

FEATURE ARTICLES

Motivating Gifted, Defiant, and Unconvinced Students to Succeed at The John Dewey Academy

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The John Dewey Academy (JDA) provides intensive instruction for bright troubled and troublesome teens who need residential treatment. In its 20-year history, all graduates have attended colleges of quality, and more than 70% complete at least their secondary education. This article describes the primary guiding principles that have produced positive results unrivaled by other special purpose schools and residential treatment centers for adolescents who are not amenable to traditional approaches.

Keywords: unconvinced and unmotivated adolescents; residential treatment for youth; drug-free; confrontation

The John Dewey Academy is a voluntary, residential, college preparatory, and therapeutic high school. Dewey (1899, 1902, 1936), who proclaimed the goal of self-renewal, identified three kinds of growth—intellectual, emotional, and moral. Expanding Dewey's thoughts, this Academy enlarges the curriculum from the traditional three "r's" (reading, 'riting, and 'rithmetic) to ten: respect, reality, responsibility, reason, relevance, research, reciprocation, resilience, reverence, and reform.

When feeling empowered, students are more likely to respect teachers, others, and themselves (Bratter, Bratter, & Bratter, 1998). When teachers are responsive, passionate, and committed to active learning, they inspire students to want to learn. Glasser (1969, pp. 23–24) suggested students "need teachers who . . . will encourage them to make a value judgment [about] . . . behavior, . . . who will not excuse them when they fail, . . . who will work with them . . . as they commit and recommit until they finally . . . fill a commitment . . . so . . . they gain maturity, respect, love, and a successful identity."

Until students shatter restricting boundaries of innocence and ignorance of immature thinking, learning has no meaning. In view of the rapid pace of technological advances,

education prepares students to cope with change because no one and nothing remains homeostatic; it must help them gain the resilience needed to endure inevitable stress, failure, rejection, fear, and pain.

At JDA, students learn to think analytically and to communicate those thoughts verbally and in writing. Gardner (1991) asserts that the acquisition of problem-solving skills is more important than the regurgitation of facts. Bratter (1983) condemned the rigid atmosphere of the five "c's" (competition, care, custody, conformity, and control) of traditional education and substitutes seven (choice, cooperation, change, community, civility, constructive criticism, and creative communication). Fromm (1976, pp. 28–29) criticized rote learning in traditional education. He said "students . . . will listen to a lecture [in order to] . . . pass an examination . . . The students and the content of lectures remain strangers . . . except that each student has become the owner of a collection of statements made by someone else."

Bratter (1974, 1975, 1977a, in press) wrote after Dewey students produce quality work, their therapists and teachers become advocates to convince colleges to them, even though their grades and standardized test scores are not competitive. Bratter and Parker (1994, 1995) described valuable contributions that justify colleges of quality to admit recovering students.

MORAL EDUCATION: TEACHING VALUES

The Academy's value system traces its origins to the Judeo-Christian and Puritan heritage that prizes honor, integrity, honesty, decency, excellence, sincerity, and respect for one's self and others. Kilpatrick (1992, pp. 225–226) contended that "the core problem [for contemporary education] . . . is a moral one . . . Attempts at school reform are unlikely to succeed unless character education is put at the top of the agenda . . . The primary way to bring ethics and character back into schools is to create a positive moral environment . . . The ethos of a school, not its course offerings, is the decisive factor in forming character."

Moral education includes implementing ethical obligations of conduct to help students (re)gain and maintain self-respect by performing good acts. Gardner (1999, p. 69) asserted that "the existence of moral intelligence rests on the existence of an identifiable moral domain. That domain must . . . extend beyond the usual spheres of intra- and interpersonal intelligences." He defined moral intelligence as "a concern with those rules, behaviors, and attitudes that govern the sanctity of life . . . A moral sense entails the capacity to recognize and make judgements about such issues" (p. 70).

Dewey (1916, p. 33) opined that teachers need to inspire the student "to be good for something" by developing "the capacity to live as a social member so what he gets from . . . others balances with what he contributes. What he gets . . . [is] a conscious life—a more intense, disciplined, and expanding realizations of meanings." Bratter, Bratter, and Bratter (1997) suggest that Dewey teachers become facilitators who use the dialectical teaching method to develop critical thinking skills. Students apply rational reflection to develop a philosophy of life by applying an evocative approach to problem-solving to identify educational, personal, and professional goals.

PSYCHO-SOCIAL-EDUCATIONAL CHARACTERISTICS OF JOHN DEWEY STUDENTS: REJECTION OF THE DSM-IV LABELS

Before attending John Dewey, a third of adolescents at Dewey had been hospitalized and/or had attended drug and alcohol treatment programs for at least 1 month. Three-quarters of these students had been treated by mental health professionals. Interestingly,

few psychiatrists and psychologists refer patients, but 20% send their daughter or son. Two-thirds of the students arrived psychologically and physically dependent on psychotropic medication. Two-thirds had self-medicated to decrease their feelings of inadequacy, loneliness, pain, stress, failure, fear, and rejection. Experimentation with psychoactive substances has become a rite of initiation to most adolescents in the 21st century. Many youth crave excitement and freedom that produce immediate gratification. Their reality testing is flawed. When asked why they were depressed or felt guilty, these adolescents typically answered they had made poor choices. After being convinced that success could be achieved by working diligently, students no longer remained unconvinced, unmotivated, or unable to perform.

Bratter, Bratter, Bratter, Maxym, and Steiner (1998) stated students who arrived at JDA had received from in-patient programs and community-based therapists a myriad of DSM-IV diagnoses that exceed 100% (see Table 1). Bratter (2002) contended psychiatric diagnoses are not helpful for acting out and alienated adolescents because these labels inadvertently provide excuses for irresponsible behavior. Many drug-abusing youth, furthermore, manipulate therapists to label them with an emotional disturbance to justify being

TABLE 1. The Percent of Entering Students Diagnosed With DSM-IV Conditions

Attention deficit hyperactivity disorder	60%
Conduct disorder/aggressive	20%
Conduct disorder/none-aggressive	16%
Opposition defiant disorder	33%
Antisocial personality disorder	33%
Kleptomania	10%
Gambling	10%
Date rape	10%
Anxiety disorder	20%
Avoidant personality disorder	16%
Eating disorder	20%
Sleep disorder	4%
Tourette's	6%
Asperger's	6%
Histrionic personality disorder	10%
Alcohol intoxication	66%
Amphetamine abuse	10%
Cannabis abuse	50%
Cocaine abuse-dependence	20%
Affective disorder	20%
Dysthymic disorder	25%
Bipolar disorder	18%
Narcissistic personality disorder	22%
Borderline personality disorder	20%
Obsessive-compulsive disorder	20%
Posttraumatic stress disorder	16%
Thought disorder	8%
Sociopathic	16%
Self-mutilation	20%
Suicidal thoughts	20%
Suicidal attempts	10%
Iatrogenically induced akathisia associated with antidepressant use	25%

medicated so they can sell medications that are prescribed to them. Creating constant crises with self-destructive acts, adolescents who abuse psychoactive substances need a structured, safe, and supportive residential environment to help them become abstinent.

TIMBERLAWN HOSPITAL: SIMILAR KIDS, DIFFERENT TREATMENT AND OUTCOME

Adolescents treated at Timberlawn Hospital in Dallas, TX, had similar psycho-social-economic characteristics to those enrolled at The John Dewey Academy for a 2-year period. Gossett, Lewis, and Barnhart (1983, p. 54) described Timberlawn patients whose symptoms "prior to admission include[d] severe academic under achievement, drug and alcohol abuse, promiscuity, runaways, delinquent acts, severe and chronic conflict with authorities, and a failure to respond to prior treatment." Timberlawn Hospital did not medicate much because this hospital's study predated the relatively recent trend to medicate patients. Lewis, Gossett, King, and Carlson (1973, p. 342) described the hospital's psychoanalytic orientation as one that viewed problems "as a function of personality development. Consequently, therapeutic goals involved more relief of symptoms or change of maladaptive behavior; when possible, they aim at modification of basic motivation and at personality reconstruction." Easson (1996) identified two treatment premises to which Timberlawn Hospital subscribed: First: youth lacked ego strength to control impulsive drives; Second: patients lacked the capacity to sustain intimate interpersonal relationships. When the therapist communicates to the patient that (s)he cannot control behavior, this negative statement undermines the probability of change. Timberlawn's posthoc outcomes exposed the ineffectiveness of traditional residential treatment and teaching approaches.

THE REJECTION OF PSYCHOTROPIC MEDICINE

Depression is caused by dysfunctional and destructive decisions, not by biological aberrations. Sixteen "d's" mire adolescents in depression. They feel devastated, demoralized, discouraged, debilitated, different, damaged, disgruntled, disgusted, despondent, distressed, drained, disenfranchised, and defeated, all of which beget self-deprecation and self-doubt, which reinforces defeat. Worse, often the treatment goal has been reduced to helping students settle for mediocrity—hardly an inducement for improvement. Frankl (1967, p. 27) described this dilemma when he wrote "if we take a man as he is, we make him worse; if we take him as he ought to be, we help him become it."

Collabолletta, Gordon, and Kaufman (2000) stated that The John Dewey Academy rejects the assumption that persons are biochemically defective because such thinking obscures more realistic explanations about the noxious impact of self-destructive decision making. Valenstein (1998, p. 3) asserted that "claims about the relationship of brain chemistry to psychological problems and personality and behavioral traits are . . . wrong. The claim . . . psychotherapeutic drugs correct a biochemical imbalance . . . [remains] unproven." Markel (2000) confirmed Levinson and Nissenbaum's (1981, p. 198) warning that "medication should be used as a last resort."

Most John Dewey adolescents have been prescribed multiple psychotropic medications. Medication is devastating because it offers no solution and, worse, suggests that the young person cannot control personal behavior. When the cause of depression is attributed to a

chemical imbalance, this reductionist thinking relieves teenagers from accepting responsibility for acts; when viewed from this perspective it is countertherapeutic. If there were a medical solution, observable behavior improvement would occur soon after the young person ingested medication.

Since the 1980s, Breggin (1999a, 1999b) has emphasized pharmacological cures while minimizing talking approaches. Breggin (1991, p. 11) lambasted neuropsychiatric researchers when he suggested that "the modern psychiatrist may have no interest in 'talking therapy.' His or her . . . training . . . is . . . devoted to 'medical diagnosis' and 'physical treatment' [and] may look at you with all the empathy and understanding of a pathologist staring through a microscope at germs, and then offer you a drug."

In 2003, 4,000 readers responded to a *Consumer Reports* questionnaire to evaluate the effectiveness of "talk therapy" versus pharmacological approaches. This sample was reduced to 3,009. Excluded from this survey were those who had not sought any treatment. Forty-three percent described themselves as depressed and anxious. There were two significant *Consumer Reports* (2004, p. 22) findings.

First: "Talk therapy rivaled drug therapy in effectiveness. Respondents who said their therapy was mostly 'talk therapy,' and lasted at least 13 sessions had better outcomes than those whose therapy was 'mostly medication.' "

Second: "The rates of adverse drug side effects that our respondents experienced were much higher than those noted on the medications package inserts. Forty percent said they experienced a loss of sexual interest or performance and almost 20% said they gained weight."

Ingestion of a pill does not cure noxious narcissism and negative attitudes. No pill produces self-respect.

CONSCIOUS CHOICE

Students take control of their lives, which rejects un/pre/subconscious, mental illness, and predestination models. Rational thought and self-determination are realistic treatment goals. Glasser (1960) proposed that choice and change are integral in all systems of psychotherapy. The Dewey treatment milieu helps its members change because they cannot justify mediocrity or failure by commiserating how "unlucky" or "unjust" their lives have been. Glasser (1998, pp. 334–335) asserted, we are not doomed to repeat our past unless we choose to do so . . . We can correct . . . [toxic] relationships with behaviors that are satisfying to both parties." Breggin (1991, p. 45) maintained each person can "choose . . . to overcome any hardship or oppression . . . [It is] the helper's role to encourage . . . self-determination."

THE CARING COMMUNITY: POSITIVE PEER PRESSURE

When teenagers live in an uncompromising and unrelenting setting with escalating high expectations for improvement, they change. In this caring community, the concept of responsible concern has been borrowed from AA and the self-help residential ex-addict-run therapeutic communities of the 1960s and 1970s described by Bratter, Collaboletta, Fossbender, Pennacchia, and Rubel (1985). Positive peer pressure helps students mobilize

superior intellectual abilities. Bratter, Bratter, Radda, and Steiner (1993) asserted that in the Dewey caring community members help each other become responsible and productive. This creates new roles for teachers and therapists who become catalysts-consultants. The traditional therapeutic dyad becomes a triad: the peer, the student, and the therapist.

Berkovitz (1972) was one of the first to recognize that group therapy is the most effective treatment modality for adolescents. Weekly at Dewey, students attend at least four 2-hour groups. The group insists that members not only accept responsibility for self-destructive behaviors but also resolve intrapsychic and interpersonal difficulties. Sugar (1972) stated that adolescents relate to, and identify with, peers who suggest solutions and strategies for change. Nightly Dewey students attend a 1-hour group where there is no adult participation. Members assert themselves and in so doing they build a community governed by human decency, honesty, and work and concurrently gain confidence that their opinion is valuable.

SELF-RESPECT: THE GOAL OF PSYCHOTHERAPY

At The John Dewey Academy, students learn the summum bonum is to (re)gain and maintain self-respect. Self-respect means "to thine own self be true—" not to be indulgent, but to maintain the balance between the obligations to discharge responsibilities and to satisfy personal needs without depriving others of their rights. During the zenith of psychoanalytic thought, Horney (1945, p. 19) refuted Freud's pessimistic pronouncement that "man . . . is doomed to suffer or to destroy." She formulated what became the primary premise for humanistic psychology: "Man has the capacity . . . to develop his potentialities and become a decent [person] . . . [and] can change." Horney contended that therapy helps the person become a "force [who can] . . . make decisions] . . . [and can] recognize obligations in whose values he believes, whether they relate to his children, parents, friends, employees, colleagues, community or country" (p. 45). Bratter (1993, p. 302) argued that self-respect is the most important treatment and personal goal. It contains three components:

First: The individual needs to learn how to be assertive—that is, not only to articulate but also to defend personal beliefs . . . Self-respect requires maintaining the equilibrium between reality (cognition) with the actualizing of emotional needs . . . The . . . mature person knows that intellect is more crucial to the decision-making process than pure passion . . .

Second: Being sensitive to the needs of others . . . is an integral . . . [to] self-respect. The student needs to recognize others retain the right to fulfill their needs which may require modification of . . . behavior . . .

Third: The respect for the property of others. The individual will not damage or abuse the property of another when borrowed items are used.

Glasser (1969, pp. 3–4) contended when the student learns "(1) what to do, (2) how to do it, and (3) *where to get the strength to get it done*, self-respect becomes a byproduct" [emphasis his]. Glasser (2000, p. 227) replaced "*responsibility* with the more explicit idea that *we choose . . . our behavior*" [emphasis his].

COMPASSIONATE CONFRONTATION: AN EFFECTIVE TREATMENT ORIENTATION

Though he never used the term, Freud confronted patients when he interpreted behavior to make conscious the unconscious. A cognitive and confrontational therapeutic approach

helps gifted, suspicious, and self-destructive youth begin to use, rather than abuse, their superior potential. There are two types of confrontations. Behavior assessment is the most direct. The confronted knows what act(s) are disapproved of and dysfunctional. The second approach helps students gain a realistic perspective, asking them to confront themselves. Helpful questions include: "Does your current behavior help you achieve your goals?" "Do you have self-respect?" "Are you happy?" Confrontation helps students unlearn destructive behavior patterns while learning how to help and be helped, how to trust and be trusted, how to respect and be respected, and how to love and be loved. Bratter (1977b, p. 190) listed seven principles of confrontation:

1. Attack the malignant and dysfunctional aspects of behavior.
2. Penetrate the facade of justification of behavior.
3. Force individuals to accept responsibility for behavior.
4. Help persons evaluate . . . behavior.
5. Assist individuals to be aware and to anticipate the consequences and payoffs of their behavior.
6. Challenge persons to mobilize their resources.
7. Define a direction so that persons can continue growth and development.

John Dewey students have remained immune to traditional therapeutic and teaching techniques. They have erected formidable barriers and defenses, which need to be cracked before they will think rationally. In the Dewey treatment environment, peers confront each other by demanding that each member accept accountability for immature, irresponsible, illicit, and self-destructive acts rather than attribute the cause to others or to circumstances beyond personal control.

Self-destructive, deceitful, drug-dependent adolescents present unique challenges and treatment concerns. Complicating treatment, alcohol- and drug-dependent youths know that self-medication produces an ephemeral, drug-induced narcissistic relief. Confrontation is the most effective psychotherapeutic approach for bright, angry, and alienated youth. Unless prepared to wage war with this hard-to-treat population, the therapist is advised to decline to become engaged. In a war in which drug abuse often escalates to become a life or death struggle, many will be casualties, some will survive, and a few will succeed.

Rather than be sympathetic (which prolongs the homeostasis that mires the student in self-imposed depressive states) the treatment agent needs to become confrontational to force these adolescents to pierce their protective armor. Denial, deceit, and distortion have produced loneliness, failure, and dangerous behavior, such as alcohol- and drug-related car accidents, felony convictions, prolonged incarceration and institutionalization, suicide and/or murder. Bratter (2004) asserted that the most uncaring therapeutic act is to enter into the conspiracy of silence with the adolescent pretending behavior will be self-correcting when the youth matures. When the goal of therapy is to protect and preserve life, confrontation is a caring and constructive intervention. This, then, becomes the most positive and potent expression of responsible concern.

Confrontation is similar to surgery, which, when judiciously used, attacks and eradicates malignant cells. Chemotherapy, radiation, and surgery are painful. Few criticize medical attempts to rid the body of malignant cells. Like medical treatment for cancer, confrontation can be painful, but this reality does not make it controversial. Confrontation to facilitate communication has gained respectability. Patterson, Grenny, McMillan, and Switzler (2005, p. 4) collaborated in a treatise written for public consumption when they defined confrontation, "to hold someone accountable." The net results, this quartet concluded, are "problems are resolved. Relationships benefit" (p. 5). These are valid treatment goals.

CONCLUSION

In a 16-year longitudinal, multivariate study describing how adolescents function after discharge from the Timberlawn Hospital, Gossett, Lewis, and Barnhart (1983, p. 64) reported:

Three-quarters of the sample had graduated from high school . . . Several were actively involved in college work but only six had graduated from college. This is . . . notable since most . . . came from middle- or upper-class-oriented families . . . The severe educational deficits . . . continued to exist . . . in spite of a very intensive focus on educational achievement in the treatment program . . . Half of the group continued or returned to outpatient psychotherapy . . . , [and] psychiatric rehospitalization occurred for about one-fifth.

They add "the focus on negative outcomes . . . should not obscure the fact . . . that 65–70 percent [showed] . . . substantial treatment benefits, reflected in . . . improved peer and family relationships, more successful educational and vocational functioning, reduced symptomatic status, and much greater subjective contentment" (p. 83). Anthony, Buell, Sharatt, and Althoff (1972, p. 451) concluded after reviewing the rate of recidivism from inpatient [psychoanalytic] . . . programs, often shorter in duration, they assessed "a 70% return in a five-year post-discharge period."

All John Dewey (100%) graduates, in comparison, attend colleges of quality. Like most elite prep schools, The John Dewey Academy wants to be judged by the reputations of the colleges that admit its graduates and, more important, by their performances at those institutions of higher learning. More than a third make the Dean's List at Barnard, Bates, Carleton, Columbia (College & University), and Connecticut College; Cornell, George Washington and Georgetown universities; Haverford, Hobart, Holy Cross, Mount Holyoke and Muhlenberg colleges, NYU (Arts and Sciences & Tisch School of the Performing Arts), Oberlin College; Ohio Wesleyan University, RPI, Rochester University, Spelman and Skidmore colleges, Syracuse University (Visual and Performing Arts & Newhouse School of Communications), Trinity College, Tufts University, Union College, the Universities of Chicago, Hartford, Massachusetts, & Oregon; Vassar, Wellesley, & Williams colleges. More than 70% graduate from college. At least a third attend graduate school. In the new millennium, less than 10% of Dewey graduates have discontinued higher education and become recidivists. Equally significant, less than 10% of this school's alumni resume psychotherapy or take psychotropic medication. These data offer compelling evidence that when dually diagnosed self-destructive adolescents attend a school where they are confronted to achieve academic excellence and gain personal integrity, they transcend their pasts. Confrontation psychotherapy with escalating expectations for growth produces positive outcomes that warrant more scrutiny.

Critics claim that confrontation psychotherapy is painful and simplistic. But they cannot explain how and why adolescents, who were extreme casualties, improve. The John Dewey Academy proves that intellectual excellence and moral integrity can be achieved without compromising one for the other.

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