

The John Dewey Academy for Talented, Troubled, and Troublesome Teens: Nine Guiding Principles, Part II

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This is the second installment that describes nine psychological and psychotherapeutic guiding principles for the John Dewey Academy. This academy is the most effective college preparatory, voluntary, residential, and therapeutic high school in the United States for students who are gifted but engage in self-destructive behavior.

Keywords: compassionate confrontation psychotherapy; gifted adolescents who engage in self-destructive behavior; rejection of psychotropic medication; escalating treatment expectations; empowerment; moral education

There are nine psychological and psychotherapeutic principles that, when combined, make the John Dewey Academy, a college preparatory and therapeutic high school the most effective program of its kind in the United States that provides intensive instruction and treatment for what Bratter (2009) labeled “gifted, alienated, and dually diagnosed . . . students who were self-destructive” (p. 16).

Dewey teens resisted traditional teaching methods and therapeutic interventions. They exist in the existential present and are thus oblivious to future consequences and payoffs. The mission of this academy is to nurture academic, psychological, moral, social, and spiritual growth. Bratter, Bratter, and Radda (1986) delineated social, cognitive, creative, ethical, and academic goals:

- To develop a positive concept of self and a proactive philosophy of life.
- To assume responsibility for one's behavior and to recognize that constructive change is possible.
- To formulate intermediate and long-term goals.
- To be aware of meaningful rewards for productive behavior and tangible consequences for irresponsible acts.
- To learn how to use, rather than continue to abuse, personal potential.
- To understand one's role in society and to contribute constructively to its betterment.
- To love and be loved, to trust and be trusted, to respect and be respected, and to help and be helped.

Some adolescents have a history of incarceration and/or institutionalization. They need to comply with six rules: (a) To remain drug-free from psychoactive substances (including alcohol and nicotine), (b) to avoid threats, intimidation, and/or acts of violence, (c) to be sexually abstinent, (d) to be honest, (e) to respect the rights of others, and (f) to contribute to

the common good of the community. Applicants need to agree to abide by remarkably few rules. Admission to the academy is based on a mandatory on-campus interview conducted by the clinical staff and random students. At its termination, the applicant needs to confirm that he or she wishes to remain because the John Dewey Academy is voluntary. One of the purposes of the day-long interview is to provide the student with an abundance of data, so the family can make an informed decision. Repeatedly, the candidate is counseled that if attending a competitive college is not a goal worth pursuing, then selecting the John Dewey Academy would be a mistake. The applicant can leave when deciding not to stay. (Several terminated the interview.) This interview ignores academic performance and standardized testing. After confirming a commitment to become a contributing member of the community, provisional admission is offered to the prospective student. After a probationary period, which lasts more than a month, the prospect will request a vote by peers to determine if membership in the community will be granted. A majority determines outcome.

PSYCHO-EDUCATIONAL CHARACTERISTICS OF DEWEY STUDENTS

Elsewhere, Bratter (2002, pp. 297–298), Bratter, Bratter, Coiner, and Steiner (2006, pp. 8–10), Bratter, Sinsheimer, Kaufman, and Alter (2007, pp. 71–73), and Bratter (2009, pp. 17–18) have described the psycho-educational-social characteristics of Dewey students who engage in dangerous and self-defeating behaviors. The John Dewey Academy provides a safe, structured, and supportive residential treatment milieu designed to help angry and alienated youth contain and curtail self-destructive behaviors.

McKinnon, the psychiatrist head of Montana Academy, compiled a list of diagnoses encountered at that institution. This list is representative of diagnostic profiles for JDA students.

Cyclothymic Disorder (301.13); Panic Disorder (300.01); Post-traumatic Stress Disorder (309.81); Adjustment Disorder with Mixed Disturbance of Emotion and Conduct (309.4); Generalized Anxiety Disorder (300.02); Social Phobia (300.23); Obsessive-Compulsive Disorder (300.3); Anorexia Nervosa (307.1); Dissociative Disorder (300.15); Somatization Disorder (300.81); Conversion Disorder (300.11); Body Dysmorphic Disorder (300.7); Gender Identity Disorder in Children (302.6); Bulimia Nervosa (307.51); Primary Insomnia (307.42); Pathological Gambling (312.34); Intermittent Explosive Disorder (312.4); Identity Problem (313.84); Adverse Effects of Medication NOS (995.2); Parent-Child Relational Problems (V61.20); Physical Abuse of a Child (V61.21); Sexual Abuse of a Child (995.54); Bereavement (V62.82); Asperger's Disorder (299.89); Attention Deficit/Hyperactivity Disorder (314.01); Conduct Disorder (312.8); Oppositional Defiant Disorder (313.81); Separation Anxiety Disorder (309.2); Reactive Attachment Disorder (313.89); Alcohol Abuse (305.00); Sedative, Hypnotic or Anxiolytic Dependence (304.1); Amphetamine Abuse (305.70); Cannabis Abuse (305.20); Cocaine-Related Disorder Not Otherwise Specified (292.9); Hallucinogen Abuse (305.30); Inhalant Abuse (305.30); Polysubstance Dependence (304.84); Hallucinogen Persisting Perception Disorder (292.89); Schizoaffective Disorder (295.7); Schizophrenic Undifferentiated Type (295.9); Brief Psychotic Disorder (298.8); Major Depressive Disorder (296.33); Bipolar Disorder (296.65). (McKinnon, 2008, pp. 31–32)

Abuse of and/or addiction to psychotropic medications as well as tobacco, alcohol, and other recreational and illicit substances is common. At least 10% of students suffered significant side effects and sequelae caused by psychotropic medication use.

After reviewing the oppositional defiant (ODD) and conduct disorder (CD) literature during the 1990s, Loeber Burke, Lahey, Winters, and Zera (2000) described the behaviors of ODD as, “patterns of negativistic, defiant, disobedient, and hostile behavior toward authority figures, which lead to impairment.” The prominent features of CD are “a repetitive and persistent . . . behavior in which the basic rights of others and major age-appropriate societal norms . . . are violated” (p. 1446). The John Dewey Academy experience confirms this contention.

While not belaboring these profiles, since the John Dewey Academy minimizes the validity of *DSM-IV* diagnoses, there are labels that need to be included that Montana Academy omits. The proportion of adopted students and children of divorce is high. It appears reasonable to contend that the John Dewey Academy admits more dysfunctional adolescents, than do Montana Academy and other special purpose schools, who have been diagnosed with: induced anxiety disorder (292.89); induced mood disorder (292.84); identity problem (313.82); impulse-control disorder NOS (312.30); mood disorder NOS (296.90); adjustment disorders with depressed mood (309.0); noncompliance with treatment (V15.81); and/or sibling relational problem (V61.1). The John Dewey Academy would add several *DSM-IV* diagnoses. The John Dewey Academy concurs with McKinnon’s (2008) assertion that the Montana Academy “did not find answers in conventional wisdom” (p. 38). In fact, the John Dewey Academy became skeptical of *DSM-IV* diagnoses having validity for struggling teens.

McKinnon’s (2008, p. 30) lists of dysfunctional behaviors and emotions are more useful than the *DSM-IV* diagnoses. These include:

Deflated mood; self-loathing; anxiety; insomnia; nightmares; mood swings; tantrums (with or without property destruction); threats; fights; brandished weapons; assaults; vandalism; theft; shoplifting; self-injury (covert or overt) including scratched, cut, abraded or burned skin on wrists, thighs, ankles or breasts; pulled hair; suicidal gestures, threats, hints or serious attempts; school anomie; truancy; collapsed academic effort; poor concentration; classroom squirming; disruptive talking in class; failure to do or turn in assignments; failing or failing grades; suspension or expulsion; rudeness with adults and peers; oppositionality or defiance with teachers or parents; eating disturbances (binging, purging, self-starvation, compulsive use of laxatives); drug or alcohol intoxications or addictions; arrests for intoxication or possession; drunk or intoxicated use of motor vehicles; drug dealing; sexual harassment; compulsive looking at pornography; rape (perpetrator or victim); family discord, including alienation from parents; mean mistreatment of siblings; family squabbles and fights; destruction of belongings or property; failure to keep curfews; compulsive playing of computer games; compulsive instant messaging or web surfing; hacking; chore refusal; running away; pilfering to pawn; lying; and other sneakiness.

There are nine quintessential guiding principles that govern the John Dewey Academy. Five are general and four are treatment orientated.

FIRST: PROVIDING A MORAL EDUCATION TO AUGMENT ACADEMICS

This college preparatory and therapeutic school in 1985 implemented a comprehensive moral education program that stressed character development. Bratter (2006, p. 8) asserted that the optimal objective of moral education is to nurture the student’s superior innate intellectual, intuitive, and creative abilities. The student learns how to formulate

and communicate opinions and how to find connections between intelligence and the moral and ethical obligations (the categorical imperative) of conduct. When learners discover right from wrong, what they feel most passionately about, and activities that interest them, they formulate a proactive philosophy of life that transcends traditional education. Teaching ethical values encourages academic excellence and rejects mediocrity. Ryan and Bohlin (1999) suggested, "Values can be good or bad . . . Acquiring strong views and attitudes on . . . moral issues is an integral part of becoming mature . . . Virtues . . . enable us to . . . lead worthy lives . . . Our success or failure at instilling in our students those virtues which are the backbone of good character, will determine their destinies" (p. 49). Gardner (1999) defined moral intelligence as "a concern with . . . rules, behaviors, and attitudes that govern the sanctity of life . . . A moral sense entails the capacity to recognize and make judgments about [these] issues" (p. 70). Gardner further suggested persons who possess moral intelligence will display, "Recognition of issues related to the sanctity of life . . . Facility in mastering . . . symbolic renderings and codifications . . . Potential for [extending] conventional approaches to create new forms of processes that regulate . . . human interaction" (pp. 70–71). Moral education helps students to make informed choices. Moral education produces a commitment to truth, decency, and personal integrity. Moral education examines beliefs, values, expectations, and knowledge to promote continued intellectual growth. The curriculum at Dewey has been expanded from the so-called three r's (reading, 'riting, and 'rithmetic) to include 13 more: responsibility, reality, respect, responsiveness, renewal, reason, relating, reform, research, reciprocation, relevance, resiliency, and reverence. The use of Socratic teaching methods and small class size enhances trust, respect, and the internalization of proactive values. Three-quarters of the faculty possess doctorates. A third have been elected to Phi Beta Kappa. One is a Rhodes Scholar, another is a former special Ambassador to the United Nations, and a third has taught high school in many diverse cultures for 50 years. The teachers are mature and experienced, thus enabling them to function as responsible role models and as quasiparental surrogates. Teachers are critical members of the clinical team at John Dewey Academy.

SECOND: REJECTING PSYCHOTROPIC MEDICATION

No one argues that prescribing psychotropic medication for children and adolescents has become pandemic. Harris (2008), reporting for the *New York Times*, noted, "Powerful antipsychotic medicines are being used . . . too cavalierly in children . . . More than 389,000 children and teenagers were treated in 2007 with Risperdal [which is an] atypical antipsychotic. Of those patients, 240,000 were 12 or younger." Harris also warned, "From 1993 through the first three months of 2008, 1,207 children given Risperdal suffered serious problems, including 31 who died. . . . [One death] was a 9-year-old . . . who suffered a fatal stroke 12 days after [being prescribed] Risperdal" (p. A20). Bratter (2009, pp. 23–25) castigated the Food and Drug Administration (FDA) and condemned psychiatrists who prescribed medication not approved by the FDA for children and adolescents. Why there has not been criminal litigation for wrongful death and malpractice against the psychiatrist who *killed* a 9-year-old is outrageous. More than 75% of Dewey students have been treated with one or more psychotropic medications. Attempts to medicate psychic pain

only exacerbate feelings of helplessness and hopelessness. Bratter (2002, pp. 295–296; 2009, pp. 16–28) discussed the rejection of psychotropic medication at Dewey. Unfortunately, the medical model unwittingly encourages those who are prescribed psychotropic medication to think and act like they are victims of genetic and biochemical abnormalities. Breggin (1997) suggested:

The sense of . . . helplessness must be resolved because behind emotional psychological helplessness lies a subjective judgment about our . . . capacity to handle ourselves . . . Nothing is more crucial than encouraging people to overcome . . . feelings of helplessness. Helplessness reflects a judgment . . . that nothing can be done, that all is lost, that there's no sense trying, that it's time to surrender . . . The alternative to helplessness is a feeling of self-determination and mastery, the sense of taking control over one's . . . feelings and thoughts, and giving direction to one's life. (pp. 72–73)

The John Dewey Academy asserts that medications mask symptoms, so the use of these ineffective pharmacological agents causes damage because medicine communicates that “illness is beyond control.” Breggin (1996) delivered a polemic against the brain dysfunction assumption when he exposed its counter-therapeutic message.

The biopsychiatric approach reinforce[s] the patient's worst feelings and attitudes. . . . Often the patient feels mentally defective. Unfortunately, the biopsychiatrist's approach will encourage the patient to think and act like a . . . victim of overwhelming forces, namely genetic and biochemical abnormalities. The doctor . . . prescribes physical agents . . . to counteract the genetic and biochemical influences. This further reinforces the patient's self-destructive helplessness. (p. 4)

Valenstein (1998) noted, “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 that is the . . . cause of most psychological problems . . . is . . . an unproven hypothesis” (p. 3). Over a decade earlier, Winsberg and Camp (1981) warned, “Until medication is proven to be effective and safe, there should be a moratorium on prescriptions of amphetamines” (p. 144). Inexplicably, this realistic and pragmatic warning has been ignored—essentially corrupted by the financial clout of the pharmaceutical industry and its effective lobbying of Congress.

Since the publication of Breggin's (1991) *Toxic Psychiatry*, Barber (2008), Breggin (2008a, 2008b), Glasser (2003), Horowitz and Wakefield (2007), Jackson (2003), Moncrieff (2008), Petersen (2008), Szasz (2008), Scott (2006), and Whitaker (2002) have written books that reject psychotropic medication as a viable treatment. Diagnostic labels justify polypharmacy, which is a misguided attempt to deal with psychic pain. The John Dewey Academy contends that psychiatric labels and psychotropic medications decrease chances of recovery. At the John Dewey Academy, drug-free living is a viable goal.

THIRD: BEYOND GROUP PSYCHOTHERAPY—THE CARING COMMUNITY

Peer pressure is a formidable (positive or negative) force for youth. Agreeing with this premise, Azima (1996) asserted that “group psychotherapy is . . . the treatment of choice for

adolescents” (p. 3). Bratter (2002, pp. 293–308) confirmed Azima’s contention. Rachman (1995) reported that adolescents need to establish positive personal identities while learning how to form gratifying interpersonal relationships. Berkovitz and Sugar (1975) offered nine reasons why group psychotherapy is the preferred treatment modality for teenagers:

- to support assistance and confrontation from peers;
- to provide a miniature real life situation for study and change of behavior;
- to stimulate new ways of dealing with situations and developing new skills in human relations;
- to stimulate new concepts of self and new models of identification;
- to feel less isolated;
- to provide a feeling of protection from the adult while undergoing changes;
- to maintain continued self-examination;
- to allow the swings of rebellion or submissions which will encourage independence and identification with the leader;
- to uncover relationship problems not evident in individual therapy. (p. 22)

At John Dewey, groups achieve these goals. Credentialed therapists conduct at least five 2-hour groups per week. At night students participate in a 1-hour leaderless group to facilitate a sense of community and promote personal empowerment. Meeks and Bernet (1990) recommended “requiring each group member to formulate . . . personal treatment goals” (p. 215). Students write growth plans with a realistic assessment of problems as well as intermediate and long-term personal, educational, and professional goals; these plans often are distributed to the community. In addition to growth plans, other forms of therapeutic writing are used; these writings are shared with others to expand group psychotherapy into a caring community. Members help each other to make amends for unacceptable behaviors and find solutions to problems. Students become active in recovery, rather than remaining passive and dependent. “Teach a man to fish and you feed him for life” is more effective than feeding the person a fish for a day, which breeds dependency.

FOURTH: INVOLVING THE FAMILY

The John Dewey Academy includes the family for treatment. Freud excluded family from treatment to minimize intrusive and controlling tendencies. The Freudian model viewed change as emanating from the resolution of the transference neurosis. Freud (1920) wrote:

Psychoanalytic treatment may be compared to a surgical operation . . . How many operations would be successful . . . if they had been performed in the presence of . . . the family, who [cry during the] operation . . . at every cut of the knife? The interference of relatives in psychoanalytic treatment is a . . . danger . . . It is impossible to approach the relatives of the patient with any . . . explanation, one cannot influence them to hold aloof from the whole affair, and one cannot get into league with them because we run the danger of losing the confidence of the patient . . . Besides those who know the rifts that often are formed in family life will not be surprised as analysts when they discover the patient’s . . . relatives are less interested in seeing him cured than in having him remain as he is. (p. 398)

Rejecting Freud’s supposition, this academy contends that family dysfunction must be resolved by empowering parents to regain their lost child. Regardless of the family’s

education and professional achievements, parents had been reduced to impotent observers and objects whose value to the offspring is to be bankers, rescuers, and enablers. By excluding the family from treatment, Freud tacitly abetted the continuation of the toxic system. Mothers become angry limit-setters. Fathers sabotage by criticizing wives when children can hear and retaliate by becoming workaholics who absent themselves from dealing with family strains. Without therapeutic intervention, this conflict distracts the family from recognizing the inexorable deterioration of the daughter's or son's life when parents blame each other's failings rather than demanding the adolescent take responsibility for behavior. Treatment quells conflicts by helping parents become unified and rational enforcers of limits. Treatment attacks not only malignant beliefs but also helps the mother and father regain control. To achieve these goals, every six weeks, parents attend groups at the school. There are seven groups. The goals for these groups are to promote communication about areas of family discord and to propose more effective treatment strategies.

- One: There is an introductory session for parents to discuss why their son or daughter needs residential treatment, which encourages parents to bond. This group often exceeds 6 hours. All members of the clinical staff attend.
- Two: There is an intergenerational group. Family members participate in different groups to permit them to discuss issues without other relatives being present. Each group has mothers, fathers, and students, so the individual can ask questions and seek advice from the group how to resolve interpersonal failures.
- Three: There is a group for divorced parents and stepparents in which the goal is to decrease bitter dissent by helping the dyad agree to compromise by presenting a unified approach rather than forcing the son or daughter to select one parent over the other.
- Four: There is a senior parents group, which helps participants learn how to become more effective parents by demanding improvement and setting limits. During the spring senior retreat, which convenes in a motel for a weekend, most families felt intimidated and, therefore, acquiesced when their offspring agreed to remain abstinent for a year or two rather than demanding a longer commitment to sobriety and were reluctant to demand a curfew.
- Five: There is a sibling group attended by the student's brothers and sisters. Frequently, resentment is confronted because the acting-out student has become the focal point and has received more than his or her fair share of the family's emotional and financial resources. Some brothers and sisters, moreover, have suffered because they have become targets of peers' and teachers' reactions, which has produced intense resentment.
- Six: There is a group for adopted parents to discuss specific problems relating to adoption. Many adopted adolescents resent (and in extreme cases hate) the adoptive parents who chose them more than they do the biological family who abandoned and rejected them. Families have been battered and bruised by these unappreciative and sometimes mean adoptees. Not infrequently, adoptive parents experience an irrational guilt, which needs to be resolved before they can regain control that they lost to these entitled and angry adolescents. The adolescents are confronted by peers for their failure to appreciate the adoptive family for improving the quality of life.
- Seven: There is a monthly mother's and father's dinner held at different families' abodes. This is a social and therapeutic event that provides the opportunity to discuss problems in dyads and/or larger groups. Some parents travel significant distances to attend these dinners because they appreciate the value of engagement, advice, and support. Extending the family group, there is an Internet forum available for alumni and parents. Similar to the Alcoholics Anonymous fellowship, the forum provides 24-hour coverage. The average number of monthly visits to the Web site is over 150,000. Interestingly, some alumni and parents remain active for more than

a decade. By deliberate design, the staff has been excluded so parents can converse candidly and discuss criticisms they may not want clinicians to know.

FIFTH: CONFRONTING TOXIC ATTITUDES AND BEHAVIOR

Prior to attending the John Dewey Academy, most youths (a) had a virulent attitude, (b) reduced others to objects to satisfy voracious narcissistic needs, (c) felt entitled, (d) suffered from self-aggrandizement, and (e) possessed flawed reality testing. They were depressed, sometimes severely so, knowing they had compromised (and in extreme cases destroyed) their options. They rightfully felt demoralized, which needs to be ameliorated before change can occur. Bratter (2008) believes that when viewed from this perspective, compassionate confrontation (CC) becomes the potent catalyst to induce constructive and creative change. Raubolt and Bratter (1976) stressed the nurturing, supportive, and caring elements present when the helping person cares enough to demand the cessation of masochistic and sadistic acts and the adoption of productive and responsible behaviors. CC has two phases: (a) unlearning dysfunctional behaviors and (b) learning more actualizing responses. Rachman, an analyst, reported that peer confrontation "is an important psychodynamic . . . A peer can confront a peer without evoking the negative parental transference . . . When the group analyst is the sole confronter it . . . attenuate[s] issues of power, control and status" (Rachman, 1995, pp. 127–128).

When describing the Delancey Street Foundation, an ex-addict administered program, Hampden-Turner (1976) identified four theoretical constructs of confrontational psychotherapy:

1. The use of negative evaluation . . . [to eradicate] . . . pretentious exaggerations . . .
2. Negative . . . denunciations can [occur in] a community that cares for its members and assume responsibility for them . . .
3. Persons cannot combine and synthesize moral axioms until they . . . learn to exercise and to accept the polarities they have expressed . . .
4. Delancey's contribution to social progress is that it [embraces] radical synthesis and [rejects] radical polarity.

Bratter (1977) identified seven CC principles which are cognitive and existential. Confrontation:

1. Attacks malignant and dysfunctional aspects of behavior.
2. Penetrates the . . . justification of behavior.
3. Forces individuals to accept . . . responsibility for behavior.
4. Helps persons evaluate their behavior.
5. Assists individuals to be aware and to anticipate the consequences and payoffs of behavior.
6. Challenges persons to mobilize their resources.
7. Defines a directionality so that persons can continue their growth and development (pp. 307).

Bratter et al. (2006, pp. 12–14) stated that CC penetrates barriers of denial and distortion that insulate these adolescents from reality and *forces* them to become more responsible, realistic, rational, responsive, and respectful. Brook (1996) provided the rationale for demanding accountability when he wrote that with supportive confrontation group members "learn to evaluate difficult situations more realistically . . . [and] to confront

denial and accept responsibility for . . . actions” (p. 258). Bratter (1989, pp. 163–189), Bratter (2002, pp. 293–308), Bratter (2008), and Bratter and Sinsheimer (2007) called CC the most potent psychotherapeutic technique to shatter avoidance-denial dynamics and interrupt the frustration-fright-fight-flight pattern. CC helps students gain hope when challenged by peers and the therapist to improve. Maslow (1967), the originator of humanistic psychology, described his reaction to a confrontational group he attended at Daytop Village, an ex-addicted administered program that justifies using caring confrontation: “People are . . . tough . . . [Confrontation shatters] defenses, rationalizations, the veils, the evasions . . . *This brutal honesty, rather than being an insult, implies a kind of respect. You can take it . . . And this can be the basis for respect and friendship*” (pp. 28–29, italics in the original). A few clinicians wonder if outcomes (ends) justify the means. When compared to other treatment modalities such as prescribing poisonous psychotropic medication and using shock therapy, CC is the least painful and damaging and most effective treatment technique. Collabолletta (2002) reported that despite an unequalled record of success, “Controversy . . . swirls around The John Dewey Academy after a quarter of a century. Much . . . criticism is generated by ignorance about the effectiveness of . . . caring confrontation . . . What many critics fail to recognize is traditional psychotherapeutic techniques have failed . . . with [alienated, angry, and gifted students] . . . Anything less becomes a band aid approach to healing wounds that require surgery” (p. 22).

SIXTH: ACCEPTING RESPONSIBILITY FOR BEHAVIOR

When dysfunctional behavior is judiciously confronted, the confronted individual understands the consequences of choices. (Personal choice is incompatible with the antitherapeutic view that mental illness is a biological substrate.) Patterson (1966) proposed, “Although there are biological, psychological, and sociological factors influencing man’s responses, there is . . . an element [of] . . . choice. He cannot . . . control the conditions with which he is [challenged], but . . . is . . . responsible—for his responses, his choices, and his actions” (p. 466). This primary assumption Singer (1965) suggested, “Underlies all forms of psychotherapy: The proposition . . . [that adolescents are] capable of change and capable of bringing this change[s] themselves” (p. 16). The therapist can acknowledge the pain and shame but needs to resist being seduced into exonerating or excusing the youth from accepting accountability for the genesis of personal problems. Horney (1945) defined the goal of psychotherapy as helping the person accept, “Responsibility for himself . . . feeling . . . capable of making decisions and of taking the consequences . . . [This implies appreciating an obligation] to children, parents, friends, employees, colleagues, community or country” (p. 245.)

The prevailing ethic at the John Dewey Academy is to respect others and be respected because it creates an unrelenting environment that demands human decency and personal integrity. Bratter, Bratter, and Bratter (1995) asserted that the primary goal of psychotherapy is to help the learner (re)gain self-respect. These authors wrote, “The attainment of self-respect involves a passion for the good and just life rather than for the abuse of sex, drugs, and material possessions” (pp. 67–68). Bratter (1993) identified three major components of self-respect:

First: The individual needs to learn how to be assertive . . . rather than acquiesce to the demands (and needs) of others . . . Self-respect requires maintaining the equilibrium between reality

(cognition) with the actualizing of emotional needs . . . The . . . successful and mature person knows intellect is more crucial to the decision-making process than . . . passion . . .

Second: Being sensitive to the needs of others and not ignoring their rights is an integral component of self-respect. The student needs to recognize others retain the right to fulfill their needs which may require modification of personal behavior . . .

Third: The respect for the property of others. Explicit is that the individual will not damage or abuse the property of another when borrowed items are used. (p. 49)

Self-respect means "to thine own self be true," not to be self-absorbed or self-indulgent but to maintain personal integrity. Self-respect means doing the right thing for good reasons. Carter (1996) noted that there are three components to achieving integrity, synonymous with self-respect, "(1) Discerning what is right and . . . wrong; (2) *acting* on what you [know], even at personal cost; and (3) . . . acting on your understanding of right from wrong. The first criterion captures the idea of integrity . . . The second [demands] keeping commitments. The third reminds us that a person of integrity is unashamed of doing right" (p. 7). An integral part of self-respect is maintaining the dynamic balance between the obligation to discharge responsibilities and the ability to fulfill personal needs without depriving others of their rights. Self-respect rejects the notions of freedom and hedonism by stressing the individual's roles as family member, friend, student/worker, and citizen.

SEVENTH: EMPOWERING STUDENTS

New students at the John Dewey Academy, especially those who have attended other residential programs, are bewildered by the expectations of self-control. Empowerment enable the person to make a difference regarding the quality of life in the community by becoming an active role model. Breggin (1996) urged the psychotherapist to empower persons who seek help when he wrote, "In philosophical terms, they . . . are capable of self-determination" (pp. 2–3).

When discussing the residential self-help therapeutic community from which the John Dewey Academy originates, DeLeon (1986) provided the rationale for a community approach when he wrote, "Negative patterns, attitudes and roles were not acquired in isolation, nor can they be altered in isolation . . . This assumption is the basis for the community itself . . . A socially responsible role is acquired" (p. 9). Peer support and confrontation stimulate change. Almond (1974) wrote, "Healing charisma . . . [encourages] individuals [to] believe they can . . . become what they would like to become and . . . believe that another member of the group . . . has the power [to help them change]" (p. 326). Students learn how to trust and depend on each other. This social contract stresses contributing to the common good. Dewey students do building maintenance, preparation of meals, and grounds work. More importantly, residents have input regarding violations of the social contract and determine consequences. The demand to live cooperatively traces its philosophical origins to Locke and Rousseau. There are elements of spirituality inherent in this approach; although not sectarian, this community incorporates humanistic moral values of the major religions.

The concept of empowerment in residential treatment programs was developed by ex-addict run, self-help therapeutic communities in the 1960s described by Casriel (1964)

and Yablonsky (1965). Jobs and tasks needed to be done. There was no money to purchase expertise. The phrase “act as if” urged residents to assume that they knew what to do but most importantly “to do it” because no one knew how to fix electrical and plumbing malfunctions. There were remarkably few reports of fire when electrical work was done by novices. Teams of residents hustled food, furniture, and professional services from local businesses. Dewey students, in contrast, are supervised by a building superintendent. They maintain the buildings and grounds by making minor repairs. Students shovel snow and rake leaves. These tasks serve two purposes: (a) to teach skills needed to maintain a home and (b) to instill the pride of knowing they have improved the Dewey buildings and property. Students order the food and prepare meals, which teaches them how to cook. Students make decisions and perform tasks, which provide pragmatic learning opportunities. It would be more cost effective to employ a dietician-chef who could balance meals, order appropriate quantities of food, and purchase items on sale. Though periodically there is waste and insufficient quantities, few complain about the quality of meals, which is superior to that of most restaurants. Rarely is lunch late because preparers know this would interfere with afternoon classes.

Empowerment includes making management decisions about whom to admit, what faculty to hire, assigning students to do tasks, doing quality control, and assigning consequences for mediocre work. Students become vested quickly into the program, which they consider to be their home. The noxious we/they dichotomy that characterizes other residential programs is notably lacking at the John Dewey Academy because there is a unity of purpose. Students learn how to disagree and criticize “superiors” in ways that do not place them in no-win situations where disrespect and anger can create major problems. In addition, this system of checks and balances keeps everyone relatively sane. The president deliberately provokes students who are placed in uncomfortable positions where they not only must assert themselves but also confront (and criticize) him. Bratter (1989) has discussed the abuse of power in residential programs when the charismatic leader amasses too much power by refusing to be accountable to consumers, faculty, and parents. This peer-centered treatment approach is utilized by Alcoholics Anonymous and in residential therapeutic communities run by ex-addicts it keeps everyone relatively sane. All members of the community (including staff) are confronted when they do not do assigned tasks. The confrontation may be an innocent question (“Have you done your job?”) or more critical (“Since you refused to work today, I was forced to do your task!”).

Treatment no longer remains the exclusive domain of trained mental health personnel, which suggests additional roles for the psychologist, psychiatrist, and social worker such as becoming a catalyst and consultant. Psychotherapy becomes a collaborative venture that can be labeled as a triad therapy when the therapist serves as a consultant/supervisor to the peer who helps. Reissman (1965) described the “helper principle” in which the helper may benefit more than the helpee.

EIGHTH: HAVING ESCALATING POSITIVE EXPECTATIONS FOR IMPROVEMENT

Perhaps because it appears so obvious, the role of negative and positive expectations that determine treatment outcomes has not been subjected to rigorous study after Merton’s

(1958) seminal volume. Bratter (1977) and Bratter and Sinsheimer (2007) have written about the potency of expectations.

The clinical challenges complicating working with this most difficult-to-treat population is that attitude determines productivity. If an adolescent is prepared to work diligently, the probability of success is maximized. If the truth be known, having worked with these teens for almost half a century, I know prediction of success is imprecise. More than a decade ago, at graduation when parents asked me what they could do to help their son, I facetiously responded, "Make a \$50,000 contribution to your favorite charity and pray!" If asked what the best case would be, I would have estimated a "B-" average and college graduation. I was wrong. The male was elected to Phi Beta Kappa. Since then I have maintained impossibly high expectations. I fear that erring by conceding mediocrity can and will do much damage. No one wants either to be a loser, a retard, or a reject or to work with this kind of individual. When the youth disappoints me, rather than punishing by condemning, I adopt a stoic stance—that is, "Sorry, you did not achieve the heights to which I know you are capable. Hopefully next time the results will be better." We examine what sabotaged success and devise a new, more ambitious strategy. This approach minimizes staff and student burnout because often the results are dramatic and heroic. The learner responds positively to high expectations. Too many classically trained theoreticians underestimate the impact of expectations. This crusade banishes cynicism and increases the probability for growth and improvement.

Based on standardized testing, Paul was deemed to be in the 99.9 percentile regarding intelligence. His high school performance, at best, was mediocre. Paul received several D's. Ignoring Paul's elaborate rationalizations, pleas, and protests, much to the consternation of the faculty, I ordered Paul to enroll in honors courses. Paul proudly reported he had received all A's. Undaunted, I quipped, "Had you really worked you probably could have achieved A+s." Initially, it was as if a cannonball had pierced the major sail on a boat in a hurricane. Crushed, Paul stumbled out of my office, no doubt furious and hating me for not rejoicing with him. An hour later, Paul returned to complain about my abusive cruelty. Angrily, he asserted that teachers do not give A+s. I countered, "You are right, but for the wrong reason. Until a student earns an A+, there will be none!" While deliberately frustrating him, I communicated a much more therapeutic message—that is, "You can do more!" Inevitably, those who are sadistic simply do not understand the special clinical challenges these adolescent have. Indeed, Paul responded. He earned more than his fair share of A+s at Columbia University, was the class salutatorian, and was elected to Phi Beta Kappa. He graduated from Harvard Law School. Would these achievements have happened had I praised Paul and not demanded more? Probably. But escalating high expectations certainly did not decrease the probability of an awesomely laudable college career.

NINTH: ASSUMING AN AGGRESSIVE ADVOCATE ROLE

Bratter (2002, pp. 301–302; 2007, pp. 85–101) urged the therapist to become an aggressive advocate who seeks preferential consideration for the student. If the student demonstrates change and leadership, the therapist agrees to serve as an advocate. Students know the therapist risks his reputation if they fail. At Dewey the treatment agent restores hope by agreeing to advocate for the student during the college admissions

process. The restoration of hope is so powerful that it vanquishes suicidal thinking. Only one student has made a suicidal gesture during the first month of her stay. She completed a doctorate in clinical psychology. Stotland (1969) has identified six components of hope:

1. The greater the expectation of attaining a goal, the more likely the individual will act to attain it.
2. The more important a goal is, the more likely is the individual to attend selectively to aspects of the environment relevant to attaining it.
3. Increased importance of the goal leads to more overt action to attain it.
4. Increased importance of the goal leads to more thought about how to attain it.
5. Increased expectation of goal attainment leads to more thought about how to attain the goal.
6. Increased expectation of goal attainment leads to more selective attention to aspects of the environment relevant to attaining the goal (p. 17).

DOCUMENTING THE JOHN DEWEY ACADEMY'S TREATMENT SUCCESSES

The John Dewey Academy wants to be judged by the reputations of the colleges that admit its graduates and the performances of the academy alumni at those colleges. Since 1987, all graduates have attended college. Seventy-five percent of graduates attend the most selective 50 colleges as determined by *U.S. News and World Report*. The class of 2008 attends Amherst College, Brandeis, Columbia University (2), Goucher, Oberlin, Sarah Lawrence (2), and the University of Chicago. All made the dean's list, and half will be resident assistants. The 2009 class attends Columbia University (2), Grinnell, Mount Holyoke, Skidmore College, the University of Chicago (2), and Vassar College.

There are 172 John Dewey Academy graduates. Amherst, Barnard, Bates, Binghamton, Brown (4), Bryn Mawr, Carleton (2), Colby College, Columbia (College & University) (11), Connecticut College; Cornell, George Washington, Georgetown, Grinnell, Haverford, Hobart, Holy Cross, Mount Holyoke (4), Muhlenberg, New York University (College of Arts and Sciences & Tisch School for the Performing Arts) (5), Oberlin College (2), Ohio Wesleyan University, Rensselaer Polytechnic Institute, Rochester University, Spellman, Skidmore College (9), Syracuse University (Visual and Performing Arts & Newhouse School of Communications), Trinity College, Tufts University, Union College, the University of Chicago (10), the University of Hartford, the University of Massachusetts, Vassar, Wellesley, and Williams (4). (Sarah Lawrence College has no dean's list. Eleven alumni have achieved academic excellence at Sarah Lawrence College.) More than a third attend graduate schools. Almost 10% of Dewey graduates are lawyers. Two members of the academy class of 2002 graduated from Harvard and NYU Law Schools. Two members of the class of 2003 attend Albany and Pace Law Schools. A member of the class of 2005 will attend the Vanderbilt Law School. A 1989 graduate has degrees from the University of Michigan Colleges of Business and Law. Graduates from the classes of 1997 and 1998 attended Boston College School of Law, Chapman University School of Law, and Cardozo School of Law. No other special purpose school that has many more graduates than does the John Dewey Academy can match the number of attorneys.

Less than 10% recidivate. Less than 10% continue psychotherapy and/or seek pharmacological treatment, which is lower than those who graduate from the most elite prep schools. More than a third of this group, however, return to college and graduate, which reduces “failures” to 6%. Two percent have been incarcerated.

These results make The John Dewey Academy indistinguishable from the most elite prep schools in the country, which admit the most gifted 1% or 2% based on academic performance and standardized test scores.

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