

Rejection of Psychotropic Medicine and DSM–IV Nomenclature Produce Positive Outcomes for Gifted, Alienated, and Dually Diagnosed John Dewey Academy Students Who Were Self-Destructive: Part I

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This is the first installment of a two-part article that describes the rejection of psychotropic medication and DSM–IV nomenclature at The John Dewey Academy (JDA), which has proven to be extremely effective for gifted, dually diagnosed, and unmotivated adolescents. One of the least studied phenomena that impact outcome are positive and negative expectations. These two psychotherapeutic principles maximize. Outcome results, when viewed from this perspective, certainly challenge the validity of the assumption that attributes pathology to a chemical imbalance, and in so doing ignores the roles of personal responsibility and choice (as opposed to compulsion). The second article will explicate the treatment guiding principles and effectiveness of compassionate confrontation. Critics challenge the philosophical and psychotherapeutic orientations that the JDA utilizes because they believe these constructs are simplistic and harsh, but cannot explain how superior success rates have been attained for a quarter of a century with a population of adolescents who rejected traditional therapeutic and teaching techniques.

Keywords: unconvinced and gifted adolescents; rejection of psychotropic medicine; confrontation psychotherapy

The John Dewey Academy is a voluntary, college preparatory and therapeutic high school for gifted, alienated, angry adolescents who engaged in destructive behavior. Consequently, these teens need placement in a safe, secure, and structured treatment milieu to prevent them from harming others and themselves. This residential school provides individual, group, and family therapy for students who are at risk and have negative self-concepts and attitudes described by Bratter (1989, 2003, 2006) and Bratter, Bratter, Coiner, Kaufman, and Steiner (2006).

The John Dewey Academy has a credentialed and experienced faculty. Two-thirds possess doctorates. A third have been elected to Phi Beta Kappa. The faculty is led by a Rhodes Scholar who has taught at Middlebury College, Stanford University, Mount Holyoke, and Smith College. Before coming to The John Dewey Academy, the Spanish teacher was a

special ambassador to the United Nations. Five members of his family have been president of Nicaragua. The math–science teacher was a professor at the University of Alaska. More than half have taught in colleges and graduate schools. When students have scintillating teachers who are passionate, they will work diligently. Students study outside class for a minimum of 3 hours per day, 7 days a week. There are no management problems. Class size averages six. The average age of the faculty is 60. I do not believe inexperienced and young teachers can be effective teaching bright students who were reticent and unconvinced.

Faculty turnover is rare. All faculty have been at The John Dewey Academy for more than 5 years. Retirement is the general reason for teachers leaving. Job satisfaction and morale are high. There is continual communication between the faculty and clinical staff. When students succeed their success is attributed to the team.

There is no other special purpose school or residential treatment center that works with gifted dually diagnosed adolescents, who by objective criteria require residential treatment, can assert that 100% of graduates attend colleges of quality, and more than 75% graduate from college. The dropout rate is approximately one-third. The John Dewey Academy refuses to be apologetic because the program is voluntary. Early dropouts are prevented when the parents have commitment to keep their child in the Academy. They inform their son or daughter that they will go to another residential program should John Dewey not work out. If students were required to *convince* the Academy to admit, this, too, would decrease premature departures. Prospective applicants could be required to write a 10 page essay about why they should be admitted or yell for help. Yelling for help is an activity that shatters the impenetrable images many project. The implementation of these safeguards would maximize the probability of graduation, but would skew the treatment population. These two decisions would contaminate the outcome data because the primary requirement for admission is voluntary agreement to attend. Some students know that if they refuse to attend Dewey, their families will insist that they attend another residential program. Ultimately, however, the student needs to verbalize a desire to attend and comply with reasonable regulations.

PSYCHOLOGICAL PROFILE OF STUDENTS

John Dewey Academy students possess similar psychosocial and educational characteristics. Reduced to its lowest common denominator, the presenting problem is an extremely negative and often antisocial attitude. These students are endowed with superior, intuitive intelligence, though often neither standardized tests nor academic performance confirm their potential. They have abused, rather than used, their intellectual and creative talents. They remain action oriented to ameliorate agonizing feelings of emptiness and depression by existing in the present. Holden Caulfield, whom Salinger (1951) immortalized in his novel *The Catcher in the Rye*, personifies the alienation and nihilistic attitudes of those who attend The John Dewey Academy. Holden's former teacher, Mr. Antolini, accurately describes their plight:

This fall I think you're riding for—it's a special kind of fall, a horrible kind. The man falling isn't permitted to feel or hear himself hit bottom. He just keeps falling and falling. The whole arrangement's designed for men who, at some time or other in their lives, were looking for something their own environment couldn't supply them with. So they gave up looking. They gave it up before they . . . got started. (pp. 243, 244–245)

All Dewey teens suffer from what Driscoll (1989) described as self-condemnation, which he defined as “self-criticism, self-contempt, self-deprecation, self-doubt, self-punishment . . . seeing the worst in oneself; . . . and by accompanying feelings of failure, inadequacy, worthlessness, embarrassment, guilt” (p. 104). Glasser (1972) wrote that

a child with a failure identity . . . who lacks a concept of himself as loved and worthwhile . . . will not work for . . . long-term goals . . . Even if the child gains a successful independent role, if he does not . . . achieve some reasonable goals that will support his role, he will slowly lose his successful identity. (pp. 161–162)

Since the trend to prescribe psychotropic medication during the first decade of the third millennium has attained pandemic proportions, more than three-quarters of students arrive addicted to potent psychotropic medication, from which all are detoxified.

These adolescents made poor choices that imprisoned them in a no win/no exit labyrinth where the primary negative self-fulfilling expectation is that frustration begets frustration, fear begets fear, rejection begets rejection, and failure begets failure from which they could extricate themselves. Their external attitude is one of arrogance, but beneath, there is a desperate hope to be persuaded to change by someone they can trust. These teens are frightened, fearful, and fragile, which they try to conceal with bravado and anger. They enter JDA feeling depressed and demoralized. Contributing to a poor prognosis are toxic attitudes of entitlement that reduce others to objects to satisfy narcissistic needs.

Bratter and colleagues (2006) noted that most John Dewey students are characterologically difficult, exhibiting features of the *DSM-IV* diagnoses of oppositional defiant, bipolar, and borderline personality disorders. Many students chose to be promiscuous in efforts to neutralize loneliness. A fifth considered or made suicidal attempts, a few of which were death defying. A third had been hospitalized for 1 month. Some have stolen cars, computers, and credit cards. Several had eating and sleeping disorders. By objective psychiatric criteria, these students have remained unresponsive to traditional psychotherapy and teaching techniques, and they need a therapeutic milieu to help them curtail dysfunctional behavior.

Academically, many John Dewey students enter at least one grade level below their chronological age. Their grades are inconsistent and, at best, mediocre. The John Dewey Academy does not inflate grades. Few achieve all “A’s.” Most grades are “B’s.” There are “C’s” and “D’s.” Gifted adolescents, rightfully so, feel depressed because they know poor grades received during their high school careers eliminate the possibility of admission to competitive colleges.

POSITIVE EXPECTATIONS DETERMINE OPTIMISTIC TREATMENT OUTCOMES

Positive and negative expectations are present in all treatment alliances. Expectations profoundly impact therapeutic outcomes because they become self-fulfilling prophesies. While this assertion appears obvious, the power of expectations is one of the least studied phenomena in the therapeutic transaction. Bright and alienated adolescents know that at the very least they have compromised and, in some cases, destroyed options. Many therapists concede defeat by counseling bright, self-destructive, and unconvinced youths to reduce educational and vocational goals, which produces an insidious sense of hopelessness and helplessness. When the psychotherapist informs the adolescent, “You are ‘damaged goods’ so you *cannot* change,” it is devastating. Sadly, the adolescent feels

demoralized and has no incentive or, worse, support to improve. This hemorrhage needs to be stopped before a meaningful therapeutic relationship can be established.

Having no or low expectations for growth becomes a negative self-fulfilling prophecy that inadvertently condones stagnation laziness, mediocrity, irresponsibility, deceit, and failure. Ellis (1967) discussed the pernicious impact of the pessimistic prediction for the person in treatment:

Instead of indicating . . . that some . . . behavior is inefficient . . . , we insist that he is psychotic or sick . . . gives in to his illness, and keeps perpetuating ineffectual behavior that he actually has the ability to stop. To the degree he feels denigrated by the label of “mental illness,” he is likely to continue to act in a negative manner that is congruent with this label, self-deprecation . . . Labeling an individual as emotionally ill or schizophrenic often tends to exacerbate this cause. (p. 43)

Fiske and colleagues (1970) declared “positive expectancies seem to be a necessary condition for therapeutic effectiveness” (p. 27). Meltzoff and Kornreich (1970) defined that positive self-fulfilling prophecy to be a “prognostic expectancy . . . that is looked for with belief, faith, confidence, or conviction of being [achieved] . . . Therapeutic expectancy bring about the anticipated goal” (p. 258). Bratter (1977a) discussed the curative impact of positive expectations when he contended that when placed in an environment with escalating expectation that is unrelenting, adolescents can change and in so doing help each other to adopt more responsible and productive behavior (p. 68).

Restoration of hope dramatically modifies the traditional treatment relationship. While perhaps an exaggeration, frequently the psychotherapist needs to become a cheerleader to exhort more effort. Not possessing the intelligence to determine what symbolic rung on a ladder the adolescent can attain, I always overestimate. If the adolescent fails to climb as high as I expect, I do not criticize or punish. Instead, I laud the achievement but retort that, “I am confident that next time you can do better.” The therapist needs to convince the youngster not only to trust but also to recognize that the treatment agent possesses the expertise and power to become an advocate (which will be discussed in the sequel article). Positive expectations, in contrast, can change the treatment transaction from a pathogenetic to a salutogenetic orientation—that is, to take control of his or her life. When I expect or demand growth and improvement, however, this becomes a positive self-fulfilling prophesy that produces the incentive for creative and constructive change. It is impossible to calculate the impact that escalating expectations for improvement have. Frankl (1967), an existential psychiatrist and survivor of the Nazi concentration camps, urged mental health professionals not to treat an individual “as he is” because to do so makes “him worse” but “if we take him as he ought to be,” we maximize the chances of constructive and creative change (p. 27).

While admittedly a simplification, demanding the best from adolescents by refusing to accept less and rejecting psychotropic medication that negates individual responsibility are two potent treatment principles at The John Dewey Academy.

DIAGNOSTIC LABELING IS COUNTERTHERAPEUTIC

Diagnosing the psychosocial characteristics of deceitful and gifted adolescents can never be a benign therapeutic act. Verbalizing this concern, Meeks (1989) cautioned, “we need to remember the risk of over-diagnosing and over labeling . . . From a counter-transference point

of view, there is . . . a temptation to over-diagnose . . . abrasive or hostile adolescents” (p. 3). Bratter et al. (2006) listed the percentage of entering students who had been diagnosed with DSM-IV conditions. Since most had multiple diagnoses, the percentage exceeded 100%.

Pruyser and Menninger (1976) noted the diagnostic process can be influenced by value judgments reflecting the biases of mental health workers who moralize by using terms such as “perversion, psychopathic, inadequate personality, infantile personality, and character disorder . . . Accusatory expressions [such as] castrating female, passive father . . . and schizophrenogenic mother . . . Some word usage is tendentious: compulsive for orderly, depressed for sad” (p. 25). Szasz (1961, 1970, 1974) used incendiary rhetoric, but made the valid point that what masquerades for a diagnosis often reflects the bias of the therapist (and institution). Thus, it stigmatizes and justifies prescription of psychotropic medication. Applying psychiatric nomenclature to “diagnose” for purposes of receiving third-party payments has become a reality, which rejects the notion that adolescents intentionally hurt themselves and others. These deceitful, dysfunctional, and destructive adolescents need no justification to continue poor performance. Unfortunately, a DSM-IV label inadvertently provides such an excuse. Bright teenagers welcome these diagnoses by manipulating the psychotherapist to use such terms as Borderline, Attention Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, Bi-Polar ad nauseam, which excuse dysfunctional behavior. Diagnosing becomes complicated because the dichotomy between *normal* and *at risk* involves degree. Exacerbating any diagnosis, Erikson (1956) characterized adolescence as a period of emotional turmoil and identity crisis, so it becomes difficult to differentiate between *normal* and *abnormal*. Teenagers suffer from what Breggin (1991) has labeled a psychospiritual crisis, usually surrounding issues of basic identity, shame, and, typically, overwhelming feelings of outrage, “by refusing to diagnose or to label people who . . . feel rejected and humiliated, we welcome them back to the human community and promote humane, respectful, and loving attitudes toward them” (pp. 45–46).

Making an accurate DSM-IV diagnosis is also complicated. Given that the effects of psychoactive substances can mimic symptoms of pathology. Amphetamines can cause a temporary psychotic state that is easily confused for a schizophrenic psychosis or manic episode. Cannabis and amphetamines, when combined with other hallucinogens, can produce paranoid symptoms. Clinicians need to discount the acute or chronic impact of drug abuse. After making a tentative diagnosis, it is judicious to delay until after detoxification to ascertain whether symptoms continue.

It makes more sense therapeutically to force the teenager to accept responsibility for behavior rather than using psychiatric nomenclature, which can abet in the abdication for accountability. When assessing the relative appropriateness of adolescent responses, it becomes essential to note capricious and unpredictable behavior, conflict, testing of limits, and rejection of authority can all be considered normal. It is healthy for adolescents to assert themselves by questioning authority. When behavior becomes dangerous in a community-based setting, residential treatment needs to be implemented. Wexler’s (1991) definition of those who need residential placement describes John Dewey adolescents, who

have made suicide attempts, . . . abused drugs and alcohol, . . . fought with family members, constantly run away or have been truant from school, stolen property, engaged in self-destructive sexual promiscuity . . . They are neither hard-core sociopaths nor criminal types who are serious dangers to society. They do not suffer from severe psychological organic dysfunctions. (pp. 7–8)

It can be countertherapeutic to attribute etiology to subconscious, preconscious, or unconscious forces. Implicit in the psychoanalytic approach is free association and fantasy

which have, at best, a tangential relationship to actual events making interpretation a subjective act. Those being analyzed receive tacit approval to insulate themselves from reality; they become passive by free associating (hence innocent) and vulnerable (hence impotent) to control thoughts, feelings, and behavior. Bratter (1985) ridiculed the viability of the psychoanalytic model regarding the addictions:

Psychoanalysis obfuscates the real issues and . . . protracts myths which rarely have been questioned. What is the essential nature of addiction and how can it be most effectively treated needs to be re-evaluated. Psychoanalytic research . . . has not produced anything decisive beyond the “discovery” that addiction is due to a psychopathogenic fixation at the oral stage and/or to the disturbances of early object relations. The psychoanalytic stereotyped views offer the concerned clinician few viable treatment options for helping drug dependent individuals to experience a positive response from the world. All such global analytic views, which remain imprecise and generated after the fact, are predicated upon unconscious needs and obsessions which appear to be reductionistic. The analytic model subscribes to the myth of unchangeability because behavior has been blocked by subconscious forces. In this sense, patients subtly are relieved of any responsibility for their acts and behavior. (p. 564)

DEPRESSION: REALITY-BASED, NOT AN UNPROVEN CHEMICAL REACTION

There are two ways to view a depressed or dysfunctional teen. Sadly, the first and most prevalent model is to reduce the person to a biological aberration and prescribe medication to correct this disorder. At John Dewey, these claims are repudiated. The Academy asserts that personality and affective disorders rarely are cured by medicinal approaches. There is no pill that teaches self-respect, cures noxious narcissism, dishonesty, and anti-social attitudes. No potent psychotropic mood or mind altering medication, therefore, is prescribed at John Dewey. Drug-free is viewed as a viable treatment goal.

The second and least sophisticated concept, but most effective, known as the self-help orientation used by recovering persons, contends that behavior is a conscious choice. At The John Dewey Academy, students are viewed as self-destructive and irresponsible *persons* who struggle with psychospiritual and identity issues, rather than as *patients* who suffer from chemical imbalances or unresolved unconscious, preconscious, and subconscious impulses.

Many clinicians fail to recognize that despair is a realistic reaction to an environment that alienated adolescents feel is too painful, pessimistic, and hostile to endure. Depression signals that there is a problem that needs to be corrected.

Breggin (1991) rejected not only the biological theory of depression but also the use of MAOIs to treat this disease when he asserted that:

The dominant biological theory of depression . . . was derived from speculations on how and why medications sometimes seem to alleviate depression. One of the earlier groups of antidepressants, the monoamine oxidase inhibitors (MAOIs) such as Parnate, Marplan, and Nardil—tends to increase the levels of . . . norepinephrine in the central nervous system . . . It was hypothesized . . . depression might result from . . . too little norepinephrine. Later studies showed that some . . . depressants may cause an increase in the availability of another neurotransmitter, serotonin. So the theory was enlarged: some forms of depression may be due to too little serotonin . . . Eventually the theory was punched full of holes by contradictory evidence. (pp. 141–142)

Beneath the layers of depression, alienation, and apathy lurks anger and an unquenchable sense of entitlement. (Generally, clinically depressed individuals rarely get angry.) The clinical mandate is to help gifted and alienated students redirect anger or rage into productive deeds. Hurt can escalate into jealousy, cruelty, revenge, viciousness, and violence against others, self, and property. The antidote to anger is reason, which can defuse escalation. To ward off painful feelings of anomie, rejection, loneliness, and failure, many teens choose to medicate themselves with alcohol or drugs. This provides temporary relief, which negates the justification for prescribing antidepressant psychotropic medication.

When asked, bright and alienated students can have realistic reasons as to what caused depression. Munoz and Ying (1993) noted when depression can be neutralized, it will increase the youth's desire to change (p. 16). Too frequently these students are believed to be unmotivated, hence unwilling to change. Gifted adolescents are unconvinced; they are not unable. When convinced not only about the wrongness of ways but also that they can succeed at those tasks they consider meaningful, these teens can and will change. Sadly, those who rebel often are endowed with innate superior intellectual and intuitive abilities. While the pain they experience is self-inflicted, some is caused by external factors beyond their control. Sometimes the environment did not satisfy intellectual, personal, emotional, and social needs. Given superior potential, in fact, they never can be normal! These students are too bright.

Concept of self is influenced most by the values of the peer group whose beliefs may conflict with those of the family, mental health workers, and teachers. Youth is a time of intense confusion, conflict, and contradiction concerning what to do, whom they can trust, and what they believe. In view of this turmoil, is it any wonder that depression becomes a ubiquitous experience for this age group? Shantall (1999) suggested

when the individual gains the courage to choose a course of action that seemed dictated by his or her . . . conscience as the morally right or courageous thing to do . . . these choices had a sustaining effect on them. They felt imbued with a . . . real sense of meaning that decreased depression. (p. 110)

Blair (2004, p. 343) contended that when teenagers acquire values, goals, and strengths, they are more likely to derive meaning from depression and in so doing resolve it. After discovering and pursuing the actualization of that meaning within their value system, these adolescents increase self-understanding and discover more gratifying levels of meaning that reduces the existential vacuum and often minimizes depressive symptoms.

REJECTION OF PSYCHOTROPIC PHARMACOLOGY

Unlike other residential programs that view medication to be a life commitment, less than 10% of Dewey utilize psychotherapy or pharmacology. More than three-quarters had been treated by psychiatrists, most of whom prescribed potent psychotropics such as benzodiazepines, stimulants, selective serotonin reuptake inhibitors (SSRIs), monoamine oxidase inhibitors (MAOIs), and tricyclic antidepressants. More than two-thirds had medicated themselves.

Psychopharmacologists and biological psychiatrists claim that intrapsychic problems are best treated with psychotropic medications. The John Dewey Academy rejects this unsubstantiated assumption. Therefore, no psychotropic mood- or mind-altering medication is prescribed at John Dewey. Abstinence and psychotropic medicine-free are viable treatment goals. Medication does not change attitudes, which explains why the recidivism rates for medicated teens remain high. No pill can teach self-respect or cure noxious narcissism,

dishonesty, and antisocial acts. Feelings of depression, pain, inadequacy, shame, and fear, which overwhelm adolescents, are caused by conscious dysfunctional, dishonest, destructive, and dangerous decisions. When asked why they feel depressed or ashamed, students can provide realistic explanations.

THE FDA: SNAFU

During World War II, there was a popular acronym, “SNAFU” which often was used in newspaper headlines and articles. SNAFU’s literal translation is: “Situation Normal All F---ed-Up.” Today, perhaps more than yesteryear, this describes the operations of the Food and Drug Administration.

Aesop wrote a fairy tale about the tailor who defrauded the emperor by claiming to make a beautiful invisible suit which the monarch proudly wore. None of the subjects had the courage to confront the king he was making a fool of himself. It took the candor of a boy who exclaimed what everyone knew that the monarch was naked.

For four decades, the Food and Drug Administration has endured so many scandals that no one protests, nor demands accountability, because implicitly all concede that the FDA is incompetent. The fact that Congress has not investigated is outrageous. Inevitably, Congress will wage an investigation. It falls outside the purview of this article to explore why the FDA fails to engage in decisive action when most world mental health agencies have prohibited the use of psychotropic medication for children and adolescents. When the scandal is exposed, tragically the irreparable damage done to children and adolescents cannot be reversed.

Connor (2004) protested, “How can we practice in the best interests of child and adolescent patients if negative trial data is withheld from the scientific journals and only positive studies are published?” (p. 127).

Three decades ago, the National Institutes of Mental Health stopped funding research regarding psychotropic medication. The powerful pharmaceutical cartel filled the funding vacuum which corrupted the research. Brent (2004) observed that, “This problem is exacerbated when studies are financed and directed by the pharmaceutical industry when there is a great disincentive to publish negative results . . . The FDA should require that these data be made public in a timely manner” (p. 127). A *quid pro quo* exists. If researchers want to receive funding their research needs to justify medication. Consumers are no longer protected by the FDA. Profits are the objective. Subsidized by advertising from Big Pharma, psychiatric journals know salvation depends on these monies. *Lancet*, a respected and trusted British medical journal, castigates the pharmaceutical industry regarding selective serotonin reuptake inhibitor (SSRI) research and the use of SSRI use in childhood depression when asserting the research is confused and manipulated (“Depressing research,” 2004, p. 1335).

Serzone (Bristol Myers Squibb), an anti-depressant, has been discontinued in Europe, Australia, New Zealand, and Canada due to “adverse events including liver failure.” When Serzone was first marketed there were no warnings about potential liver damage. The FDA has 55 documented cases of liver failure, including 20 deaths, and 39 cases of less severe liver damage. In 2002, eight years after Serzone was marketed, the FDA demanded Bristol Myers Squibb warn about “rare reports of liver necrosis and liver failure, and in some cases leading to liver transplantation and/or death.” Most psychiatric practitioners and researchers agree with Olsson et al. (2006a) that “there has been a[n] . . . increase in antipsychotic treatment among children and adolescents in office-based medical practice” (p. 679). This

psychiatric team cautions that for second generation antipsychotic medication . . . there exists a “need to increase and extend the experimental evaluation of these medications in children and adolescents” (p. 684). Olsson et al. (2006b) concluded “*there may be an association between antidepressant drug treatment and suicide attempts and completed suicide in severely depressed children and adolescents in the Medicaid program after hospital discharge (italics added)*” (p. 872). Leon et al. (2006) note “*do not rule out the possibility of suicidal thoughts or non lethal suicide attempts among youths taking antidepressants (italics added)*” (p. 1057).

Significantly, an editorial which purports to redefine Bipolar Disorder contends “increasingly sophisticated neuro-imaging and genetic research have deepened our understanding of the neuro-biology of bipolar disorders as one involving complex disturbances in relationships, linking environment, genes, neural systems, and behavior” (Phillips & Frank, 2006, p. 1135). But two sentences later, this editorial contradicted the original hypothesis. “*Although the understanding of the pathophysiology of bipolar disorders remains limited, preliminary findings from recent neuro-imaging studies have indicated persistent dysfunctions specific to bipolar disorder within neural systems underlying mood and cognition (italics added)*” (p. 1135).

Whittington and colleagues (2004) warned since the dispensation of medicines might increase suicide attempts by children and teenagers, “The possibility that a drug might increase that risk without clear evidence of benefit, should in our view discourage its use . . . A possible increased risk of suicidal ideation, serious adverse events, or both, although small, cannot be ignored (p. 1344).”

In 2003, The British equivalent of the FDA, the Medicines and Healthcare Products Regulatory Agency warned the medical community to cease prescribing Paxil (Glaxo-SmithKline), Prozac (Eli Lilly), Zoloft (Pfizer), Luvox (Solvay Pharmaceuticals), Effexor (Wyeth), Wellbutrin (GlaxoSmithKline), Celexa (Forest Laboratories), and other antidepressant medications for patients younger than eighteen because there is evidence that the selective serotonin reuptake inhibitors (SSRI's) not only increase the probability of suicidal behavior but also have never been proven effective for these age groups. The Australian government has issued a similar warning. The FDA has ignored the alert issued by the manufacturer of Paxil to Canadian physicians that the medication should no longer be used to treat depression in children and adolescents.

The FDA (2003) released a statement regarding Paxil, an antidepressant for pediatric depression. In the third paragraph of the statement is the sentence that “three well-controlled trials in pediatric patients with major depressive disorder (MDD) failed to show that . . . Paxil was more effective than placebo. Connor (2004) writes, “These studies never have been published” (p. 127). Harris (2008) reported:

More than 389,000 children and adolescents were treated last year with Risperdal . . . known as atypical anti-psychotics. Of those patients 240,000 were 12 or younger . . . In many cases, the drug was prescribed to treat attention deficit disorders. But Risperdal is *not (italics added)* approved for attention deficit problems, and its risks—which include substantial weight gain, metabolic disorders, and muscular tics are too profound to justify its use in treating such disorders . . . From 1993 (until 2008), 1,207 children suffered serious problems, including 31 who died. Among the deaths were children whose treatment with Risperdal was *unapproved (italics added)* by the FDA . . . FDA officials said no studies had been done to test the long-term safety (A20).

Meier and Carey (2009) reported the latest fraud which the FDA failed to detect. “The Justice Department charged . . . Forest Laboratories . . . with [fraud] by illegally marketing . . . Celexa and Lexapro for unapproved uses in children and adolescents . . . Federal prosecutors

alleged . . . Forest concealed . . . a clinical study that showed . . . [these] drugs were not effective in children and might . . . pose risks . . . , including some to become suicidal . . . [These] drugs are currently approved by the [FDA] only for adults” (p. B1).

Incredibly, despite this recent disclosure, the FDA engages in a second scandal by refusing to prevent physicians from prescribing Celexa and Lexapro. The two reporters wrote, “Doctors are free to prescribe to patients, including children, for whom those drugs are not approved . . . But it is illegal for companies to actively promote such uses (p. B3).

Incredibly, the FDA continues to reject these ominous warnings and, indeed, exacerbates this problem by refusing to demand that the powerful international pharmaceutical corporations publish all studies, including negative ones. Outrageously, the FDA refuses to release its data regarding the number of suicide attempts citing *manufacturer confidentiality* which not only is scandalous but also a conflict of interest since this government agency’s *raison d’etre* is to protect consumers. There can be no justification for this decision, which exposes how corrupt the FDA has become because it panders to the financial interests of manufacturers.

In a fund raising letter for Public Citizen, Claybrook (2009) provides a sobering conclusion for this section:

Only Congress can grant the FDA the authority to make concrete, enforceable demands on the pharmaceutical industry. Only Congress can force the FDA to better regulate the disgraceful, misleading marketing of drugs that attempt to turn patients into the agents of pharmaceutical companies as they pressure physicians for medications they’ve seen on TV. And only Congress can abolish the sickening financial payments from Big Pharma to the FDA that create a conflict of interest so immense it puts everyone’s health and safety at risk.

Unlike the mythical little boy who exclaimed and, thus, exposed the Emperor’s nudity to the kingdom, Mundy (2009) has exposed the scandal of the FDA to the world when she wrote: “Recent approval of a new . . . followed a campaign that overcame reported rejections by scientists within the [FDA] agency documents show . . . some senior FDA staff members complained in documents that the handling of . . . shows how political and industry pressure can influence scientific conclusions (italics added)” (p. A1). The article appeared on the first page of “The Wall Street Journal,” a newspaper read by most Congressmen and Senators. Obama needs to immediately appoint a special prosecutor to ascertain whether the FDA should be sanctioned and if litigation should be implemented for violation of public trust, bribery, concealing documents. Mundy (2009) quotes the former head of the FDA who response was, “This shows the FDA at its worst.” There is no reason to believe this assurance because it may very well be the tip of the iceberg. The details of this latest scandal are irrelevant.

How and why this government agency remains exempt from criminal investigation needs to be answered. The reader needs to ponder why the government initiates civil litigation when it has not been injured and refuses to prosecute the Forest executives who illegally concealed the negative results from a study financed by the corporation which may have resulted in suicides.

Harris (2008) provided a most appropriate conclusion when the reporter quotes Laughren of the FDA who said “the agency could do little to fix the problem.” He tries to transfer the responsibility to medical specialties (which) “must do a better job educating doctors about the drugs’ side effects” (p. 20). On reflection the better ending would be, “guilty as charged!”

The SNAFU condition continues to plague the FDA! The only question that demands an immediate answer is when the Senate will demand an investigation!

CONCLUSION: OUTCOME DATA VALIDATES A MEDICINE-FREE APPROACH

Despite more than 30 articles appearing in professional literature, the mental health establishment ignores John Dewey's laudable 25-year outcome record. Psychologists and psychiatrists rarely refer patients, but, significantly, they send sons and daughters.

While perhaps criticized because the statistical data for The John Dewey Academy is simplistic, the outcomes are compelling.

Since the first class graduated in 1987, all graduates attend college. Similar to elite prep schools, The John Dewey Academy wants to be judged by the reputations of the colleges that admit graduates. Seventy percent attend the most selective 50 colleges. Sixty percent attend the most selective 100 institutions of higher learning. A third have made the Dean's List at Barnard, Bates, Binghamton and Brown Universities, Carleton, Colby, Columbia (College and University), and Connecticut College; Cornell, George Washington, and Georgetown Universities; Haverford, Hobart, Holy Cross, Mount Holyoke, and Muhlenberg Colleges; NYU (College of Arts and Sciences and Tisch School for the Performing Arts), Oberlin College, Ohio Wesleyan University, RPI, Rochester University, Skidmore and Spelman Colleges, Syracuse University (Visual and Performing Arts and Newhouse School of Communications), Trinity College, Tufts University, Union College, the Universities of Chicago, Hartford, and Massachusetts; and Vassar, Wellesley, and Williams Colleges. More than a third achieve academic excellence at college by making the Dean's List. Lawyers and physicians make up 10% of Dewey graduates. Two members of the JDA class of 2002 are completing Harvard and NYU Law Schools. Two members of the class of 2003 attend Albany and Pace Law Schools. Another 2003 graduate is enrolled in a clinical psychology doctoral program at Yeshiva University.

Before November, the Dewey class of 2009 has received assurances that they will be admitted by Columbia University (3), Skidmore College, the University of Chicago, and Vassar College. One member of the class of 2008 was wait-listed and two were rejected, but after I assumed an aggressive advocate role, each was admitted by the schools of their choice, Amherst and Oberlin Colleges and the University of Washington.

The academic achievements of Dewey graduates make this Academy indistinguishable from the most elite and prestigious prep schools in America. If admissions were based on standardized testing and clinical reports, rather than a multihour interview, the outcome data might be even more impressive, but it certainly refutes the need for psychotropic medicine.

REFERENCES

- Archibald, W. P. (1974). Alternative explanations for self-fulfilling prophecy. *Psychological Bulletin*, 81, 74–84.
- Blair, R. G. (2004). Helping older adolescents search for meaning in depression. *Journal of Mental Health Counseling*, 26, 333–347.
- Bratter, T. E. (1977a). The psychotherapist as advocate: Extending the therapeutic relationship with adolescents. *Journal of Contemporary Psychotherapy*, 8, 119–127.
- Bratter, T. E. (1977b). Together. *Journal of the Association for Specialists in Group Work*, 2, 60–75.
- Bratter, T. E. (1985). Special clinical concerns for alcoholic and drug addicted individuals. In T. E. Bratter and G. G. Forrest (Eds.), *Alcoholism and substance abuse: Strategies for clinical intervention* (pp. 523–574). New York: Free Press.

- Bratter, T. E. (1989). Group psychotherapy with alcohol and drug addicted adolescents: Special clinical concerns and challenges. In F. J. C. Azima and L. Richmond (Eds.), *Adolescent group psychotherapy* (pp. 163–189). Madison, CT: International Universities Press.
- Bratter, T. E. (2003). Confrontational group psychotherapy with gifted, dually diagnosed, and self-destructive adolescents in a residential setting. *Group*, 27, 131–146.
- Bratter, T. E. (2006). Advocacy: Its impact on the treatment alliance with gifted, angry, self-destructive, and drug-dependent adolescents. In L. T. Flaherty (Ed.), *Annals of adolescent psychiatry* (Vol. 30, pp. 85–100). New York: Analytic Press.
- Bratter, T. E., Bratter, C. J., Coiner, N. L., Kaufman, D. S., & Steiner, K. M. (2006). Motivating gifted, defiant, and unconvinced students to succeed at the John Dewey academy. *Ethical Human Psychology and Psychiatry: An International Journal of Critical Inquiry*, 8, 7–16.
- Breggin, P. R. (1991). *Toxic psychiatry: Why therapy, empathy, and love must replace the drugs, electroshock, and biochemical theories of the "new psychiatry."* New York: St. Martin's.
- Breggin, P. R. (1996). Introduction: Spearheading a transformation. In P. R. Breggin & E. M. Stern (Eds.), *Psychosocial approaches to deeply disturbed persons* (pp. 1–7). New York: Haworth Press.
- Breggin, P. R. (2005). Recent U.S., Canadian, and British harm to self and others: A review and analysis. *Ethical Human Psychology and Psychiatry: An International Journal of Critical Inquiry*, 7, 3–22.
- Breggin, P. R. (2008a). *Medication madness: A psychiatrist exposes the dangers of mood-altering medication.* New York: St. Martins.
- Breggin, P. R. (2008b). *Brain-disabling treatments in psychiatry: Drugs, electroshock, and the psychopharmaceutical complex* (2nd ed.). New York: Springer.
- Brent, D. A. (2004). Dr. Brent replies. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 127–128.
- Claybrook, J. (2009). *Citizen alert: FDA exposed.* (Letter available from Public Citizen, 1600 20th Street, N.W., Washington, DC)
- Connor, D. E. (2004). Paroxetine and the FDA. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 127.
- Depressing research. (2004). *The Lancet*, 369, p. 1335.
- Driscoll, R. (1989). Self-condemnation: A comprehensive framework for assessment and treatment. *Psychotherapy: Theory, Research and Practice*, 26, 104–111.
- Ducan, B., Miller, S., & Sparks, J. (2000). Exposing the myth-makers. *Networker*, 24, 24–32.
- Ellis, A. (1967). Should some people be labeled mentally ill? *Journal of Consulting Psychology*, 31, 39–49.
- Erikson, E. H. (1956). The problem of ego identity. *Journal of the American Psychoanalytical Association*, 4, 56–121.
- FDA Home Page. (2003). Retrieved June 19, 2003, from <http://www.fda.gov/bbs/topics/ANSWERS/2003/ANSOI230.html>
- Fiske, D., Hunt, H., Luborsky, L., Orne, M. T., Parloff, M. B., Reiser, M. F., et al. (1970). Planning of research on effectiveness of psychotherapy. *Archives of General Psychiatry*, 22(1), 22–32.
- Frank, J. D. (1975). *Persuasion and healing.* Baltimore: Johns Hopkins.
- Frankl, V. E. (1967). *Psychotherapy and existentialism: Selected papers on logotherapy.* New York: Simon and Schuster.
- Friedman, H. J. (1963). Patient-expectancy and symptom reduction. *Archives of General Psychiatry*, 8, 61–67.
- Glasser, W. (1972). *The identity society.* New York: Harper and Row.
- Harris, G. (2008). Use of antipsychotics in children is criticized. *New York Times*, CLVIII, 54, 499, p. A20.
- Karp, D. D. (1996). *Depression, disconnection, and the meaning of illness: Speaking of sadness.* New York: Oxford.

- Leon, A., Marzuk, P. M., Tardiff, K., Bucciarelli, A., Piper, T. M., & Galea, S. (2006). Antidepressants and youth suicide in New York City, 1999–2002. *Journal of the American Academy of Child and Adolescent Psychiatry*, 45, 1054–1058.
- Meeks, J. E. (1989). Diagnosis and psychotherapy of adolescents. *Highland Highlights*, 2, 2–6.
- Meier, B., & Carey, B. (2009). Drug maker is accused of fraud. *New York Times*, CLVIII, 54, 598, B1, B3.
- Meltzoff, J., & Kornreich, M. (1970). *Research in psychotherapy*. New York: Atherton.
- Merton, R. (1958). *Self-fulfilling prophecy*. New York: Van Nostrand.
- Mundy, A. (2009). Political lobbying drove the FDA process. *The Wall Street Journal*, CCLIII, 53, p. A1, p. A12.
- Munoz, R. F., & Ying, Y. (1993). *The prevention of depression: Research and practice*. Baltimore: Johns Hopkins University Press.
- Olfson, M., Blanco, C., Liu, L., Moreno, C., & Gonzalo, L. (2006a). National trends in the outpatient treatment of children and adolescents with antipsychotic drugs. *Archives of General Psychiatry*, 63, 679–685.
- Olfson, M., Marcus, S. C., & Shaffer, D. (2006b). Antidepressant drug therapy and suicide in severely depressed children and adults. *Archives of General Psychiatry*, 63, 865–872.
- Phillips, M., & Frank, E. (2006). Redefining bipolar disorder: Toward DSM-V. *American Journal of Psychiatry*, 163, 1135–1136.
- Pruyser, P. W., & Menninger, K. (1976). Language pitfalls in diagnostic thought and work. In P. W. Pruyser (Ed.), *Diagnosis and the difference it makes*. New York: Jason Aronson.
- Salinger, J. D. (1951). *The catcher in the rye*. Boston: Little Brown.
- Shantall, T. (1999). The experience of meaning and suffering among holocaust survivors. *Journal of Humanistic Psychology*, 39, 96–124.
- Shean, G. (2001). A critical look at some assumptions of biopsychiatry. *Ethical Human Sciences and Services. An International Journal of Critical Inquiry*, 3, 77–96.
- Szasz, T. S. (1961). *The myth of mental illness: Foundations of a personal conduct*. New York: Harper and Row.
- Szasz, T. S. (1970). *The manufacture of madness: A comparative study of the inquisition and the mental health movement*. New York: Harper and Row.
- Szasz, T. S. (1974). *Ceremonial chemistry: The ritual of drugs, addicts and pushers*. Garden City, NY: Anchor Press.
- Tiihonen, J., Lonnqvist, J., Wahlbeck, K., Klaukka, T., Tanskanen, A., & Hankka, J. (2006). Antidepressants and the risk of suicide and overall mortality in a nationwide cohort. *Archives of General Psychiatry*, 63, 1358–1367.
- Wexler, D. B. (1991). *The adolescent self: Strategies for self-management, self-soothing, and self-esteem in adolescents*. New York: W.W. Norton.
- Whittington, C. J., Kendall, T., Fonagy, P., Cottrell, D., Citgrove, A., & Boddington, E. (2004). Selective serotonin reuptake inhibitors in childhood depression: Systematic review of published versus unpublished data. *The Lancet*, 363(9418), 1341–1345.

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