

The Myth of ADHD and the Scandal of Ritalin: Helping John Dewey Students Succeed in Medicine-Free College Preparatory and Therapeutic High School

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INTRODUCTION

The John Dewey Academy is a drug and psychotropic medicine -free high school for talented, troubled, troublesome, and tortured teens. More than seventy percent who arrive addicted to psychotropic medicine are detoxified. Although we developed our theories independently, Breggin's rejection of medicine has radicalized The John Dewey Academy's decision to prohibit all psychotropic medicines.

Breggin's Anti-Medicine Mission

Breggin was among the first to attack and reject the trend to medicate when he pronounced taking pills under medical supervision communicates the anti-therapeutic message that "something is wrong with your brain, and you need a potent medication to function as 'normal.'" Breggin (1991) writes, "biopsychiatrists...reject psychological approaches and instead make extraordinary claims for their efficacy" (p. 150). Breggin (1991) lambasts neuropsychiatric/psychological researchers and the profession when he writes the psychiatrist's "training and commitment is more likely devoted to 'medical diagnosis' and 'physical treatment.'" The therapist may view the person-in-distress "with...all the empathy and understanding of a pathologist staring through a microscope at germs, and then offer...a drug" (p. 11). Breggin condemns the damage done to children and adolescents whose only crime may be excessive enthusiasm, energy, and exuberance. Breggin excoriates researchers who dehumanize children; they forget it is "age appropriate" for adolescents to be distracted and, at times, disruptive. When viewed from this perspective, prescribing Ritalin can be "cruel and unusual punishment" for those who are irritating.

There is no reputable study in a reputable journal that substantiates the cause of psychological aberrations to be chemical imbalances in the brain. Breggin (2001 & 1998) refutes the psychopharmacology cause of ADHD in a book that should be required reading for those who diagnose children and adolescents. Breggin's research is comprehensive, citing more than six hundred publications which substantiate his anti-medication and anti-Ritalin position. Understandably, Breggin received a massive, hostile reaction motivated by economic concerns from the proponents of the "better living through chemistry" club who want to silence him, especially after Breggin & Cohen (1999).

Biological psychiatry assumes mental illness is caused by a chemical imbalance in the brain. Pharmacological solutions create the comforting illusion that deviance can be controlled easily and cheaply by pills. Breggin excoriates pharmacologic researchers and the FDA for uncritically accepting self-serving and flawed studies financed by pharmaceutical corporations for economic gain. Breggin (1991) debunked assertions and justifications for medication with observations that have gained increasing validity in the past fifteen years:

In...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...biopsychiatric research is based too often on distortions, incomplete information, and sometimes outright fraud-at the expense of reason and science.

Breggin notes, a quid pro quo exists: If researchers want to receive funding, research needs to justify dispensing medication. Psychiatric journals, subsidized by advertising from Big Pharma, know that survival depends on this money.

Breggin (1999a) continues his noble crusade by exposing the scandal of treating ADD/ADHD with methylphenidate. Breggin (1999b) documents "hundreds of studies have tried to show Ritalin is effective...few have aimed at identifying adverse reactions. Investigator bias in favor of drugs...encourage the...tendency to look for good effects rather than bad ones" (p. 19). The 1990s will be remembered when "better living through chemistry" became the rallying call for most psychiatrists. Ritalin has played a prominent part in this campaign. Breggin (1998) reports that today's generation of children will assume that they: (1) "Have something wrong in their brains...(2) Have been given pills instead of love...and (3) [Have been given] medication...rather than]...psychological and spiritual support. [These individuals will...blame] themselves for wanting more love and attention than they have been given" (p. 95).

Breggin (1991) laments that with the availability of amphetamines, there is "a new wave of stimulant addiction and abuse among American children who obtain the drug illegally. Shockingly, many ADHD/Ritalin advocates...deny the addictiveness of stimulants and show...little concern about making these drugs available to so many children, their families, and their friends" (pp. 66-67). Having documented the existence of cognitive toxicity

produced by prolonged use of Ritalin, Breggin (1998) asserts no researcher "has attempted to confirm whether or not the brains of children can recover from the malfunction inflicted by amphetamines" (p. 49).

Smith & Kronick (1979) warned that

One of the more disturbing problems facing modern society is the role drugs should possess in the control of deviant behavior...To treat social problems as medical ones may at first glance seem [to be]...enlightened; in fact, it may prove to be a step backward...If we are to avoid raising generations of adults dependent upon treatment drugs, we must proceed cautiously and thoughtfully, carefully airing our finds (p. 939)

Twenty years later, Breggin (1998) states the hypothesis of his scholarly book, when he writes

Every time we drug a child, we are choosing our convenience...over the child's real needs. This is another reason never to use drugs. It is unethical [and, more importantly, unlawful] to drug a child for our ...convenience. It is wrong to distort the function of a child's brain with drugs in order to "improve" the child's behavior...

The drugging of children for behavior control should raise profound spiritual, philosophical, and ethical questions...Society ignores these critical questions at great peril...to the well-being of...children (pp. 116-117)

Contemptuously, the FDA ignored these crucial concepts which Breggin discussed almost a decade ago. Why?

Sandberg's (1986) assertion that "no one has...produced convincing evidence for the existence of a discrete hyperkinetic syndrome, let alone support for widespread use of diagnosis. However, there is general agreement that individual components of hyperkinetic behavior—particularly overactivity, inattentiveness, and distractibility—are common" remains valid (p. 68). Recently, Glasser (2003) confirms Sandberg and has joined the Breggin Crusade when he proposes

There is hardly a shred of experimental evidence to buttress such trendy childhood 'disease' entities as minimal brain dysfunction, learning disorder, or attention deficit hyperactivity disorder. No underlying local organic malformation, physiological malfunction, or chemical basis has ever been clearly demonstrated for these syndromes and no well-controlled clinical studies have ever unequivocally supported them either. **This has not stopped the escalating prescription of such stimulants as Ritalin and Dexedrine despite a host of negative side effects, including tics, spasms, growth suppression, and chronically elevated heart rates and high blood pressure** (p. 212).

Breggin no longer can be dismissed as quixotic in his titanic struggle to educate the public; many organizations and research scientists have joined his crusade.

Valenstein (1998) argues "the claims about the relationship of brain chemistry to psychological problems and personality and behavioral traits are...most likely wrong. The claim...drugs correct a biochemical imbalance that is the root cause of most psychological problems...rests on

a...shaky scientific foundation. These ideas are...an unproven hypothesis" (p. 3).

The Myth of ADHD

Walker (1998), a neurologist and psychiatrist, in the introduction, asks two provocative questions, "is hyperactivity a disease? Does Ritalin successfully treat it?" His response is "no and no."

Rather than concluding his book, Walker (1998) begins **"hyperactivity is not a disease. It's a hoax perpetrated by doctors who have no idea what's really wrong with these children"** (p. 6). (Italics in the original)

The diagnosis of aberrant behavior rarely is objective since the assessment relies on the subjective assessment by mental health professionals who often do not interview the student, but rely on self-serving reports from teachers who justify their dull teaching performance by claiming the youth suffers from ADHD, rather than being consumed by boredom. Taylor (1986) suggests that there is consensus that "hyperactivity is disorganized and chaotic. Its cardinal feature is the combination of restlessness and inattention to a degree inappropriate to the child's age" (p. 6). The problem is not with identifying the symptoms, but rather determining the cause(s) which can be immaturity and giftedness, not a metabolic imbalance.

Therapists retain vested interests to expand patient caseloads inasmuch as they receive reimbursement from insurance companies for treatment regarding this mythical disorder. Bratter (2002) contends that psychiatric diagnoses are not helpful for gifted, acting-out adolescents who display dangerous, destructive, and dysfunctional behavior because these labels inadvertently provide excuses for their behavior.

Complicating rendering an accurate diagnosis is the existence of nineteen "I's" which describes not only "immature behavior" but also brilliance: Impulsive, impetuous, inquisitive, inattentive, inconsiderate, indolent, inept, ineffective, inferior, insolent, inappropriate, intemperate, insulting, irrational, ignorant, irresponsible, irritating, impertinent, intimidating, and insidious. All these symptoms describe superior intelligence, so there is legitimate confusion. Being gifted is an asset, but receiving the ADHD label is, at best, a neutral; but, more than likely, used as a pejorative.

Sadly, medication has become the primary treatment modality. Wender (1971) proposes a biochemical treatment for minimal brain dysfunction in children. During the 1970s, learning-based, cognitive, and existential therapeutic approaches were in embryonic stages, so these approaches were not effective helping children and adolescents control their impulsivity. Wender (1971) observes "some MBD children are...not hyperactive but...gave the impression...because of their constant shifting of activities and lack of goal direction...[They] are no more active than

other children on the playground but cannot curtail their activity in the classroom" (p. 13). Wender suggests hyperactivity is caused by immature and negative attitudes, though other factors such as a chaotic home environment, and the dislike of learning need to be identified. Wender (1971) posits "negativism and stubbornness ...may be looked upon as a reaction formation to an inadequate sense of self-control" (p. 145). Contrary to claims by pharmaceutical corporations which have significant financial vested interests, there is no quick medical cure for the "I" syndrome. If there were a medical solution, after ingestion of a "magic" pill, an observable behavior and attitude improvement would occur immediately. This reality infuriates the potent pharmaceutical industry which makes billions of dollars duping the public ADHD can be cured medically. No pill can create self-respect and honor or cure noxious narcissism, dishonesty, and anti-social attitudes. When viewed from this perspective, medication is ineffective because it does not cure a psychological problem. Until students are convinced that education is relevant and meaningful, they will remain disruptive and will neither concentrate or study.

Obscuring treatment, many adolescents manipulate the therapist to label them as having an "emotional disturbance" which justifies medication that is abused and/or sold. Inexplicably, medical ethics are ignored. Is it medically feasible to prescribe medication for an adolescent who has a psychoactive substance problem? During the twenty-first century, most Departments of Psychiatry emphasize biochemical cures, not teaching interns how to become sophisticated clinicians to ask realistic questions before rendering an assessment. Few are trained to recognize deceit because most treatment agents assume that what they are told is truthful and realistic.

Clinicians, furthermore, no longer take the time nor are trained how to ask four realistic questions: (1) "Does distraction occur because there is insufficient intellectual stimulation?" (2) "Are there realistic explanations for behavior and attitude patterns?" (3) "Do multiple tasks challenge or frustrate?" and (4) "Can the student concentrate for more than a half hour without being distracted in any activity?" Either the youth has ADHD or not! Clinicians rarely ask questions about the student's competencies and interests. If psychotherapists invested the time and asked the right questions, they would recognize that there are realistic explanations explaining student discontent in the classroom. Forced to teach from a sterile and obsolete curriculum, teachers, who are boring, bored, and "burned out," escape blame. Overwhelmed by the child's psychological problems, parents are excused for not helping children learn self-control. Students complain that they neither respect nor trust teachers, that the curriculum is obsolete which does not help them gain a proactive concept of self or a positive identity.

When using the ADHD label, neurological psychia-

trists attribute concentration problems to a disorder which can be treated medically. In so doing, these mental health professionals relieve the student from taking control. When discussing a multi-disciplinary assessment for ADHD, Goldstein & Goldstein (1990) question whether medication is needed since they believe ADHD must be "understood from a developmental perspective. Problems with attention span, over-arousal, hyperactivity, impulsivity and difficulty with gratification have a varied impact on children of different ages...any two children randomly compared within the [ADHD] group may be experiencing very different problems" (p. 367).

Once a child receives the Attention-Deficit/Hyperactivity label, however, no one is held accountable. Rather than blaming the sterility of the curriculum, the incompetence of teachers, and/or a biochemical imbalance in students, before the trend to medicate became epidemic, Glasser (1972) explains "a child with a failure identity...who lacks a concept of himself as a loved and worthwhile individual will not work for any long-term goals" (pp. 165, 162). While the trend is to medicate disruptive students, Glasser (2000) rejects the contention that "clients are victims of mental illness caused by a neurochemical imbalance **over which they have no control**...The brain is not defective...[Medication] such as Prozac, may make clients feel better but cannot teach them how to connect or reconnect with people" (p. 24). [italics in the original]

The Anti-Ritalin Literature: A Brief and Biased Review

After more than a half century of abuse, Rollins et al. (2006) document "significant functional impairments methylphenidate (MPH) for pre school aged children which **has not been** approved by the U.S. Food and Drug Administration for use in children younger than age 6."

This team of sixteen provides more shocking data when they write about children but which is relevant to adolescents:

Previous MPH preschool trials provide mixed results, with two studies failing to detect differences between placebo and active (Barkley, 1988; Cohen, 1981) and one reporting higher rates of adverse events compared with older children (Handen et al., 1999). Methodological differences in these studies preclude data pooling and overall assessment of MPH safety and efficacy (Greenhill, 1998). One fundamental problem is the validity of the preschool ADHD diagnosis... Furthermore, psychometric data on the validity of diagnostic instruments for preschoolers have not been published and **there are no standard research diagnostic methods** (p. 1275).

Rollins and his colleagues describe the ineptitude of the FDA which has adopted a benign neglect policy when they decry "the lack of standardized diagnostic approaches or age-related drug safety and efficacy information has not deterred physicians from prescribing MPH for preschoolers (IMS American, 1995; Kaufman et al., 1996; Rappley et al.

(2007)" (p. 1276). Why had the FDA not prohibited the use of psycho stimulants until these safety studies were concluded or is the FDA suppressing clinical data which warns that there are adverse long-term effects? In an often quoted, but ignored study, Rie, Rie, Stewart, & Ambuel (1976) contend that when being treated with Ritalin "children were relatively but unmistakably affectless, humorless, and apathetic" (p. 258). Even more daunting is the evidence that psycho stimulants interfere with learning. Breggin asserts "the notion of a biochemical imbalance in the brains of children diag-nosed with ADHD is...speculation" (p. 172). Several countries and organizations have discontinued the use of Ritalin due to increa-sing consternation regarding adverse effects of Ritalin such as violence, psychosis, dysphoria, and excitability. Sweden prohibited Ritalin use in 1968 due to the consternation about adverse effects such as violence, psychosis, dysphoria, and excitability. In 1971, the World Health Organization concluded Ritalin and other stimulants are the "most addictive drugs in medical usage." The same year, the U.S. Department of Justice affirmed the findings of WHO. During the 1970's, Japan had an epidemic of amphetamine addiction.

Barkley (1988) tries to justify the use of Ritalin. In an "unabashed...attempt to construct a wholesale theory of attention-deficit/hyperactivity disorder," (p. vii) Barkley (1997) claims that "ADHD **impairs the human will and one's volition**" (p. 315). [italics in the original]

I...appreciate the conundrum such conclusions about ADHD pose for...accountability and responsibility ...The argument could be used...to seek a finding of "diminished capacity..."

I submit that **the required response of others to the poor self-control shown by those with ADHD...is not to...excuse them from personal accountability...** (pp. 316, 317). [italics in the original]

Barkley's theory offers few treatment and educational options for clinicians or educators but, worse, reinforces "diminished capacity." Since Barkley assumes that the brain is defective, the ADHD child is excused for dysfunctional and dishonest behavior.

Goode (2000) observes "little is known about the effects of psychiatric drugs on the developing brain or the long-term impact on social relations, academic achievement or personality in young children who take such drugs...Most of the medications have not been specifically tested or had their dosages calibrated for young children" (Section 4, p. 5). ADHD labelling reinforces attempts by psychiatrists to attribute dysfunction to an under developed prefrontal cortex which can be treated medically.

The FDA: Abdicating its Mission to Protect Consumers by Pandering to Pharmaceutical Corporations

The Food and Drug Administration has an inexplicable sorrowful history ignoring studies which document the

adverse effects of Ritalin. The US House of Representative (1970) issued a document revealing its concerns that:

- Safety and long-term outcomes for the treatment of children with amphetamines has not been adequately researched.
- Normal children are being drugged.
- Treatment suppresses symptoms, but does not address the etiology of ADHD.
- Bradley (1937) verbalized concern that long-term use of amphetamines could produce addiction.
- Parents are coerced to medicate their children by direct pressure or through transmission of erroneous data that minimizes risk.

A quarter of a century later, after reviewing 9,000 articles and 300 reviews regarding Ritalin at a symposium conducted by the US Department of Education, Swanson (1993), whose Attention Deficit Disorder Center is funded by the US Department of Education, concludes

- Long term beneficial effects have not been verified by research.
- Short-term effects of stimulants should not be considered a permanent solution to chronic ADD symptoms.
- Stimulant medication may improve learning in some cases but impair learning in others.
- In practice, prescribed doses of stimulants may be too high for optimal effects on learning, and the length of action of most stimulants is viewed as too short to affect academic achievement (p. 44).

Why do these Congressional concerns raised by the US House of Representatives almost four decades ago remain unanswered? While beyond the purview of this essay, the only logical conclusion is that the drug industry obstructed vital research. Whitaker (2002) documents that drug companies have purchased positive brain research done by respected researchers to reinforce the efficacy of medication. Outrageously, the FDA continues to ignore Congressional concerns and Swanson's clinical findings. Since funding his center, it is assumed that the US government respects and trusts Swanson. Breggin (2001) documents 100 studies done by respected medical researchers and reported in trusted professional publications that support the ominous, but minimized, conclusion in the 1996 FDA warning that "Ritalin should not be used in children under six years old, since safety and efficacy...have not been established..." This concern was proposed by the International Narcotics Control Board (1999) which protested the escalating abuse of psycho stimulant drugs. "In the United States, performance enhancing drugs are... given to children to boost school performance or to help them conform to the demands of school life" (p. 1). The INCB criticized, furthermore, the "aggressive advertising by certain pharmaceutical firms." The National Institute of Health concludes research is inconclusive about whether stimulant use increases the potential for abuse; it questions if there is a scientific basis

for the diagnosis of ADHD. The NIH (1998) warns that psycho stimulants produce **“little improvement in academic achievement or social skills”**; even more alarmingly, there are **“no data on the treatment of ADHD, Inattentive type”** (p. 21). [Italics added for emphasis] Subsequent to the NIH findings, Breggin (1999a) has documented the adverse drug reactions of “methylphenidate (Ritalin), dextroamphetamine (Dexedrine Adderall) and methamphetamine (Desoxyn, Gradumet)” (p.214). Breggin (1999b), in his two-part survey of psycho stimulants in the treatment of children and adolescents diagnosed with ADHD, warns about adverse reactions to stimulant medication which includes “persistent brain dysfunction and potentially irreversible CNS damage... **Enough is...known about the...negative impact of stimulants to stop prescribing them for ADHD or the control of any symptoms or behaviors in children**” (p. 233). [italics added for emphasis] Brown (2000) writes “stimulant treatment for children with ADD-HD has not been without controversy...However, while medication decreases inappropriate behavior, it does not improve appropriate behavior without additional intervention directed to building requisite academic and social behavior” (p. 199). Brown continues “the side effects of stimulant medication have also been of concern...Stimulant medication has been associated with the development of tics, and these medications should be used cautiously” (p. 200).

In 2003, 10,000,000 children and adolescents in the United States took Ritalin. Mathews & Abboud (2005), reporters for **The Wall Street Journal**, report that “The Food and Drug Administration said it plans to add information about possible [adverse] psychiatric side effects...[for] Concerta and Ritalin...and will investigate other ADHD medicines for similar problems (p. D1). Isn't this policy to inform scandalously overdue? Since there is an increasing number of reports which assert Ritalin is dangerous, it needs to be asked why did the FDA take an additional year to issue a tentative conclusion which Mathews & Hensley (2006) report “in a surprise move..., a FDA advisory committee voted [8-7 with one abstention] to recommend that stimulant drugs prescribed for attention-deficit hyperactivity disorder [need a warning that these medications are known to increase] blood pressure and heart rate, which can potentially result in increased risk of heart attack, stroke, or sudden death” (p. A3). The studies which confirm the causal relationship between psycho stimulants and increased risk for cardiac problems are disregarded.

Zito et al. (2000) document that at least 1.5% of children between the ages of two and four are medicated with stimulants, anti-depressants and anti-psychotic drugs, despite the paucity of controlled scientific trials confirming safety and long-term effects with preschool children.

The treatment of ADHD is lucrative for manufacturers and psychotherapists who treat. The process of approving medication appears to have been corrupted by medical cor-

porations which compensate scientists and invest substantial payments to universities for “overhead” and improving facilities. Why are not these “donations” viewed to be bribes? Kauffman & Julien (2000b) assert “the FDA...relies heavily on the same academic researchers who have taken money from the industry, giving the agency a conflict of interest” (p. A8). These reporters reveal Congress inadvertently contributes to the conspiracy against the consumer. Criticized for slowness to approve new medicines, the FDA acquiesced to this pressure in the 1980's. “By the end of the decade, Congress...[had transformed the FDA from an] adversarial agency into a kinder, gentler bureaucracy [which treated] pharmaceutical companies...as ‘stakeholders’ “ (p. A8). Strangely, public outrage has been muted despite Kauffman & Julien's (2000a) ...warning “drug companies...make it very clear what the results better be if you [the researcher] want any more money from them” (p. A10). Kauffman & Julien (2000a) quote Angell, the editor of **The New England Journal of Medicine**, as saying “imagine a judge who has before him a case involving two companies suing each other—and he owns one of the companies. And he says, ‘Not to worry. I'm a judge and I learned how to evaluate things in a dispassionate way.’ He'd be laughed out of court” (p. A1). **The New England Journal of Medicine** which has seen its revenues increased from \$386,000 in 1979 to more than \$20,000,000 panders to the pharmaceutical industry. Before Drazen became the editor of this journal, he received major research grants from nine major pharmaceutical corporations which should have disqualified him from this position. Altman (2000) reports that Drazen defends “the need for doctors to work closely...with the drug industry. ..[Defending] his ties to the drug industry, Dr. Drazen said ‘I have what it takes, and you are just going to have to wait and see whether you believe it. There is no way to judge it up front’” (p. A16). Perhaps not, but such assurance, at best, is premature. It seems likely that the number of scientific studies which refute the efficacy of medication will decrease, especially if any criticize the nine corporations which have compensated the new editor.

Frequently, the FDA has been forced to withdraw many medications after approval because subsequently they were proved to be deleterious and toxic. If Breggin's assertions are correct, it is scandalous Congress has failed to investigate whether a pharmaceutical conspiracy exists when the FDA has minimized the dangers of Ritalin. There can be no justification for the federal policy of pandering to corporations. Connor (2004) protests, “How can we practice in the best interests of child and adolescent patients if negative trial data are withheld from the scientific journals and only positive studies are published?” (p. 127).

Cohen (2000), president of Children and Adults with Attention Deficit/Hyperactivity Disorder, claims that “there is a high level of confidence that stimulant medications are effective [to provide short-term improvement of symptoms and produce minimal short-term side effects.”

But he contradicts himself when asserting **“there is insufficient research to assess the long-term benefits or side effects of medication use”** (p. 5). [italics added for emphasis] If the truth be known, Cohen has no relevant training or experience to justify his comments. Cohen ignores Swanson’s (1993) comprehensive review, which never has been refuted, that “teachers and parents should not expect...improved reading or athletic skills, positive social skills, or learning of new concepts...[and they] should not expect long-term improvement in academic achievement or reduced antisocial behavior (p. 46) with Ritalin. In 1994, CHADD, which is financed by Novartis and the pharmaceutical cartel, and has no scientific staff, petitioned the Drug Enforcement Agency to reduce Ritalin from Substance II to III because it “is not a dangerous and addictive substance, and...is a beneficial and relatively benign medication which assists millions of children daily.” Breggin’s (1998) comment is worth noting, “this... conflicts with three decades of widespread Ritalin abuse and addiction” (p. 239). In 1993, the DEA concluded “methylphenidate is a central nervous system stimulant with a high potential for abuse and diversion for illegal purposes.”

All physicians take the Hippocratic Oath to “do no harm” to patients but ignore this when prescribing toxic medication never proven effective nor safe for children and adolescents. If the spate of studies are accurate, then physicians engage in a criminal conspiracy which hurts, not helps, those whom they treat.

The Rejection of Psycho Stimulant Medication at The John Dewey Academy

The John Dewey Academy rejects the unproven assumption bio-mythology of ADHD that claims persons are biochemically defective. Winsberg & Camp’s (1981) caveat remains valid two decades post hoc “neither popularity, nor the most fervent desire for a ‘better’ cure can alter...there is no scientific data to support the efficacy claims of any of these modish interventions” (p. 144). Criticizing the American tendency to over-medicate, while confirming Winsberg & Camp’s finding, Sandberg (1986) contends the scientific inadequacy of any diagnosis for the hyperkinetic impulse disorder, first described by Laufer, Denhoff, & Solomons (1957) “has not been disproved by rigorous enquiry...[nor] has it met the criterion of predictive validity in spite of a wealth of research. Regardless...it remains a very popular diagnosis that has increased markedly over the last 20 years in the United States” (p. 65). Winsberg & Camp (1981) urge caution: “Until medication is proven to be effective and safe, there should be a moratorium on prescriptions of amphetamines” (p. 144). Taylor (1986) describes adverse reactions caused by amphetamines such as “sleeplessness, headache and abdominal pain...Dysphoria has already been mentioned as a possible hazard...Increases in heart rate and blood pressure can occur...” (pp. 202, 203). Duncan, Miller & Sparks (2000) warn “our culture’s ...faith in these psychi-

atric medications rests not on science, but on brilliant marketing by a profit-driven industry. Outcome research...funded by companies that manufacture medication—has not found these drugs to be any better than therapy, and only marginally better than placebos” (p. 27).

Prescribing medication creates psychological problems. Mender (1994) provides perspective when asserting that the treatment of neuro-psychiatric problems with medication “foster an atmosphere in which the doctor takes control instead of helping the patient control himself...[The] surrender of...autonomy by patients can have profoundly negative consequences” (p. 29). Dispensing medication relieves the adolescent from accepting accountability for causing pain and shame to one’s self, family, and friends. The presenting problem is a negative attitude, not a metabolic disorder or chemical imbalance. No estimations exist how many youth have been damaged by this reductionist thinking.

Psychological and Educational Profile of Dewey Students

When admitted to The John Dewey Academy, a third had been hospitalized or attended drug and alcohol treatment programs for one month, more than three-quarters had been treated by mental health specialists, and approximately half arrived addicted to potent psychotropics from which they need to be detoxified. Bratter, Kaufman, Lubbock, & Sinsheimer (2006) have listed the myriad of **DSM-IV** diagnoses given by inpatient programs and community-based psychotherapists to those who attend The John Dewey Academy.

Dewey youth are driven by intense emotions they can neither understand nor identify. They create crises and chaos to escape feelings of depression and loneliness. Creating constant crises with self-destructive acts, they need a structured, safe, and supportive residential environment to help them control and curtail their behavior.

When entering, the majority of Dewey students have significant educational problems. More than half have three “C’s” or lower and function at least one grade level below their chronological age. Though never visiting the Academy, Santa (2006) describes Dewey students as possessing “a myriad of diagnoses... Many are classified as dyslexic, as learning disabled, or diagnosed with attention deficit disorders...They have been subject to stimulants and anti-depressants, mood stabilizers, school IEP’s, special education classes, tutors, and therapy. Despite these interventions, these students continue not to perform in school” (p. 32).

When adolescents can be helped to help themselves, they experience internal gratification and external reinforcement from others which motivates them to perform “good and decent” acts for the right reasons. One of the most neglected aspects of therapy is the power of positive and negative expectations. Therapists and teachers, who stress choice, negate the anti-therapeutic concepts of

ADHD, predestination, mental illness and/or the pre/un/subconscious etiology. Fromm (1964) wrote the person can choose "to regress or to move forward...The problem of freedom versus determinism is...one of conflict of inclinations and their respective intensities" (pp. 115-135). Fromm believed individuals are capable of rational thought and self-determination. The construct of self-respect becomes an interplay among the moral distinctions of what the person is, who the individual ought to be, and which specific moral acts are performed. Bratter, Bratter, Bratter (1995) asserted the primary treatment goal is to create the conditions to facilitate (re)gaining self-respect, not pursuing pleasure. Glasser (1965, & 1960) opines the concepts of choice and the capacity to change are explicit in most systems of psychotherapy. Helping the adolescent to take control can best be achieved at The John Dewey Academy because no one will excuse mediocrity or failure by commiserating how "unlucky" or unjust life has been. Glasser (1998) explains how past acts influence our present identity. "But revisiting this painful past can contribute little...We are not doomed to repeat our past unless we choose to do so...We can correct...unsatisfying relationships" (pp. 334-335). Agreeing with Glasser, Breggin (1991) proposes "every individual must choose whether or not to overcome any hardship...Human beings retain a measure of free will as long as they remain conscious. Indeed, without the exercise of that flickering will, there is no hope for people; that is the helper's role to encourage every hint of self-determination" (p. 45). The staff and faculty at The John Dewey Academy demand all students become active rather than remaining passive and dependent. Since Dewey students have become active learners, no potent psychotropic mood or mind altering medication is required. The John Dewey Academy has proven that Medicine-free is a realistic goal.

Conclusion: The Validation of a Medicine-Free Approach

The John Dewey Academy provides a positive educational and emotional experience that provides (1) an evocative approach to problem-solving maximizing constructive and creative options; (2) the opportunity to (re)gain self-respect; (3) a resilience to endure inevitable painful fears, failure, and rejection; (4) help to formulate realistic intermediate to long-term educational, personal, and professional goals and the strength to achieve them; (5) an optimistic outlook about one's self and one's capacity to succeed at tasks considered important; (6) a desire to change rather than remain complacent; (7) an ability to take control of one's life by making conscious, responsible choices; (8) the courage to shatter restricting boundaries of innocence and ignorance which characterize immature thinking; and (9) a desire to seek truth.

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 chronological age, so they needed intensive, individualized instruction to remedy educational deficits. If The John

Dewey Academy excluded those who had poor academic performances and inferior standard-ized test scores, this record would be more impressive. The two Dewey admissions criteria are (1) having a positive attitude about being honest and working diligently and (2) agreeing to become a contributing member to the community in this voluntary educational-treatment program. Objectively, The John Dewey Academy is not elite. Seventy-five percent of those who have a mandatory interview are admitted. Elite prep schools, in contrast, demand tangible proof that the applicant not only has superior academic potential but also has excelled educationally. Enrollment is limited to those who are in the top five percent. Like all 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. In its twenty-three year history, all John Dewey (100%) graduates attend competitive and prestigious colleges. Seventy percent attend the most selective one hundred institutions of higher learning. More than a third have made the Dean's List at Barnard, Bates, Carleton, Columbia (College & University), & Connecticut College; Cornell, George Washington, & Georgetown Universities; Haverford, Hobart, Holy Cross, Mount Holyoke, & Muhlenberg Colleges; NYU (College of Arts and Sciences & Tisch School for the Performing Arts), Oberlin College, Ohio Wesleyan University, RPI, Rochester University, Spelman & Skidmore Colleges, Syracuse University (Visual and Performing Arts & Newhouse School of Communications), Trinity College, Tufts University, Union College, the Universities of Chicago, Hartford, & Massachusetts; Vassar, Wellesley, & Williams Colleges.

Two members of the JDA class of 2002 attend Harvard and NYU Law Schools. Two members of the class of 2003 attend Albany and Pace Law Schools. Another 2003 graduate has enrolled in the clinical psychology Ph.D. program at Yeshiva University.

In the 2000s, less than ten percent of Dewey graduates have discontinued higher education and become recidivists. Equally significant, less than ten percent of this school's alumni resume psychotherapy or take psychotropic medication. None has taken any psycho stimulant to assuage academic problems.

Bratter, Bratter, Coiner, & Steiner (2006) contend "critics ...cannot explain how and why adolescents, who were extreme casualties, improve" in a...treatment milieu with escalating expectations for "intellectual excellence and moral integrity [that] can be achieved without compromising one for the other" (p. 14). It needs to be stressed there is no other special purpose school or residential treatment program that rivals the performances of graduates, which confirms that The John Dewey Academy disproves the need for medication.

Gifted and unconvinced adolescents need to be held accountable for behavior, not given excuses, no matter

how logical and legitimate, for mediocre performances. Unless bright students are expected to learn, to become responsible and productive, they will settle for mediocrity.

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