

When Psychotherapy Becomes a War: Working with Gifted, Alienated, Angry Adolescents Who Engage in Self-Destructive and Dangerous Behavior

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ABSTRACT:

This article was a keynote address at the Ninth Annual Conference of the International Center for the Study of Psychiatry and Psychology held at American University's Washington College of Law in Washington, D.C. from October 7-9, 2006.

Where to begin? I started graduate studies at Teachers College, Columbia University in 1962. During that fateful summer, I had the good fortune to meet Alex Bassin, who wrote the proposal to NIMH which funded Daytop Lodge, the progenitor of Daytop Village described by Casriel (1963). Daytop, a confrontational program run by ex-addicts, employed methods pioneered by Synanon, described by Yablonsky (1965). These residential treatment programs not only were effective; they also rejected psychobabble, psychoanalysis, and non-directive counseling, two diverse psychotherapeutic orientations espoused by Teachers College. Carole and I were frequent visitors to Daytop Village. On the weekends, we participated in "games" when ex-addicts confronted visitors. These ex-addict workers were not polite. In fact, many confrontations were harsh. Not infrequently, the confronted sobbed uncontrollably, which produced intense catharses—especially when formidable, self-protective barriers of denial and deceit were obliterated. The symbolic repressed genie escaped from the bottle, never to return.

I attended groups at Daytop Village which forced addicted individuals to confront vicious and sometimes violent acts. "Tough" men and women who had been addicted to heroin for more than a decade and had committed sadistic acts related to shame, guilt, self-hatred, cruelty, anger, and rage. (The average age of Daytop Village residents was thirty-five.) In so doing, these addicts were forced to become vulnerable and transparent by letting the sun shine into darkness where feelings festered, were rotten, and smelled. These persons were forced to accept responsibility for themselves rather than blaming others or society. They were forced, furthermore, to recognize that much of their anger and rage was, in fact, internalized. Often, underneath their hostile and protective facade was a decent person who was consumed by chronic shame and guilt. I was amazed by the immediate transformations catalyzed by confrontation. It was exhilarating to observe this humanizing process produce change every time I visited the program, either to transport an

addict or to "play the game" on the weekends. These individuals, previously immune to the traditional therapy I was being taught, grew and improved when confronted. For a while at Teachers College, I remained a closet confronter. I listened to professors lecture, but knew traditional techniques were ineffectual with deceitful and destructive individuals who knew that heroin produced temporary relief. I felt smug, because I knew more than my professors—they were oblivious to this potent treatment methodology.

I was forced out of the closet during a practicum which traumatized a psychoanalytically oriented professor. Since I had access to a patient population of angry and alienated Scarsdale teen-aged substance abusers, I refused to "treat clients" who came to the Columbia Psychological Center. The first case I presented was my most dramatic, because I waged "guerilla warfare." I described the adolescent using terms such as "self-destructive," "angry," and "alienated," which intrigued the class but upset the professor, who wanted a more clinical and sophisticated diagnosis. Everything changed when I was asked to play an excerpt from the counseling session. The "nice" Tom Bratter changed into a foul-mouthed monster who did everything wrong. I was hostile. I was sarcastic. But the professor and the class were transfixed, as I had been when I first attended Daytop Village. The angry professor, probably feeling challenged by my therapeutic aggression, demanded I stop the tape recorder.

Predictably, his first question was whether I knew about the transference and countertransference theory which, much to his amazement, I did. When satisfied I had learned what I needed to, he then asked, "Why did you do what you did?" I responded, "Because it works." I countered by quipping, "I will bring the adolescent and his family to the next class, and you can question them yourself." A crazy proposition, but the professor was intrigued. I often have wondered what the professor's countertransference was to me—the heretic who dared to defy Sigmund Freud. I had the good sense to assert that "ole Sigmund" never would have worked with my kids. I asked, "Can you imagine what the kid's response would have been when Sigmund asked him or her to lie down and free associate?" The kid would have laughed and said, "You're a crazy dude. I'm out of here."

Fast forward. Twenty years later, Carole and I were at

Tanglewood listening to the Boston Symphony Orchestra. Our car broke. While it was being repaired in Great Barrington, with nothing to do, we were told that Searles Castle was for sale. We bought it. The rest is history. In 1985, we had an empty building with no kids and no furniture.

The John Dewey Academy provides intensive and individualized instruction for thirty-five gifted adolescents. Since the teens create constant crises by performing self-destructive and dangerous acts, they need structured, safe, and supportive residential treatment to help them control and curtail potentially self-annihilative choices. They had poor impulse control and flawed reality testing. These students, however, possess superior intellectual and creative potential which standardized tests may not confirm, though the average IQ is 125. SATs range from 1580 to 520. Admission to Dewey is based on an interview, not standardized test scores and transcripts or psychological and psychiatric reports. Prior to attending The John Dewey Academy, most students functioned more than one grade level below their chronological age, so they need to remedy massive educational deficits before attending college.

Bratter (1993) writes that The John Dewey Academy is unique because its primary identity is as a school which provides individual, family, and group therapy for bright, self-destructive adolescents that Bratter et al. (1989, 2003, and 2006a & b) describe. Most students were impulsive and have been diagnosed with ADD or ADHD. All entered the Academy with negative self-concepts complicated by extremely destructive and dangerous patterns of acting out. They were characterologically difficult, exhibiting prominent features of multiple DSM-IV disorders such as Oppositional Defiant Conduct, Substance Abuse, Dysthymic, and Bipolar. A significant number has contemplated or made suicidal gestures. These teenagers need to establish stable identities while concurrently learning how to form positive interpersonal relationships. In group sessions, peers confront each other's destructive attitudes and acts by relating to personal experiences and providing advice on how to change. Peers, not mental health professionals, provide the catalytic conditions for self-exploration and growth. The group demands that members not only accept responsibility for failures but also helps to resolve intrapsychic and interpersonal problems. The treatment goal is to nurture psychological and moral growth. Gifted, creative, alienated, and angry adolescents respond positively to a confrontational, cognitive, and existential therapeutic orientation with high expectations for improved behavior. The Academy stresses self-respect, integrity, and human dignity, as Bratter et al. (1995, 1997) and Bratter (1972) have described.

Incoming students, especially those who have been in traditional therapy and been institutionalized, experience shock at being expected to take control of their lives and to accept responsibility for their decisions. Dewey stresses choice, which negates the anti-therapeutic concepts of pre-

destination, mental illness, and un/pre/subconscious etiology. The expectation that teens will behave responsibly and honestly continues to escalate and is intense. Students respond to these expectations by becoming active rather than remaining passive and dependent. Bratter (1983) condemns the rigidity of the four "C's": Care, custody, conformity, and (institutional) control. The John Dewey Academy stresses ten "Cs": Care, choice, change, communication, cooperation, community, candor, confrontation, concern, and charisma. Perhaps, the most profound difference between these two attitudes involves the definition of "care." In traditional institutions, "care" connotes restrictive treatment; at Dewey, in contrast, it suggests sincere concern.

The John Dewey faculty is one of the most credentialed and experienced in the United States. I do not believe inexperienced and young teachers can be effective with bright, angry, unconvinced students. The average age of our faculty is fifty-five. Most who leave, retire. Faculty turnover is rare. Half possess doctorates. A third has been elected to Phi Beta Kappa. Our faculty is led by a Rhodes Scholar who taught at Stanford University, Middlebury, Mount Holyoke & Smith Colleges before joining our staff. Our Spanish teacher has been an ambassador to the United Nations, and four members of his family have been president of Nicaragua. The chairperson of the math-science department was a professor at the University of Alaska before joining our staff. Half have taught in colleges and graduate schools, and the faculty has more than 120 publications. Most have worked at The John Dewey Academy for several years, because job satisfaction is high. When students have scintillating and passionate teachers, they work diligently. Class size averages six.

Similar to other elite prep schools, The John Dewey Academy wants to be judged by the reputations of the colleges which admit its graduates and, more important, by their performances at those institutions of higher learning. All (100%) alumni attend colleges whose reputations compare favorably to those graduates from the most eminent prep schools. More than seventy-five percent complete their BA degree and attend the most competitive fifty colleges. An additional ten percent attend the most selective one hundred schools. Dewey students compete against the "brightest and best," who have excelled since elementary school, for admission. A third have made the Dean's List at Barnard, Bates, & Carleton Colleges; Columbia (College and University); Connecticut College; Cornell, George Washington, & Georgetown Universities; Haverford, Hobart, Holy Cross, & Mount Holyoke Colleges; NYU (College of Arts and Sciences & Tisch School for the Performing Arts); Oberlin College; Ohio Wesleyan University; RPI; Rochester University; Spelman, Skidmore & St. John's (MD) Colleges; Syracuse University (Visual and Performing Arts & Newhouse School of Communications); Trinity College; Tufts University; Union College; the Universities of Chicago,

Hartford, Massachusetts & Oregon; and Vassar, Wellesley, & Williams Colleges. The Dewey class of 2006 attends Binghamton University; Goucher College; Indiana University; Muhlenberg College; RPI (\$160,000 four-year scholarship); St. John's; Skidmore (2); the University of Chicago (2); and Williams College. Two members of the graduating class of 2002 attend Harvard & NYU Law Schools. Stated simply, there 'ain't' no damn [sic] program that works with bright, self-destructive teens which comes close to duplicating our statistics.

What works to produce these successes?

First: Until adolescents take control of their lives and accept responsibility for making deceitful, dumb, and destructive decisions, they will not change. We help adolescents gain the discipline to make thinking decisions when they do not feel like it.

Second: Gifted, angry adolescents respond to confrontation after they feel that the clinician cares about them. Freud never used the term confrontation, but was among the first to use the technique. After listening to patients free associate, the psychoanalyst interprets and, in so doing, makes the unconscious conscious. This is a confrontation. Confrontation during the third millennium forces teens not only to evaluate behavior, but also to feel shame and guilt for acting in irresponsible, masochistic, and sadistic ways.

Third: Freud was right, but for the wrong reason. He recommended hiding behind the opaque screen, which frustrated patients who craved a human relationship. For several patients, Freud was humanistic. He fed them. He lent them money. He housed a few. Subsequent psychoanalytic theory portrayed the analyst to be a scientist who objectively needed to make subjective interpretations. We reject this strategy because we demand outrageously high expectations for growth and improvement. We never compromise. We escalate.

Fourth: We know that the restoration of hope is crucial to improvement. Until there is hope, these adolescents will not contemplate change, because they know that at a young age they have ruined their futures. Their situations create depression and anger. When viewed from this realistic perspective, the sense of despair has been caused by poor conscious choices.

Fifth: For forty years, I (Bratter 1977 & 2006) have extended the role of the psychotherapist to become an aggressive advocate to help MY kids get preferential treatment. My supervisors accused me of being dominated by an unresolved negative countertransference and told me I felt deprived because my father was absentee. I countered by explaining that my father was my most effective advocate, my role model, and my mentor. I assumed the burden to convince colleges of quality to admit students whose academic record is, at best, mediocre. This transformed the treatment relationship: "If you do what I suggest, then I

will act as your advocate." I became a consultant and catalyst, not an enforcer. My favorite question is, "Is your current behavior helping you to achieve your intermediate to long-term goals?" This conversation is brief. If the kid answers, "No," I reply, "Then change." I write lengthy recommendations which are characterized by candor. I call or visit deans of admissions, college presidents, trustees, professors, and powerful alumni—anyone who can help. The act of advocacy entitles me to demand the best from my students because I act "above and beyond the call of duty." If the youth fails to produce, I delay support until I am convinced. In extreme cases, I either refuse to write a recommendation or rescind what I have written, because I refuse to tarnish my reputation by endorsing a "jerk," a liar, or a loser. It is a quid pro quo transaction: "You do what you need to do, then I will do what I need to do. It's really that simple." The burden always remains that of the adolescent to convince me to intervene. Then, it becomes my obligation to use my best efforts to convince the college or employer to grant preferential treatment.

Sixth: Prescribing psychotropic medication paradoxically decreases the probability of recovery. Worse, by attributing depression to an unproven metabolic disorder, clinicians inadvertently mire teens in lose-lose labyrinths. The unhealthy part of them is relieved that they do not need to accept responsibility for their acts and attitudes because they blame their problems on a chemical imbalance. Is it any wonder that these kids are angry when they know damn well [sic] that they have been their own worst enemies? If there were a metabolic disorder, why are not problems cured when ingesting the magical pills? The explanation is so simple that it becomes insulting: There is no pill that instantaneously produces self-respect and success.

Psychotherapy with troubled and troublesome teens is creative and challenging, mainly because these kids initially refuse to play by anyone's rules but their own. They arrive late for sessions or they miss them entirely. When they do attend treatment, they may be intoxicated, which creates a crisis for the therapist. If the psychotherapist decides that the teen is too intoxicated to benefit from the session, does he advise the inebriated youth to leave? If he or she does, the adolescent knows how to terminate treatment. If the therapist permits the teenager to remain, he or she inadvertently condones "getting high." I have found it effective to demand that the youngster, in order to continue the treatment relationship, not only notifies the family about his or her decision to come "high," which creates a crisis, but also to instruct someone to contact me to discuss what happened. Herein is the treatment paradox. For some, this intervention is effective, while for others it destroys any possibility of a future relationship. My only constant guideline is the preservation of treatment integrity. Once integrity is compromised, treatment is doomed. All therapists have been taught that confidentiality is the quintessence of a successful treatment relationship. I believe no kid "confides" about future behavior such as, "I plan to rob a bank," "There

will be a gang war,” or, “I plan to buy a couple of ounces of cocaine.” The healthy part of the adolescent screams for help—i.e., to intervene and “stop me.” Entering into a conspiracy of silence can result in prolonged incarceration or, worse, death. Like it or not, in life-or-death situations notifying the police can be justified to preserve life. Treatment is of no help to a dead adolescent.

While these battles are exhilarating to “win,” be prepared to pay dues and, in extreme cases, to lose. Crises rarely occur during working hours, so the therapist remains on call twenty-four hours a day, seven days a week—even when on vacation.

Do not work with troubled and troublesome teens unless you are prepared to earn every penny you receive. Refuse to provide treatment unless you are prepared to intervene. Recognize that psychotherapy with these adolescents is a WAR. In war, there are two absolutes. The first: Some will die. I (Bratter 2003) have related to the agony of suicide. The second: The treatment agent may not be able to change rule one.

Knowing what I do today, if I had the opportunity to change my profession or case load, I would choose to repeat what I have done. Now you can decide whether Tom Bratter is sane or insane. I regret the deaths, the jail sentences, and the wasted lives, but I know if you play the game of therapy, you must be prepared to pay the price. The problem is that psychotherapy with these kids ‘ain’t’ [sic] a game, but a war. Ask yourself: Are you prepared to wage war? If so, welcome to this struggle, which becomes a magnificent obsession.

What are the rewards? Being invited to a family affair and having many people approach me who say, “I know you. Thanks.” Being contacted years after therapy has ended and learning that the kid not only survived adolescence but has become a success. For me, this justifies my life and makes all the agony worth it.

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