

Confrontational Psychotherapy: A Compassionate and Potent Therapeutic Orientation for Gifted Adolescents Who are Self-Destructive and Engage in Dangerous Behavior

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ABSTRACT

Confrontational psychotherapy (CP) has been considered as "cruel and unusual" treatment. This criticism is partially correct; confrontation is painful. What is disregarded, however, is that for any treatment population that engages in extreme, self-destructive, and sometimes death-defying behavior and is not amenable to traditional approaches, Confrontational psychotherapy is a most responsible and caring psychotherapeutic approach.

The Goal of Confrontation is Awareness

Confrontation exists in every human transaction. Any question, no matter how benign, is also a confrontation by virtue of the process of reflection and reaction. Confrontation is thus synonymous with awareness. Using the language of interpretation, Freud was, in fact, confrontational in his insistence on bringing unconscious forces into consciousness. Confrontation disturbs homeostasis. To use a metaphor from nature: without wind, leaves do not move; more intense winds are required to stir leaves weighted down by rain or snow. Confrontational Psychotherapy (CP) can appear more extreme than other forms of psychotherapy, but we contend that—properly practiced—it is also vastly more effective. In communicating with reticent and self-destructive adolescents, confrontation techniques are considerably more able to pierce formidable defense systems that produce massive resistance to change. These teens have insulated themselves in protective and self-righteous cocoons, often aided inadvertently by well-meaning conventional mental health practitioners who arm them with excuses in the form of a multitude of misapplied diagnostic labels.

In this article, we limit our discussion to the application of Confrontational Psychotherapy in cases of self-destructive behaviors by bright, out-of-control adolescents. We will demonstrate why CP is a crucial tool in effective treatment for this particular population and debunk the notion that CP is 'cruel and unusual punishment'.

Confrontational Psychotherapy: A Heroic Treatment Approach

Debate about the goal of psychotherapy is valid: insight, adjustment to the status quo, understanding, feel-

ings, growth, etc. In working with teenagers who are at-risk to destroy themselves and have ruined educational, social, and professional options, there is one primary goal at the outset of treatment: **PRESERVING LIFE AND MINIMIZING SERIOUS CONSEQUENCES**. The symbolic ticking time bomb of escalating dangerous behaviors must be stopped before permanent damage or death ensues. Other therapeutic methods simply do not penetrate what Alcoholics Anonymous aptly labels "stinking thinking."

Truly effective Confrontational Psychotherapy must include other techniques such as Cognitive Behavior Therapy and Dialectical Behavior Therapy. Working with adults, Linehan et al. (2006) conclude, "dialectical behavior therapy appears to be uniquely effective [at reducing] suicide attempts" (p. 757). Though research on the effectiveness of DBT on adolescents is limited, preliminary findings suggest that DBT is a promising treatment for suicidal and parasuicidal teens (Rathus & Miller, 2002).

Many mental health practitioners confuse Confrontational Psychotherapy with Attack Therapy. Lieberman, Yalom, & Miles (1973) define a casualty of CP whose participation in an encounter group precipitated psychological distress and/or "more maladjusted mechanisms of defense" (p. 171). They also examine the relative effectiveness of various leadership styles. Their findings are important because they confirm the effectiveness of the confrontational charismatic leader in group psychotherapy. Most psychotherapists erroneously assume this "scientific study" condemns confrontation. Lieberman, et al. (1973) states, however, that participants in groups conducted by charismatic leaders "showed the most extensive changes in...values and attitudes" (p. 251).

This trio fails to note that the charismatic leaders they studied were members of Synanon, an ex-addict-run residential treatment program that later disintegrated into a cult. These ex-addicts lacked academic training and discipline. We note at least two major differences between recovering addicts and credentialed professionals doing similar work. First: Recovering persons are zealous because they believe passionately that the approach that saved them can save everyone. The need to proselytize affects their judgment and infects their efforts. Second: Since ex-addict leaders lack academic training, they do not factor in the effects of psychodynamic issues like transfer-

ence and countertransference. This trio concludes (with no data) that such leaders are more likely to abuse power. Lieberman, Yalom, & Miles (1973) concede, however, that charismatic leaders using confrontation as their primary therapeutic orientation are effective. Unfortunately, in the wake of the Synanon of the 1970s came the proliferation of encounter groups with untrained and inexperienced leaders. This particular study came out of valid concerns on the part of academically trained psychotherapists. Miller, Benefield & Tonigan (1993) conclude that confrontation is counterproductive because they believe this approach tends to lead to argument and conflict. Judiciously implemented CP actually stimulates a more honest and candid recognition of reality, which creates less conflict for the individual.

Using CP, therapists at The John Dewey Academy have conclusively proven that pathological beliefs and dysfunctional behaviors can be modified in the short term and that improvement persists after treatment ends. JDA students can transcend their pasts. Patterson (1966) proposes that individuals "cannot...control conditions [by] which [they are] confronted, but can control [personal] responses such as choices and actions" (p. 466). Explicit is the concept of **CHANGE**—i.e., unlearning (rejecting dysfunctional acts and attitudes) while simultaneously learning more responsible and productive ways to respond to the challenges of living. Confrontational Psychotherapy stresses personal choice, demanding the development of integrity and responsibility.

What of the 'Bipolar Child' and the 'Dual Diagnosis'? We believe these concepts do in fact have limited utility in helping us understand the complexities of the mind; but they are overused by a mental health establishment overwhelmed by troubled teens. There has been an increase, for example, in the diagnosis of Bipolar Affective Disorder. Many of our students arrive with this label; upon graduation, they leave medication-free and clearly **NOT** the victims of any chemical imbalance.

There are six primary uses of Confrontational Psychotherapy:

1. To expedite behavioral change.
2. To **force** accountability for attitudes and acts.
3. To understand the relationship between current behaviors and future consequences and payoffs.
4. To learn more appropriate responses.
5. To mobilize personal talents to succeed.
6. To discover a directionality and in so doing justify one's existence to oneself.

The John Dewey Academy's treatment approach utilizes a compassionate confrontational- existential-cognitive-behavioral orientation. When used constructive-

ly, CP catalyzes resilience and mental toughness—i.e., learning from errors in judgment to become responsible, positive, and productive. Bratter (1972) describes the treatment thrust of a group orientation:

Using a confrontation-teaching-interpretative-reasoning approach, the group demonstrates to the [member] the irresponsible and self-defeating aspects of...behavior [and]...he begins to understand the consequences of his acts and attempts to become more responsible to himself, others, and society. Emphasis is placed on the **eigenwelt** (the relation to one's self)—i.e., the immediate experience. The individual must acknowledge his perceptions of the conflict, the problem, his irresponsibility, etc...

The individual, gaining the candid opinions and admonishments of...peers regarding the more destructive elements of...behavior, considers a new orientation and behavior (p. 309).

In a group setting, members relate to peers whose input provides the catalytic conditions necessary for self-exploration and change. Rather than receiving sympathy and comfort—which inadvertently prolong homeostasis and paradoxically result in the student feeling misunderstood and even more alone and depressed—confrontation forces teens to face reality. Complicating the problem is that not every gifted teenager who engages in self-destructive behavior has the ego strength and desire to improve: CP does not work for all. During the intake interview and periodically thereafter, John Dewey students and families are warned that, despite the Academy's success rate of 100% of graduates attending excellent four-year colleges, this therapeutic approach is not effective for all adolescents. Our screening is an important element of the process; we seek to admit only those students who are appropriate for the program. In order to provide an effective checks and balances system against countertransference acting out, our practice of CP is a team effort.

Compassionate Confrontation: Clinical Dynamics

Based on his clinical experience, the senior author rejected psychoanalysis and client-centered therapy as irrelevant and ineffective approaches for use with acting-out, alienated, and bright adolescents. He chose Reality Therapy, a milder form of confrontation, as his primary orientation, believing it to be more effective. Three tenets of Reality Therapy form the core of confrontation:

1. To create a treatment environment that encourages the adolescent to evaluate his or her behavior.
2. To force the youth to accept responsibility for his or her conscious choices.
3. To provide support for constructive and creative change.

Forty years ago, William Glasser was criticized for being simplistic. He viewed individuals as either responsi-

ble or irresponsible. Subsequently, Glasser has been proven right with this population. Until gifted and unconvinced teens take control of their lives, they will refuse to change. Undaunted by criticism, Glasser (1998) stresses two crucial concepts: conscious choice that facilitates change and the acquisition of the necessary skills to fulfill one's potential. Breggin (1991) correctly identifies the correlation between choice and treatment outcome when he writes, "every individual must choose whether or not to overcome any hardship or oppression inflicted by the family, society, or psychiatry...Indeed, [it is] the helper's role to encourage...self-determination" (p. 45).

There are two primary kinds of confrontation. The most direct involves a third party rendering a behavior assessment so the confronted knows the specifics of an inappropriate attitude or act. The psychotherapist demands the best, rather than conceding that the perpetrator is either a victim or incapable of constructive and creative change. The second form of confrontation is to encourage the confronted to become his or her own confronter by evaluating the impact of his or her behaviors. "Does what you do today help you achieve your intermediate and long-term goals?" "Do you have self-respect?" "Are you happy?" The most effective confrontation is to ask questions so that the teen comes to a more independent understanding of his or her behaviors, thus increasing the chances of an independent decision to change. Such a dialogue results in a proactive, less passive individual. Garner (1970) urges therapists to inquire, "What do you think or feel about what I told you?" (p. 231).

Two 1972 definitions of confrontation remain relevant. Carkhuff and Berenson's concept (1972) provides a positive description of confrontation as a tool to help the person-in-treatment understand

his strengths and resources...It is a challenge to...become integrated...It is directed at discrepancies...between what the client says and does...and between illusion and reality...It implies a constructive attack upon an unhealthy confederation of...illusions, fantasies, and life avoidance techniques in order to create a reintegration at a higher level of health (p. 171).

Van Stone and Gilbert (1972) describe peer confrontation in which

Each member...is presented with candid personal facts regarding...behavior or attitude recognized by the group as being self-defeating or dishonest. If the member under scrutiny attempts to explain away or deny any observation, he is [confronted]. Intellectual insight or gentle self-interpretations are derided as an escape from responsibility for current behavior. Honesty, trust in the group, realistic self-assessment, appropriate emotional release, and changed behavior...are rewarded by sympathetic counsel and encouragement from fellow members...(p. 585).

The emphasis is on "people instead of pills..." The members are...concerned with each other, [but] are uncompromising in their demands (p. 584).

Confrontation can only be effective in the context of a positive treatment alliance. The therapist needs to accept the burden to create a special relationship. Bratter (1975) labels genuine care, of which confrontation is a basic element, to be the "responsible therapeutic Eros" when he asserts,

Angry, alienated, self-destructive adolescents equate the degree of caring by the psychotherapist with the loudness of the therapeutic protest and intensity of therapeutic anger expressed. The acting-out teenager...needs and wants...assurance that another...cares enough...to become involved and help him/her...Ex-addict...workers...have devised a term, "responsible concern," which implies...[to] get involved...and, if necessary, intervene directly to prevent him/her from harming [him/herself]...They view themselves as "my brother's keeper." Alcoholics Anonymous, in comparison, has adopted a less active-directive approach. A twelfth step worker...will respond for help twenty-four hours a day, seven days a week but will not...impose him/herself in the drinker's life and try to force the alcoholic to remain abstinent. The analyst, in contrast, remains objective, passive, detached, and uninvolved (p. 100).

Bernstein (1972) "attributes many treatment failures to the prohibition against compassionate behavior on the part of psychoanalysts. Therapists often misread...the countertransference prohibition and feel afraid [to have...] feelings...Thus instead of feeling compassion to 'help me!' they feel coldness, objectivity, and withdrawal" (p. 121). Most talk therapies caution the therapist, rightfully so, about the dangers of over-involvement. Most schools of psychotherapeutic thought suggest the therapist avoid answering legitimate questions such as "Are you married?" or "Have you used drugs? If so, which ones?" The professional response is to avoid relating. Graduate schools recommend asking, "Why is this information important to you?" hoping, of course, that the patient will yield to a change of subject. Hostile, suspicious, alienated, and challenging adolescents frequently demand an answer—or lose respect for the therapist. Effective therapy is a dialogue, not a monologue. Inevitably, there are intrusive questions on both sides of the equation. Although we accept that certain treatment boundaries must be maintained, we assert that lack of in-depth attention to this dynamic has resulted in both over-rigid and over-porous therapists. Surely we can do better in this regard.

Pre-1968: Prolonged Innocence: Boys Will Be Boys, Girls Will Be Girls

Glasser's work at the Ventura School for Girls occurred during a more innocent era. His reality of the late 1950s and early 1960s was one of racial tensions and sexual boundaries. Thus, Glasser's view of confrontation reflects those days rather than the reality of the new millennium. Glasser was a responsible revolutionary who was one of the first to challenge traditional psychoanalytic thought. While he disapproved of confrontation, he knew

of its effectiveness; Alex Bassin, one of Glasser's most loyal supporters, co-authored the proposal for funding Daytop Village. Bassin was a mentor of the senior author and introduced him to Glasser in 1963. Glasser knows that The John Dewey Academy is effective, having visited three times and read numerous articles published by members of the JDA faculty.

Keniston (1971, 1968 & 1965) warns of a new breed of alienated youth, but his works were initially dismissed because readers thought he was only discussing Yale students. Friedenberg (1957) predicts that adult values would be adopted by teens, but neglects to warn that adolescent values would filter down to influence children. One has only to observe the ever-younger ages of children entering psychiatric and psychological treatment to realize that this has, in fact, occurred.

With the wider societal changes of the 1960s in America came vastly increased pressures on youth to confront issues such as sex and drugs that had previously been limited to the adult population. Unfortunately, teenagers lack the maturity and long-term vision to help them assess these issues thoughtfully and responsibly.

Post-1968: The "New Breed" of Adolescents

During the early 1960s, Freud's psychoanalysis and Rogers' client-centered therapy were two dominating therapeutic orientations. Both approaches used a "gentler" form of confrontation. For a brief period, Reality Therapy and other cognitive-behavioral-existential reality-based orientations were effective with this challenging treatment population of teenagers **before** they became suspicious, unconvinced, and resistant to previous forms of therapy.

In retrospect, the now infamous 'generation gap' led to teenagers mistrusting adults, an attitude that evolved into societal reality. It was as though adolescent mutants developed thicker therapeutic skins that were far more impermeable than their sweet and innocent counterparts of the late 1950s and early 1960s. These changes required more powerful and intensive treatment approaches.

Without warning, 1968 galvanized society. The idea of a gradual growth and assimilation into adulthood was destroyed, releasing a torrent of rebellion. Nihilistic rage predominated for a period and had a lasting effect on the lives of teenagers to come. The quest for freedom, emancipation from families, and escape from societal restraints assumed endemic proportions.

In today's world, children lose innocence before they appreciate its value. 'Playing doctor' has been replaced by oral sex beginning in middle school, followed in short order by sexual intercourse. Drug experimentation often begins in middle school as well. Children crave adult status, while adults seem to want more childish pursuits of

late. During the third millennium, the distinction between **responsible** and **irresponsible** behavior has blurred. Further exacerbating this problem, the intense peer pressure faced by teens to perform destructive, defiant, and dangerous acts has attained pandemic proportions both in high schools and on college campuses. It is now the rule rather than the exception for teenagers to experiment with drugs and sex rather than to abstain. Thus, the age-old adolescent imperative to test limits, to question, and to reject authority has assumed a new and much more dangerous aspect. Assessment has also become more subjective because it more often reflects the values of the clinician making the diagnosis. Glasser (1998) contends that, "training programs have an ethical responsibility to provide information and opportunities for counselors to confront...cultural biases that may perpetuate racist attitudes and behavior" (p. 64).

Experimentation with drugs and sex has become a "rite of initiation" into adolescence. Today, youth who abstain comprise the minority—hence, they are **different**. "Well-adjusted" adolescents do not become addicted to psychoactive substances, self-mutilate, binge and purge, or engage in physical violence—but they can write pessimistic and "dark" poetry, may play and listen to gloomy music, sometimes glorify celebrities dead by suicide, fantasize about aberrant acts, and periodically engage in very dramatic behaviors.

Confrontation: A Failure

When Meredith arrived at The John Dewey Academy as a sixteen year old "ne'er-do-well," she was a dependent, insecure, and terrified product of a New York City prep school. This adolescent had twin goals: to be sophisticated and popular. She had perfected the art of saying what others wanted to hear. She was a master manipulator whose glibness resulted in her skating by with decent grades and without adults confronting her on her destructive behaviors, even after she was asked to leave two different private schools for a variety of infractions that included selling cocaine to her friends in order to appear cool and be liked.

Meredith arrived at The John Dewey Academy confused, conflicted, and with no sense of identity. She was a chameleon, devoid of substance. She followed the crowd and never questioned whether her decisions made sense.

Her story provides an example of both the benefits and the limitations of confrontation. Her treatment at The John Dewey Academy resulted in dramatic improvement. Confrontation, however, has thus far not preventing her from smoking cigarettes and using alcohol socially.

Meredith was lucky that The John Dewey Academy rejects DSM-IV labels; in another program, she would have been labeled Borderline and Dysthymic and would

have been prescribed psychotropic medications. Instead, we viewed Meredith as irresponsible and suffering from a failure of identity. By graduation, Meredith had developed a secure sense of self, integrity, and a strong work ethic. These changes turned out to be crucial during her first year in college, when Meredith's mother (also a smoker) was diagnosed with metastatic lung cancer. Although Meredith was no longer a student at JDA, she voluntarily maintained a relationship with the school and the senior author both out of appreciation and out of a sense that she could count on the Dewey brand of caring confrontation as she encountered the challenges of her freshman year. These affectionate post-treatment contacts are common for JDA graduates, who know they can depend on JDA staff and fellow graduates to be 'real. Sadly, CP has failed to convince Meredith to reject nicotine and alcohol. While the following confrontations are harsh and inevitably will invite some to criticize and condemn the senior author, it needs to be noted that he not only wrote a twenty-two page letter of recommendation for her college application but also has remained in contact with her since her graduation from JDA in 2006.

When Meredith first mentioned that her mother was scheduled for tests to determine whether she had cancer due to prolonged and excessive smoking, the rhetorical questions asked her included, "Are you crazy? Your mother has lung cancer. I predict she will be dead within the year! If you love her, as you claim to do, you owe it to your mother to assure her that you have learned from her misguided decision to smoke. All studies prove conclusively that smoking causes cancer. By giving her this assurance, you will make it easier for your mother to die in peace." In denial, Meredith responded that her mother did not have cancer and would live because she was in good health and only fifty-three.

"Meredith, time is running out. Tell her that you stopped smoking and promise never to start. If you wait too long, she may be in a coma."

The senior author also raised the issue of her younger sister, asking, "Don't you feel guilty your sister stupidly duplicates her mother's and your insane behavior? Don't you owe it to Abbey to become a responsible role model?"

Two weeks before her mother's death, Meredith called upset. Her alcoholic father mentioned he had had several drinks. Meredith wanted advice about what she could say or do. "You know what you need to do," the senior author screamed, "but you won't. You need to make a commitment to stop smoking and drinking if he will pledge to do the same." The confrontation was then escalated. "It is an unjust obscenity that soon Abbey will be deprived of a mother and may lose her father because you are so stupid, selfish, and stubborn. You refuse to stop, though you know carcinogens cause cancer.

While confrontation has failed to end Meredith's nico-

tine habit, she has made the Dean's List and been an active student leader at college.

Written Confrontations: Upping the Therapeutic Ante

In order to maximize the therapeutic effect of a verbal confrontation, one can follow it up with a written version. Supplying a confrontation in written form provides numerous advantages:

1. A written confrontation creates a permanent record that can be re-read and discussed *post hoc*.
2. This document can be sent to significant others not only to appraise them of concerns but also to include them on the treatment team.
3. A written document minimizes misunderstandings.
4. The written work functions as a mirror that reflects reality and does not allow for distortion.
5. The confrontation can be prepared thoughtfully, with no interruptions, and will therefore contain more precise language.
6. The effort inherent in writing provides more evidence of the sincere concern of the confronter.
7. The communication serves as a clinical record.

The following is an example of a written confrontation that has yielded awesome results. On his eighteenth birthday, the recipient was taken by ambulance to an Emergency Room because he overdosed on methadone. He is lucky to have survived.

Though twenty-one years old, Paul stayed an extra year at The John Dewey Academy as a consequence for his refusal to work, grow, and change. During his final year at JDA, the senior author wrote,

I do not regret I gave you the benefit of the doubt by not only trusting but also permitting you to take a course at Williams College. I showed **good faith** which is much more than you did...What I do regret, however, is that for the duration of your stay at The John Dewey Academy you have remained profoundly deceitful and a predator who preys on weaker individuals.

Time to recognize you for what you...are. You [will] sacrifice everything for the symbolic fix—this time it's a piece of ass, what will it be next, a shot of dope, a burglary when you need some money? Are you prepared to sacrifice everything because you want what you want when you want it and you don't give a damn whom you betray as long as you can gratify your "fucked-up" needs? Think about how dirty, disgusting, and manipulated Jill feels. In no way do I excuse her because she is as responsible as you are. Think about how devastated and frightened your parents are. They began to dare to dream that maybe finally—their son had learned his lesson and really changed. Think about how your peers, who trusted, admired, respected, and even loved you, must feel. Or don't you give a damn? Are you rotten to the core?...

Obviously, you have destroyed your dream to attend MIT. Obviously, I refuse to recommend you to any college of quality because I cannot do so in good conscience. Since one of the consequences Jill received for being stupid is to remain an extra year, at this juncture I question whether this makes any sense for you. Or are you beyond the point of no return? Honestly, I expect more shit to emerge which probably will seal your fate and result in your expulsion. You wonder why periodically you erupt in rage. Obviously, you are so damned narcissistic that you become consumed by fury when someone disappoints you or deprives you of your sense of entitlement. As long as you cling to your dope fiend attitudes, your prognosis is pessimistic—there is no damn hope that you ever will permit yourself to succeed, though this time you came close. Think about it, again you “pissed” away another year and \$56,000 of your parents’ money. I hope that digging your grave forced you to see yourself as a cruel, vicious dope fiend whom you must murder if there is to be any hope for your future. Do you ever want to marry? What kind of a father do you think you will be? How long do you think you can be a criminal without being incarcerated? What kind of a person do you want to be? When you die or are murdered, do you want to know you have lived a bogus and wasted life or do you want to die with self-respect knowing you have justified your existence to yourself?

The real tragedy is that you have been blessed and born with awesome talent which you abuse. My fear is that you will quit—actually, that is not accurate; you never started or tried. I don’t know what to write because I have worked with dope fiends for a quarter of a century. I know damn well that until they “hit bottom” and feel the shame, the disgust, the guilt, and the self-hatred, there is no chance. I have attended funerals of monsters who refused to join humanity and thrived by sucking other people’s blood. And I assure you, I felt no remorse or guilt when I breathed a sigh of relief and proclaimed the world is lucky they are dead. Is this what you want someone to say about you at your funeral? This is the path you are traveling. Each step you take brings you closer to the edge of the cliff where there is a deep abyss. I just don’t believe you will survive the next fall. You’ve had too damn many chances which you have not heeded.

The issue is not whether I can work with you because I can. The crucial question is are you disgusted with inflicting so much pain on those poor, dumb bastards whom you seduce? Like the old Delta Airlines advertisement, “We’re ready when you are!” But are you ready or do you need to sink deeper into your private cesspool? The only way...to find salvation is...to purge yourself 100% of the poison and shit which flows through your arteries. Do you have the guts, the desire, the strength to reclaim your life from the stinking sewer?

Paul attended an Ivy League college from which he graduated salutatorian and Phi Beta Kappa. He won four leadership awards at his graduation. He was admitted by one of the three most prestigious law schools in the country and has been offered a job after he graduates by a most prestigious law firm.

Paul returns periodically to The John Dewey Academy, has maintained contact with the senior author since his graduation in 2003, and has delivered the alumni address at the Academy’s last two graduation ceremonies.

Critics Confuse Compassionate Confrontation with Attack Therapy

Bratter and Sinsheimer (2007) assert that CP

forces the confronted to recognize masochistic and sadistic acts which rejects minimization and glorification of behavior, or pretending that magically one day a cure will happen. Critics contend [that] confrontation is controversial, counter-therapeutic, and cruel punishment which often brutalizes the confronted. Critics of Confrontational Psychotherapy need to remember Dewey students have engaged in dangerous, sometimes death-defying behaviors which demand heroic and desperate interventions. Unless the therapist can persuade at-risk youth to stop acting out, crises can escalate and produce devastating and permanent consequences. Critics who do not fully appreciate the extent of destructive and dangerous behavior label this treatment process to be “attack therapy.” These critics are right, but for the wrong reasons. Unless CP can remove malignant attitudes and acts, Dewey students will be consumed by a magnitude of at-risk behaviors which will produce severe consequences such as hospitalization, incarceration, and/or premature death. Undeniably, CP forces students to recognize masochistic and sadistic acts which rejects minimizing and glorifying behavior, or pretending that magically one day they will awaken cured. Dewey students have engaged in extreme, self-destructive, stupid, immature, irresponsible, illicit, dangerous, and sadistic behavior. They have toxic attitudes of entitlement and reduce others to objects to satisfy [their] narcissistic needs. Confrontational Psychotherapy penetrates denial, distortion, and dysfunctional attitudes (p. 108).

Opponents fail to understand the clinical challenges involved in treating these adolescents. When treated skillfully and for the right reasons, the confronted feels the concern of the confrontational therapist, who not only demands the termination of life-defying behaviors but also refuses to accept anything less than the best. Although perhaps difficult to hear at the beginning of treatment—when self-esteem is at its nadir—the message, “you can do much better” is both therapeutic and *prima facie* evidence of genuine care. When the intent is positive, caring confrontation becomes the ultimate expression of what Breggin (1997) terms “empathetic love.” To love and be loved, Breggin contends, “is...to feel empowered—to feel in control of one’s...spiritual state” (p. 78).

Compassionate confrontation obliterates defensive avoidance. Prior to stumbling into The John Dewey Academy, JDA students were untreatable, uneducable, unreliable, unmanageable, unruly, uncivilized, untrustworthy, unlovable, unworthy, unwanted, undisciplined, unfaithful, unpredictable, unhappy, unlawful, unstable, and unsuccessful. While often viewed as unmotivated, even by themselves, they are in reality **unconvinced**. The burden to convince them to change falls upon the therapist.

As with all treatment procedures, abuses of power are a potential risk. If the intent of the confronter is humiliation, pain and intimidation, this is a perversion of CP. Similarities exist, however, between the psychotherapist who confronts, the radiologist who x-rays, the surgeon

who operates, and the psychiatrist who prescribes. Each of these procedures is subject to abuse in the quest to attack disease and dysfunction. The surgeon, radiologist, and psychiatrist do more physical and permanent damage under the guise of medical treatment than does the therapist who confronts. Interestingly, the medical profession escapes criticism because its ends justify its means. CP can be compared to laser surgery which, when skillfully and judiciously used, attacks and eradicates malignant cells. Similar to laser surgery, however, when abuses occur (mostly caused by disappointment, frustration, and anger), confrontation becomes a counter-therapeutic technique.

Cruel and Unusual Punishment: Questions Remaining

The therapist who knows an adolescent is at extreme risk to destruct by engaging in dangerous behavior yet refuses to intervene by confronting is guilty of malpractice.

What is worse? To prescribe psychotropics which have not been well-studied in children and adolescents, or to confront a teenager in his or her own vernacular? Rejecting the medical model has incurred the wrath of the powerful pharmaceutical industry. Combining research with common sense, Breggin (1991) asserts that teenagers suffer from a "psychospiritual crisis, usually surrounding issues of basic identity and shame, and typically with feelings of outrage...By refusing to diagnose or to label people who already feel rejected and humiliated, we welcome them back to the human community and promote humane, respectful, and loving attitudes toward them" (p. 46). Ought we assume that negative behaviors can be cured by prescribing a myriad of psychotropic medicines, or to use Confrontational Psychotherapy to affect positive change?

Pharmacology does not work with these teens because the cause of deceitful and cruel acts is most often an attitude, **NOT** a chemical imbalance. Medication cannot change attitudes, which is why the recidivism rate of traditional psychiatry remains high.

Which is more destructive: to attribute irresponsible, dysfunctional, deceitful, dangerous, and lazy behaviors to a never-proven metabolic disorder, or to demand that the youth makes more rational, responsible, and realistic decisions? To conclude an adolescent suffers from ADHD, which describes characteristics that often resemble those of gifted students, and thereby condemn the student to a lifetime of stimulant medications? To assume that a teenager is dominated by unconscious and preconscious dynamics, or to hold the kid accountable for poor conscious choices? To have low expectations that result in a false sense of success, or to have high expectations that may initially create frustration but that catalyze genuine improvement? To pretend that masochistic and sadistic acts will be self-correcting, or to confront and demand improved behavior? To create a professional mental patient with psy-

chiatric hospitalizations, or to listen more carefully when an adolescent discusses fears about suicide?

The John Dewey Academy refuses to apologize for being unrelenting and uncompromising by escalating expectations to demand personal growth. We submit that the ends justify the means for this effective therapeutic approach with gifted, acting-out, unconvinced adolescents who engage in dangerous behaviors.

A Psychoanalyst Views Confrontation - William Glasser

As a psychiatrist and psychoanalyst, I have spent my professional life helping others in the pursuit of understanding. Theory tells us that understanding is a necessary basis for change, and that without analysis we are doomed to repeat our mistakes.

I believe in that theory, but in our society, it is often twisted into an excuse for bad behavior and dysfunctional relationships. It can be particularly dangerous when applied to adolescents.

I first began to understand the misuse of psychoanalytic concepts in our society during my first visit to The John Dewey Academy in July of 2002. Sent there by an educational consultant who described the Dewey approach as "controversial," I sat in on a therapeutic group of which the focus was a brilliant college dropout. He had returned to high school at JDA in order to determine why he flamed out so spectacularly during his freshman year at a prestigious liberal arts college.

That day in July, he was the focus of the group because he had once again handled a cooking responsibility poorly. As I sat listening to his self-pitying excuses about why he was incapable of cooking rice, the scales fell from my eyes. He talked at length about his powerful desire to be responsible, about his wish to be a better brother to his younger sibling, and about all the painful reasons he could not seem to do either. He was articulate and clearly not mentally ill in any conventional sense; and he seemed to believe that his wish to change, coupled with all the evidence of his pain over his failures, would make things different—or at least allow him to continue pretending that he was doing something about his problems.

As I listened, I found myself increasingly excited by the "real" nature of the dialogue in the group. Initially, I wondered if the minor crime of burned rice really warranted all the time and focus it was afforded; but as the group progressed, I understood why this was so. The group process teased apart the various elements of the situation and laid bare this boy's excuses and evasions. Repeatedly, he voiced self-pitying justifications for his failures. Repeatedly, the group exposed his dishonesty and laziness in very explicit terms. It was clear that others would not join him in pretending that he was incapable of cooking rice. Implicit in their refusal to believe his excuses was the

assertion of his basic intelligence and competence. Thus the confrontations had two purposes, both rooted in reality: they exposed the reality of his behavior and the reality of his potential, all in the same moment.

Confrontation, I have come to understand, is necessary to pierce the armor of denial and rationalization with which these dysfunctional souls are wont to surround themselves. Facing the truth is the first step towards long-lasting change. Our society abounds in methods for avoiding reality: these include drugs, alcohol, self-mutilation, eating disorders, and Internet addictions of various types, among others. Confrontation works because it attacks avoidance; sadly, other forms of therapy are often unwittingly twisted into the service of this avoidance.

That "boy of a thousand excuses" was confronted repeatedly and candidly about his irresponsibility, and his behavior changed quite rapidly. Perhaps the change was initially due to his desire to stop hearing the confrontations—but as he began to reap the benefits of his improved behaviors, he established a sort of positive feedback loop, and the improvements snowballed.

That first group I attended made me think about the psychoanalytic approach to treating alcoholism in the 1950's: endless talk and analysis, accompanied by continued problem drinking and escalating life problems. Of course, true analytic understanding can come only after the patient eschews alcohol and begins to take a clear, hard look at him- or herself. The boy who was burning the rice clearly would have been happy to talk the issue to death that day; but his talking seemed only in the service of his pathology. Only the confrontations of his peers resulted in actual change.

Analysts are trained to be endlessly patient in the quest of understanding. Psychoanalytic treatments last for years—often many years. But in the new millennium, with adolescents exposed earlier and earlier to adult dangers, I believe we do not have the leisure of devoting years to a psychotherapeutic technique which often fails to yield behavioral changes. I would argue that analytic understanding alone is the wrong approach. Further, such understanding is often misused in the service of resistance to change.

Was there a role for analytic understanding in that college dropout's recovery? Yes, there clearly was. But just as with the alcoholic in analysis, he had to face some facts and make some changes before he could benefit from understanding the underlying issues.

I have further observed that therapists who confront dysfunction and name it unsparingly are actually quite supportive—and the recipient of the confrontation is often relieved by the truth-telling. In fact, confrontations are often seen as proof of care—and, I believe, accurately so.

Critics who describe confrontational therapy as too

"harsh" are actually missing the point. When delivered with care, even the harshest sounding confrontation results in the student feeling better as well as doing better. Caring confrontation also generally results in a closer relationship between confronter and confronted. The message is simple: "I care enough about you to tell you the hard truth, even if it hurts in the short term."

Since that July day in 2002, I have spent many hours and days at the John Dewey Academy and have had the opportunity to see, over and over again, the benefits of confrontational therapy. I have also run into considerable prejudice within the mental health community with regards to the idea of CP. Most of this prejudice stems from a basic misunderstanding of the technique and a lack of skill in employing it.

My approach to clinical work has changed significantly as a result of my exposure to the dynamics and benefits of CP. In looking beyond my own practice, though, I have seen repeated evidence of the need for more truth-telling throughout our society. Theatrical confessions, breast beating recitations of guilt, and other forms of avoiding reality pervade modern life; they are corroding our definitions of integrity and honesty, and we are all the poorer for this development.

A Student Experiences Confrontation

At fourteen, Debby started seeing psychiatrists who exacerbated problems by ascribing them to chemical imbalances. This made her feel as though they were beyond her control. Debby became ensnared in the 'no-win, no-exit' labyrinth created by psychiatrists. She felt different and viewed herself as psychologically damaged. Misguided and erroneous psychiatric interpretations produced profound demoralization and depression; she felt unable to extricate herself from inadequacy, failure, and shame, which produced feelings of unworthiness.

Debby felt in control when she hurt herself. Her parents hospitalized her for eight weeks when they discovered she was self-mutilating. She was diagnosed with major depression and prescribed Effexor, Risperidal, and a bevy of sleeping pills, none of which worked. There are two DSM-IV diagnoses that concede the potential damage caused by misused psychotropic medications:

(995.2) "Adverse Reactions to Medication."

(333.90) "Iatrogenically Induced Akathisia Associated with SSRI Antidepressant Treatment."

Boisvert & Faust (2002) suggest,

iatrogenic symptoms may originate from a pathology-oriented belief system through which therapists interpret, reinterpret, or labeled clients' personal characteristics, life script, or distress. Clients may be socialized into therapy through a language system that emphasizes pejorative labels and suggests that therapists hold specialized knowledge

that, in truth, they may or may not possess. Therapists may give clients the implicit or explicit message that something is wrong or flawed with them, which...may contribute to negative treatment effects (p. 247).

These two psychologists contend, furthermore, that the degree and potential range of negative treatment outcomes may not be readily apparent to therapists whose intentions are clearly aimed at ameliorating clients' distress. However, the presence of negative treatment effects are too pervasive and the unfortunate consequences that sometimes result from treatment are too powerful to deny or dismiss cavalierly (p. 253).

Knowing the hospital and medication were ineffective, Debby's parents referred her to The John Dewey Academy. During her intake interview at JDA, she was confronted about her dysfunctional behavior. Because she remained intransigent and refused to change, the senior author wrote her a letter deliberately precipitating a crisis. She impulsively left the Academy. The senior author's treatment task in writing the letter was straightforward: to eradicate Debby's infantile and attention-seeking behavior while simultaneously affirming his belief in her potential:

You stand at the crossroads of your existence. The decision you make, in retrospect, will prove to be the most important one of your life. This choice will have profound consequences and payoffs: "Does Debby want to become an autonomous **PERSON** who has self-respect or remain a **PATIENT**?"

You agreed not to play suicidal games and not to self-mutilate. Do not purge because it will be the symbolic strike three which will end the ball game. Stated simply, Debby, I refuse to permit you to...[engage in any] further type of self-destructive behavior. The John Dewey Academy has zero tolerance. When you were interviewed, I was brutally candid describing our mission. You agreed to attend because the healthy part of you wants to have a positive and productive future...

What concerns me is you gain attention when you act

crazy and **sick**. The John Dewey Academy is the wrong place for this behavior. Those who choose to play these stupid games belong in a **HOSPITAL**. Should you continue your attention-seeking antics: the histrionics, the hysterics, the anxiety attacks; we will conclude you choose to remain "sick"...so you will be expelled.

After forty years waging war against...dysfunctional

and destructive behavior...I believe it is a product of conscious choice. While perhaps an over-simplification, what...you did prior to attending The John Dewey Academy is irrelevant. We cannot re-write our pasts; but we...can learn from previous mistakes. Should you choose to remain at The John Dewey Academy, we will help you to diminish your infantile narcissism and learn more positive and productive ways to gain attention and approval. I will confront harshly your malignant attitudes and acts because you need to **unlearn** before you can **learn** how to become assertive. You are your own worst enemy. The treatment "mission impossible" is to symbolically kill that self-created monster to permit the healthy human to grow strong and sane. I warn you this

will be painful and scary; but until you change, your prognosis remains pessimistic! For...too long you have invested your energy into cultivating a "sick persona"...you [need] to change. Either **GROW** or **GO**! This is your choice, but it will be my decision. Time is a precious commodity which you squander.

I do not doubt you are endowed with superior intelligence. I **demand** you prove to yourself that you can succeed at those positive activities you deem important.

Message sent; hopefully understood and heeded. Wishing you the very best, I remain:

IN THE STRUGGLE TOGETHER,

Debby refused to respond to CP. She was sent to a six-week wilderness program to help her realize that her behavior was intolerable. Positive expectations change the transaction from a pathogenetic to a salutogenetic orientation—eventually, Debby not only assumed responsibility for her acts and attitudes but also took control of her life. She writes:

"I am a psychiatric casualty. I failed to respond to traditional psychotherapy and two months hospitalization. Initially, I rejected Confrontational Psychotherapy. I had been convinced by psychiatrists that I was beyond help. Before I attended The John Dewey Academy, no therapist told me 'to grow up,' 'accept responsibility' for my conscious choices, and 'stop whining.' Psychiatrists told me that medication would cure my symptoms and suggested I wait patiently until the right combination of medications was found.

Confrontation differs from other therapies because it has a dual approach. I benefited because I was confronted by the truth about my poor decisions and crazy thinking. When individuals confront each other, the person making the confrontation gains integrity and self-confidence. He or she also internalizes proactive beliefs by helping another to help him- or herself to improve.

I know that confronting or being confronted often is painful. I recall often feeling forced to confront my fear to change, but I had little choice; I was forced by CP to view how damaging my behaviors were. In retrospect, I feel embarrassed because I was so unaware of the consequences of my decisions. I was terrified to confront reality and probably would have avoided it indefinitely had I not been confronted. I never doubted that people cared about me, but it would be dishonest to write that I appreciated being confronted. There were times when I hated the confronter, but deep down I knew the confrontations I received were realistic.

Once I made a commitment to transcend my craziness, I assumed the role of confronter myself. Every time I confront, I remind myself about the self-imposed hell in which I chose to live. I still am a work in progress, but I know I never will permit myself to return to the delusions and self-hatred of my past.

I do not doubt that confrontation helped me salvage and save my life. I tremble when I think of who and what I would be today had I not been confronted. I might have committed suicide or still be in a hospital."

Having graduated from a prestigious liberal arts college, Debby is currently seeking a Ph.D. in clinical psychology.

Rejection of Psychotropic Medicine at The John Dewey Academy

JDA rejects claims of psychopharmacologists and neuropsychiatrists that intrapsychic problems are caused by biologically-based disorders and chemical imbalances. Although we recognize the possibility of such disorders in certain individuals, the incidence of these among dysfunctional, bright adolescents is much lower than conventional treatment approaches suggest. Feelings of depression, pain, shame, inadequacy, and fear—which are often reality based—that overwhelm adolescents are more often caused by conscious, dysfunctional, dishonest, destructive decisions than by biological aberrations.

Breggin excoriates pharmacologic researchers and the FDA for accepting self-serving, flawed, and deliberately dishonest studies financed by corporations with economic interests in the results. Angell (2000), Bodenheimer & Korn (2000), Friedberg, Saffran, Stinson, Nelson & Bennett (1999), and Krinsky & Rothenberg (1998) protest the correlation between the pharmaceutical industry's financial impact and research outcomes. Physicians and psychiatrists are aware of this unholy (perhaps even criminal) alliance, which they disregard by continuing to prescribe medicines that have not been proven effective or safe. This—not Confrontational Psychotherapy—is "cruel and unusual punishment" and may result in class action lawsuits for malpractice.

Breggin (1991 (see also Glasser (2003)) debunks the justifications for medication:

In the world of modern psychiatry, claims can become truth, hopes can become achievements, and propaganda is taken as science. Nowhere is this more obvious than in psychiatric pretensions concerning the genetics, biology, and physical treatment of depression and mania...Bio-psychiatric research is based too often on distortions, incomplete information, and sometimes outright fraud—at the expense of reason and science.

There are no known biological causes of depression.

There is no known genetic link in depression.

There is no...drug treatment for depression.

The same is true for mania: no biology, no genetics, and little or no rational basis for endangering the brain with drugs.

The biomythology of depression denies the obvious causes of depression in the lives of most people who become depressed...

To treat a depressed person as a biochemically defective mechanism, and to blunt or damage the brain of the suffering individual, many biopsychiatrists approach the patient with an especially dehumanizing view. Out of this perspective grow extreme treatments like electroshock (pp. 182-183).

Most psychiatric practitioners and researchers agree with Olfson *et al.* (2006a) that "there has been a sharp increase in antipsychotic treatment among children and adolescents in office-based medical practice" (p. 679). This psychiatric team cautions that for second generation antipsychotic medications, there is a "pressing need to increase and extend the experimental evaluation of these medications in children and adolescents" (p. 684). All journals which are financed by significant advertising by pharmaceutical corporations should require authors to disclose whether they own stock in those corporations.

Olfson *et al.* (2006b) conclude that "antidepressant drug treatment was not significantly associated with suicide attempts in adults aged 19-64" (p. 865). However, they also state that **"there may be an association between antidepressant drug treatment and suicide attempts and completed suicide in severely depressed children and adolescents in the Medicaid program after hospital discharge"** (p. 872, emphasis added). Leon *et al.* (2006) **"do not rule out the possibility of suicidal thoughts or non-lethal suicide attempts among youths taking antidepressants"** (p. 1057, emphasis added).

Significantly, an editorial (2006) which purports to redefine Bipolar Disorder contends that "increasingly sophisticated neuroimaging and genetic research have deepened our understanding of the neurobiology of bipolar disorders as one involving complex disturbances in relationships, linking environment, genes, neural systems, and behavior" (p. 1135). BUT, two sentences later, this editorial seems to contradict its original hypothesis:

Although the understanding of the pathophysiology of bipolar disorders remains limited, preliminary findings from recent neuroimaging studies have indicated persistent dysfunctions specific to bipolar disorder within neural systems underlying mood and cognition (p. 1135, emphasis added).

The insistence that depression is a single entity with a particular biological underpinning ignores the impact of toxic acts and attitudes. In contrast, feelings of pain, shame, inadequacy, and fear that overwhelm adolescents often are caused by conscious, dysfunctional, dishonest, and destructive decisions, not by biological aberrations. When asked why they feel depressed or shameful, adolescents often can provide realistic explanations. The John Dewey Academy asserts that personality and affective disorders rarely are cured by medicinal approaches. There is no pill that teaches self-respect and cures noxious narcissism, dishonesty, and anti-social attitudes. Therefore, we eschew the use of psychotropic medications at JDA and view drug-free as a viable treatment goal.

Breggin (1996) renders a polemic against the brain dysfunction assumption by exposing its counter-therapeutic message:

The biopsychiatric approach...reinforce[s] the patient's worst feelings and attitudes. The patient...feels helpless—at the mercy of forces beyond his or her control. The patient often feels like an object or thing that can do nothing more than react helplessly to internal and external threats. In the extreme, the individual suffers from delusions and hallucinations about being influenced and manipulated by imaginary others and outside unknown forces. Often the patient feels mentally defective. Unfortunately, the bio-psychiatrist's approach will encourage the patient to think and act like a helpless victim of overwhelming forces, namely genetic and biochemical abnormalities. The doctor "takes over" and prescribes physical agents supposed to counteract the genetic and biochemical influences. This further reinforces the patient's self-destructive helplessness (p. 4).

In *The Boston Globe*, Goldberg (2007) reports that beginning January 1, 2008,

Annual checkups for...nearly half [a] million Massachusetts children on Medicaid will carry a new requirement. Doctors must offer simple questionnaires to detect warning signs of possible mental health problems, from autism in toddlers to depression in teens...**Skeptics warn that more children could end on heavy duty medications...they really do not need** (p. 3, emphasis added).

It is clear what the impact of this law is likely to be. Frighteningly, overburdened delivery of care systems find themselves depending increasingly on medications because of the lure of the 'quick fix, even though the fixes are neither quick nor effective in the long run. Despite the FDA's refusal to grant approval to doctors to prescribe anti-depressants to children and youth, "Big Pharma" and an overburdened and under-funded mental health industry are interested in "better living through chemistry," although their motivations are different. Psychiatric residents no longer are trained to do "talk therapy; instead, they are taught every disorder has a biochemical basis, though this theory never has been proved. Frighteningly, the trend is towards medicating children at younger and younger ages, although we do not understand the effects of psychotropic medications on the developing brain.

We ask: What is more "cruel and unusual punishment"? To confront or to prescribe medication of unproven efficacy and safety?

The Scandals of the FDA and Congress

Few psychiatrists doubt the corrupting and corrosive power of the pharmaceutical industry, which uses massive funds to influence research findings. Medical researchers know that future funding is contingent upon positive findings; if they wish to receive financial support, their results need to be positive. In short, research outcomes are influenced by money. There is little doubt that the massive and powerful pharmaceutical cartel has bribed key researchers

and politicians. The FDA has breached its mandate to protect the consumer because this government agency has not exercised "due diligence." How can the FDA justify not demanding that negative studies become part of the public domain?

In addition, some Senators and Congressmen accept sizeable contributions from the medical industry. At the very least, when medical legislation is discussed, these recipients need to recuse themselves due to a "conflict of interest." How these politicians have escaped censure, impeachment, and in extreme cases prosecution needs to be explained.

The FDA has also remained strangely silent about the steroid and growth hormone controversy. Congress joins this shameful conspiracy when it limits its investigation of steroids to professional athletes and in so doing ignores the pandemic of abuse by adolescent athletes who take harmful performance enhancing drugs. Escaping scrutiny and censure are colleges and high schools that admit and work with athletes whose size and strength can be attributed to these substances (Celizic, 2004). A most prestigious college—respected for its academics rather than its athletics—has, for example, recently admitted a young man who has grown from a 5'11", 130 pound freshman to a 6'5", 190 pound senior. These data were in a newspaper article sent to the Dean of Admissions.

While perhaps only tangentially relevant, when they violate the Hippocratic Oath to 'Do no harm' by prescribing dangerous and/or unproven medications, psychiatrists engage in shameful and illicit activities.

Who is more "cruel and unusual": those who confront by communicating "You are in control of your life" and "You can do much better," or those who join a conspiracy of silence, prescribing psychotropic medications that they know are harmful and ineffective?

CONCLUSION

The Reputations of Colleges That Admit JDA Graduates Validate the Effectiveness of Confrontational Psychotherapy

Since the Academy's inception in 1984, less than ten percent of JDA graduates recidivate, seek psychotherapy, or need pharmacological intervention. These raw data warrant more scientific examination.

Prior to attending The John Dewey Academy, most students had mediocre grades and inconsistent academic records. Many functioned more than one grade level below their age, so they need intensive, individualized instruction to remedy educational deficits. More than a third of John Dewey graduates make Dean's List in college. Since the first class graduated in 1987, all graduates have attended four-year colleges. Similar to elite prep

schools, The John Dewey Academy wants to be judged by the reputations of the colleges that admit its graduates. Former students have made the Dean's List at: Barnard, Bates, Binghamton, Carleton, Colby, Columbia (College & University), Connecticut College, Cornell, George Washington, Georgetown, Haverford, Hobart, Holy Cross, Mount Holyoke, Muhlenberg, NYU (College of Arts and Sciences & Tisch School for the Performing Arts), Oberlin, Ohio Wesleyan University, RPI, Rochester University, Spelman College, Skidmore, Syracuse University (Visual and Performing Arts & Newhouse School of Communications), Trinity, Tufts, Union, the Universities of Chicago, Hartford, & Massachusetts; Vassar, Wellesley, and Williams.

The John Dewey class of 2008 has been admitted to Brandeis University, Columbia, Goucher, Oberlin, Sarah Lawrence, and the University of Chicago. The only student not admitted via Early Decision has been deferred by Amherst.

Acceptances by these colleges of quality make The John Dewey Academy indistinguishable from the most elite prep schools in the country. This validates the effectiveness of compassionate confrontation; the same students who distinguish themselves as student leaders at college once were viewed as psychiatric casualties.

The results achieved by The John Dewey Academy, which utilizes Confrontational Psychotherapy, warrants further investigation and research. Polcin (2003) suggests that when the goal of confrontation is to enhance growth, it is experienced to be positive and produces positive results. There needs to be further inquiry into the effectiveness of CP with different treatment populations in different settings.

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