think those are the things I'd like to see going into the future.

On a less positive note, where I see this field going in these parlous economic times is more cut backs. We've even seen a decrease in the number of kids in special education in the latest figures from the U.S. Department of Education. I just finished a paper that will be out in *Journal of Emotional and Behavioral Disorders* looking at prevalence and the severity of emotional or behavioral disorders in our kids. You know, we get a lot of bad publicity for the children in the ED category of special education because they're not engaged after graduation, they're dropping out, they're not working, or they're being arrested in greater numbers than kids in other special education categories. But, if you look at prevalence of learning disabilities, studies suggest that it's about 20%. This is not the identification rate

but the prevalence rate. When people do Response-to-Intervention studies involving learning disabilities, for example, they start with the lowest 20% of the class. But the prevalence of children with EBD is also 20% and that's where we start. Now, learning disabilities starts at a 20% prevalence rate, and we start at 20%. But more than 5% of school children are identified for the LD category. We start at the same 20% but fewer than 1% of school children are identified in the ED category. Now, when you look at the severity difference between children identified as LD and our children identified in the ED category, our colleagues in learning disabilities have it easy, as far as I'm concerned. If they identified only 1% of school children in the LD category as we do in our category, I bet their outcomes would be much worse than ours. So, we have to pat ourselves on the back. We're dealing with a much more severely involved group of kids relative to other categories of special education.

Intervention: What suggestions do you have for persons entering the field?

Forness: Well, I think that this is the best field in special education. We are in essence the "Seal Team 6" of special education, because we not only have to teach these kids like other special education teachers, but we also have to help them manage their behavior and deal with the stigma and rejection from teachers and kids in school. It really is an elite teacher who can do all that. Working in this field is like joining the Navy Seals. If you want to join the regular infantry, go into

learning disabilities. If you want to be an elite, this is the group to be in.

But, you also need to prepare yourself. Right off the bat, I think you need to start taking advantage of our great behavioral strategies, try to get a package of these, or at least put together a package for yourself, and see how the components fit in the overall scheme involving social, cognitive, and academic domains. Also, I would recommend getting very familiar with issues of psychiatric disorders so that you can not only refer appropriately, if you need to, but also get more of a sense of what help your students actually need. I also think that being able to work with parents is critical. Teachers have to be able to counsel parents of these kids and alert them to things that need to be done. You have to be careful about that, because the school might be held responsible for paying for anything you recommend, but there are ways of saying this, such as, "We've done everything we can. Here's what I've done that works in the classroom. There may be other things going on at home and other behaviors that you see and may be concerned about, and you may want to see what your pediatrician thinks." If the pediatrician is on top of things, he or she will start to think of ADHD, depression, or anxiety disorders. There's a big initiative between psychiatry and pediatrics to train pediatricians in mental health because they are the front line psychiatrists.

I think as well that this is a hopeful field, because you get so much satisfaction out of it and there's always going to be a need for you. If I had my career in special education to do over again, I would choose this field without hesitation.

I've told this story a couple of times in talks I've given. I think that of all the divisions of CEC, Council for Children with Behavioral Disorders is probably the friendliest. I've been a lifelong member of a lot of other CEC divisions including those for learning disabilities, developmental disabilities, early children and the like. I've gone to their conferences and have a lot of good colleagues and friends in these other fields, so I have to apologize to them before I say this. They know their stuff and, when they present it, they basically take their work very seriously, but they also seem to take themselves seriously. I've noticed in our people - from the more exalted colleagues to the assistant professors doing first presentations - that they are all humble because we've all been humbled by the challenges of these kids. We take our work seriously but we don't seem to take ourselves seriously. I think I've told this story several times. I would come to work in the hospital some mornings, maybe feeling especially full of myself because I just found out that, for example, I had an article published or a presentation accepted or got a research grant or won an award. But, as principal of the hospital school, I often had to be a substitute teacher or a substitute assistant teacher. I'd be feeling

like I was pretty hot stuff until I got in my assigned classroom to help out, and maybe 3 or 4 minutes later, some kid across the room was calling me a dickhead or a doo-doo face.

We've all been through these kinds of experiences, and I think we all kind of have a great love for one another because we all know how challenging these kids can be and how much we need support. In essence this makes us all family. I think CCBD has more of a sense of family than any division I've seen. That's the thing I think sets us apart from the other divisions and from other disciplines. I've been to pediatric conferences, child psychiatry conferences, and special education conferences. None of these groups even comes close on this dimension. It's clear that we are the friendliest.

Intervention: Thank you for sharing your experiences, perspectives, and insights.

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Steven Forness's career has influenced many professionals from a variety of fields to realize the benefit of a interdisciplinary approach when working with children whose behavioral or emotional needs present a challenge to their success. His many contributions to the understanding of the impact of the setting elements in which behavior takes place has had a positive influence on how we view, interact, and advocate for children with behavioral issues. It may all be in the marketing as Steven put it, but there must be quality behind this marketing. The authors thank Dr. Forness for his continued commitment to this quality and as an example to those

of us who share this concern with making life better for those who may perhaps see us as a “doo-doo” face.