

7 Residential treatment for gifted and self-destructive adolescents

The John Dewey Academy

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Abstract

This chapter describes the John Dewey Academy (JDA), its students, and its educational and therapeutic philosophy. It offers a rationale for the efficacy of caring confrontation and the utilization of positive peer pressure within a therapeutic community setting. Psychotropic medications are not used. Outcomes are strongly positive in a population of bright adolescents who are resistant to traditional treatment. We contend that these treatment approaches make the John Dewey Academy unique.

Here's to the crazy ones.

The misfits.

The rebels.

The troublemakers.

The round pegs in the square holes.

The ones who see things differently.

They're not fond of rules.

And they have no respect for the status quo.

You can praise them, disagree with them, quote them, disbelieve them, glorify them or vilify them.

About the only thing you can't do is ignore them.

Because they change things.

They invent. They imagine. They heal.

They explore. They create. They inspire.

They push the human race forward.

Maybe they have to be crazy.

How else can you stare at an empty canvas and see a work of art?

Or sit in silence and hear a song that's never been written?

Or gaze at a red planet and see a laboratory on wheels?

Because the people who are crazy enough to think they can change the world, are the ones who do.

Anonymous poem by a student

The school and its students

Founded in 1985, the John Dewey Academy (JDA) is a therapeutic boarding school based on the concept of caring confrontation and self-help positive peer pressure within a therapeutic community setting (Bratter, Bratter, Maxym, and Steiner, 1998). JDA's primary identification is a college preparatory residential high school for grades 10–12. It provides intensive education and treatment for approximately 30 self-destructive adolescents who have failed to respond to other treatment approaches.

Admission criteria and student characteristics

Admission is determined on the basis of in-person interviews after a telephone interview with parents. There are four criteria that determine acceptability: (1) possessing the potential to succeed; (2) having the energy to succeed; (3) agreeing to become a contributing member of the community; and (4) wanting to attend college. We exclude prior educational performance, standardized test scores, and psychological reports. Approximately, seventy-five percent of those whom we interview are admitted.

We do not put much stock in prior testing and school reports, as these are often distorted by lack of motivation and/or substance abuse, and may not assess academic potential. At base, our program is a meritocracy. Students arrive, however, looking anything but meritorious.

The John Dewey Academy is not appropriate for all adolescents. Those who are organically damaged, have *true* metabolic disorders, possess less than average intelligence, and/or are psychotic are not considered viable candidates.

Referral sources

Interestingly, less than ten percent of our referrals come from mental health specialists. We believe this stems from our uncompromising opposition toward the use of psychotropic medications and diagnostic labels. Significantly, twenty percent of Dewey graduates have at least one parent who works as a psychotherapist. Most families learn about the John Dewey Academy from the Internet or from independent educational consultants they have hired to help when other treatment approaches have not worked. Now that the school is over twenty years old, we have developed a strong word-of-mouth referral base from alumni and alumni parents.

Student characteristics

Many students arrive at JDA with educational deficiencies, functioning one or more grades below chronological age. More than 90% have inconsistent and mediocre academic records, and most have inferior standardized test scores. Students who enter have stolen, cheated, lied, betrayed, manipulated those around

them, and have rejected traditional psychotherapeutic and pedological approaches. These youngsters have been branded by family, friends, therapists, and teachers as untreatable, uneducable, unreliable, unmanageable, unruly, uncivilized, untrustworthy, unlovable, unworthy, unwanted, undisciplined, unfaithful, unpredictable, unhappy, unlawful, unstable, and unsuccessful.

Prior to their admission, 33% of the students have been hospitalized or attended drug and alcohol treatment programs for one month, 75% have been treated by mental health specialists, and 50% arrive medicated with potent psychotropics. They bear a myriad of DSM-IV diagnoses given by inpatient programs and community-based psychotherapists. Some of the more common diagnoses include: bipolar affective disorder, major depressive disorder, oppositional defiant disorder, attention deficit hyperactivity disorder, and various substance use disorders. In summary, these children have been labeled with multiple and very severe disorders, and have been medicated accordingly. This is part of the insidious trend in psychiatry and education that involves labeling disruptive and disobedient students with attention-deficit disorders or conduct disorders, or even bipolar disorders (Harris, 2005).

By the time they arrive at Dewey, these youngsters are often psychological cripples, hiding behind their diagnostic shields and excuses. Furthermore, these labels can haunt the possessor in adulthood when applying for a driver's license, life insurance, licensure as a professional, and so on.

We believe there are three reasons for the plethora of diagnoses. First, bright and gifted adolescents are irritating so the therapist may give a punitive diagnosis. Second, insurance companies encourage excessive diagnoses to justify payment. Third, in professional journals, certain diagnoses become trends. In contrast to the above excessive diagnoses, our students do not come with the diagnoses they actually meet criteria for. Most of all our students actually *have* nicotine dependency and identity problems but none has ever been given either of these diagnoses. Neither has the most benign and inclusive diagnosis, adjustment disorder, been used.

Who these kids really are

These teenagers are unconvinced. They feel that life has nothing worthwhile to offer—"a fundamental psychic problem in circumstances of late modernity" (Giddens, 1991, p. 9). They are motivated by intense emotions they can neither understand nor identify. They create crises and chaos to escape feelings of depression. Some medicate themselves for the temporary relief of painful feelings. Others are promiscuous to neutralize loneliness. Their symptoms are legion, and are designed to help with the avoidance of painful reality. They include: eating disordered behavior; suicidality and suicidal thinking; self-destructive behaviors such as cutting, gambling, addiction to the Internet, or to other electronic entertainment; or stealing money or consumer goods. Creating constant crises with self-destructive acts, they need a structured, safe, and supportive residential

environment to help them control and curtail their behavior. They are similar to the adolescents with educational deficiencies in secure units that Rose (2004) describes as "likely to be disaffected with or have disengaged from education... and...they may have been...excluded from school....Also within this group are individuals who had thoughts of self-harm or suicide, some of whom have acted on these feelings" (p. 221).

These teenagers project an aura of hostility to insulate them from intimacy—hence to protect themselves from the risk of being hurt. They often project a facade of grandiosity to hide feelings of vulnerability and inadequacy. Beneath antagonistic exteriors, however, these kids have tender, battered, bruised, and bloodied psyches. They feign apathy, but fear rejection and failure. They exist in a self-imposed hell furnished with the frustration, failure, pain, fear, and rejection which result from their impulsive and poor conscious choices. These feelings of animosity often are caused by fear of being abandoned and betrayed, so they act impulsively to reject before being rejected.

Students at JDA are gifted youngsters whose intellectual, affective, and artistic needs are being ignored. Thus, they act out against an environment they feel is hostile, sterile, and pessimistic by engaging in dangerous and destructive behavior. The presenting problem, reduced to its lowest common dominator, is simply a negative attitude. All experience an identity crisis, which Erikson (1968) describes as follows:

a...disturbance in...conflicted young people whose sense of confusion is due, rather, to a war within themselves, and in confused rebels and destructive adolescents who war on...society....These new identifications are no longer characterized by the playfulness of childhood and the experimental zest of youth: with dire urgency they force the young individual into choices and decisions which will, with increasing immediacy, lead to commitments "for life" (pp. 17, 155).

Almost two decades later, Wood (1986) agrees with Erikson:

They do not like themselves and feel angry and impotent at their failure to enjoy life. From this... lack of self-respect, all else stems. They resort to... cunning schemes...to hide...their felt worthlessness....Or, encouraged by psychoanalytic-type philosophies, they blame families,...friends,... circumstances [for their failures]. These individuals are characterized by the "if only" syndrome: "if only things had been different" if only my parents had not... divorced ..." "if only I had been born more intelligent, with more money, taller, more attractive," etc. ... They shrink from challenges that they feel may put at risk their fragile self-respect ...But in attempting to insure against failure by erecting obstacles to success, they make failure more likely and paradoxically the effect is to reduce self-respect...by blaming others, but whatever happens,

the guilt mechanism is not deceived and is never effectively suppressed, causing constant psychological pain" (pp. 15–16).

These youth have abused their intellectual and creative talents. They remain action-oriented to ameliorate agonizing feelings of emptiness and depression. Most Dewey students suffer from what Breggin (1991) has labeled a "psycho-spiritual crisis" (p. 46).

We have noted several trends during the twenty-two-year history of the John Dewey Academy, trends that parallel our society. For example, the rate of diagnosis of bipolar affective disorder in children and adolescents has exploded during the past five to ten years. Parents arrive at Dewey terrified that the removal of so-called mood stabilizers will precipitate a manic episode. We believe the actual incidence of true bipolar affective disorder is not increasing. It is simply the diagnosis du jour, in much the same way that ADHD was during the 1980s.

Toward a treatment philosophy: A humanistic and pragmatic view

Persons are born with the capacity not only to hope but also to seek meaning. Adolescents need to establish stable personal identities as they learn how to form positive and responsible interpersonal relationships. Until convinced that education is relevant and that learning can be gratifying, these students refuse to invest academically. The classroom teacher thus assumes the burden of convincing them. These angry adolescents need treatment that will force them to accept responsibility for behavior while concurrently helping them recognize the correlation between current acts and future outcomes. The treatment goal is to provide strategies and solutions to change the prognosis from pessimistic to guardedly optimistic. Negative passion needs to be directed into constructive and creative acts.

The therapeutic goal is to nurture the psychological, moral, and spiritual growth of students by creating the conditions conducive to the restoration of self-respect and integrity. Each student has a primary counselor whose caseload rarely exceeds thirteen students. Group therapy is the primary therapeutic approach. Not only does the group insist that the members accept responsibility for self-destructive behavior, it also helps to resolve intrapsychic and interpersonal problems. There are at least four two-hour groups per week, conducted by credentialed therapists with whom the adolescent can relate and peers with whom they can identify. The peers offer insight and suggestions that provide the catalytic conditions necessary for self-exploration and change. Approximately one third of the time is devoted to therapeutic interventions. In addition, students participate nightly in a one-hour self-help group.

In a group setting, students can relate to peers who will confront destructive attitudes while providing catalytic conditions for self-exploration and change. The group demands that members accept responsibility for past failures, and it also helps members to resolve intrapsychic and interpersonal problems. The treatment approach, described more fully in a separate chapter in this volume, utilizes

confrontational psychotherapeutic techniques with escalating expectations for improved behavior. Peers confront each other and demand rejection for immature, irresponsible, illicit, and self-destructive acts.

Family members must renegotiate their relationships with the student and with each other. Thus, parental and family involvement is an important component of a JDA stay. Our ultimate mission regarding the family is to help members support the efforts of the John Dewey student to help him/herself. Family therapy sessions, held on weekends when parents are available, focus on changing dysfunctional and dishonest communication patterns. At least eight times a year, parents participate in three two-hour group experiences. In the first group, the parents introduce themselves and discuss their concerns. In the second group, which is intergenerational in nature, members are separated so that they will elicit help from others. The third group is a mothers and fathers group where discussion focuses on role-related problems. When there are sufficient siblings, there is a brothers and sisters group.

Institutional aspects of JDA

Despite JDA's efforts not to be "institutional," it is an institution. For a minimum of eighteen months, students live a safe, womb-like nurturing environment. As in colleges, the military, hospitals, and jails, our students do not have to worry about survival issues such as food, clothing, and shelter. Students receive a nominal weekly allowance to help them learn the value of money, and how to manage it.

Biological reductionism: Counter therapeutic to growth

Our opposition to medication is based on our belief that viewing problems as being caused by metabolic disorders, genetic imbalances, and cellular deficiencies is not helpful for the treatment of these youngsters. No pill teaches self-respect or cures noxious narcissism, deceit, and antisocial attitudes.

A focus on symptoms, rather than understanding the adolescent's world view, ignores the crucial information that is necessary for understanding etiology. Removing the symptoms, without addressing behavioral and attitude, compounds the problem because it breeds impotence and dejection. Worse, this reductionistic thinking reinforces excuses for poor choices and continuing negative behaviors.

Prescribing psychotropic medication transmits a counter therapeutic message—i.e., adolescents cannot cope and do not need to try. The attribution of depression to a chemical imbalance has spawned a proliferation of psychopharmacological treatment, and its advocates, whose views are exemplified by Koplewicz (2002) when he writes:

Medicine should be prescribed carefully and deliberately. Unfortunately, there is an almost universal belief by the public that teenagers should first try psychotherapy, and medication should be considered only after

that fails. This idea comes from two mistaken and outdated beliefs: 1) that medications may be addictive or dangerous to teenagers, and 2) that depression in young people is caused either by early trauma or by some intrinsic weakness in the teenager that can be overcome with psychotherapy (p. 262).

The readiness to resort to medication stems from the search for a quick fix and from the therapist's sense of impotence. At the very least, concerns on the part of regulatory agencies about the safety of antidepressant medications in children and adolescents should lead to greater caution in their use. The over-emphasis on biological aspects of depression ignores the impact of toxic acts, conscious attitudes, and personal choice.

Whittington et al. (2004) warn, in their systematic review of published and unpublished studies of serotonin reuptake inhibitor drugs:

In view of the high risk of suicide in this group of children and young people, 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).

Finally, most adolescents in our program report that they feel more alert and energetic when they are taken off medication.

Diagnosing: A counter therapeutic activity?

Lack of reliability

In today's climate of third-party payers and dependence on the biological quick fix, diagnostic interviews are often unreliable. This is not a new problem, but it is a worsening one. A senior staff psychologist at the Menninger Foundation, Applebaum (1977) asserts that "diagnosing...is a hyperabstract...intellectual exercise associated with a loss of feeling toward and emotional contact with a patient" (p. 161). Confirming Applebaum, Maxmen and Ward (1995) suggest that the differential diagnosis may be more subjective than generally acknowledged.

Diagnosing the psychosocial characteristics of deceitful, drug-dependent adolescents is an even more complex matter. The interviewer lacks the time (and often the skill) to establish a therapeutic alliance with the adolescent, so the youth remains guarded and dishonest. Exacerbating this problem is that these youngsters are sophisticated, so they manipulate the clinician, viewed as the enemy, with ease.

A DSM-IV diagnosis inadvertently provides justification and excuses for poor behavior. In our experience, many addicted adolescents often welcome these

diagnoses as excuses for their behavior—and as justification for the prescription of psychotropic medication. These drugs can be used inappropriately, or can be sold on the black market.

Problems with labeling

Sperry (1995) warns about the consequences of labeling:

Mention personality disorders—particularly borderline personality disorder or antisocial disorder—to a colleague and you might elicit such comments as, “Most borderlines are treatment refractory,” “Personality disorders have guarded prognoses at best,” or “Antisocial (persons) are psychopaths and should be in prison, not psychotherapy.” And what about your reaction when a colleague wants to refer a personality disordered individual to you. Do you feel stuck, apprehensive, or angry? Do you think about your...safety, after-hours emergencies or telephone calls, and whether your bill will be paid? (p. 1).

Diagnostic labeling leads to lowered expectations by the therapist, which allows the youth to settle for mediocrity. Program philosophy and treatment outcome, furthermore, will be adversely affected by negative and positive self-fulfilling prophecies related to the diagnosis. Verbalizing these concerns, Meeks (1989) cautions:

We need to remember the risk of overdiagnosing and overlabeling...From a countertransference point of view, there is...a temptation to overdiagnose...abrasive or hostile adolescents. The angry therapist can say, “I am beginning to feel that this youngster has a psychotic (or paranoid) core.” Translation: “This adolescent does not like me nearly as much as he/she should, considering what a good therapist I am” (p. 3).

Making an accurate DSM-IV diagnosis is further complicated by the effects of psychoactive substances that can mimic symptoms of psychosis and/or depression. Amphetamines can cause a temporary psychotic state and can also induce a condition resembling hypomania. Marijuana and amphetamines can both produce paranoid symptoms. Opiates and marijuana can induce apathetic states consistent with major depressive disorder. In addition, drug abuse wreaks havoc on sleep and appetite patterns, further complicating the diagnostic picture. Weiss and Millman (1991) contend that psychotic disorders, occurring subsequent to prolonged drug use, can be manifestations of premorbid psychopathology. Greene (1996) urges prudent precautions prior to diagnosis. Clinicians need to take into account the acute and chronic impacts of drug abuse. Definitive diagnosis must wait until detoxification in order to ascertain which symptoms relate directly to the drug use, and which predate it.

The diagnostic process, as Pruyser and Menninger (1976) note, can be influenced by value judgments reflecting the orientation and bias of the mental health worker:

Upon reading psychiatric reports, one is struck by tendencies which, for many writers, have become habits....Moralization comes through in such words as perversion, psychopathic, inadequate personality, infantile personality, and character disorder. Outright accusatory expressions are castrating female, passive father, and schizophrenogenic mother. Some word usage substitutes perjorative meanings: compulsive for orderly, depressed for sad (p. 25).

Szasz (1961), using incendiary rhetoric, makes the valid point that what masquerades for a diagnosis often reflects the bias of the therapist (and institution), thus justifying the prescription of medication. The use of psychiatric nomenclature in order to receive third-party payments is now *de rigeur*. This article is a plea never to forget that patients remain people who have intentionally hurt themselves and others.

What was normal then is abnormal now

Changes in normative behavior have called into question the validity of some diagnostic criteria. Before the 1960s, distinguishing between normal and abnormal was less complicated than it is today. At the beginning of the 1960s, drug use and early sexual activity fell outside the norm. In the 21st century, the distinction between responsible and irresponsible has become blurred. Testing limits, questioning and/or rejecting authority, have become the norm. The blurring of absolutes renders assessment more subjective because it is more contaminated by the diagnostician's values and experience.

In the third millennium, experimentation with drugs and sex has become the primary rite of initiation into adolescence. When discussing the oral sex epidemic of the 1990s, which has become pandemic during the third millennium, Dennis (1992), a female Canadian journalist, writes:

While having a [female] on her knees is by no means a prerequisite for a splendiferous blowjob, for some [males] it is the penultimate erotic charge. That's because with a [female] on her knees, a [male] can imagine all kinds of nasty, lovely power associations. (...Coming in a [female's] mouth, doing her up the bun or doggie-style gives many [males] a glowy feeling.)

The kneeling business, however, has sparked a passionate debate about whether there's such a thing as a politically correct blowjob, and it goes straight to the heart of one of the most controversial issues of sexual politics of our time. Some [females] agonize whether they should agree to perform blowjobs in a kneeling position (or do that other submissive stuff lots of guys seem to love) because complying means assuming blatantly servile postures, and we...know how [females]

feel on that subject. What drives [females] completely nuts on this volatile matter, however, is the fact that a fair number of them...get their *own* erotic buzz from performing the handmaiden role in these little fantasy-dramas (p. 162).

Incredibly, those who abstain are in the minority—hence, different. “Well-adjusted” adolescents can write dark poetry, can play and listen to gloomy music, can glorify celebrities who committed suicide or died of drug overdoses, can fantasize about aberrant acts, periodically dramatically scream, cry, and threaten suicide. However, they do not become addicted to psychoactive substances, self-mutilate in frankly self destructive ways, develop eating disorders, or commit violent acts. Whitaker (1989) laments:

Teenagers who don’t drink (the most popular American drug is alcohol) often must make plans to conceal their abstinence while so-called “normal” teenagers line their rooms with empty liquor bottles and beer ads and go around advertising beer on T-shirts that generally cost twice as much as highest cotton T-shirts unadorned with other people’s commercial ploys. The success of these ploys show the genius of advertisers; advertisers have actually gotten customers to pay the alcohol industry and their advertisers a premium for plugging alcohol. Mark Twain’s Tom Sawyer, who got a boy to whitewash a fence by touting that work is a privilege, has been one-upped by the alcohol industry (p. 25).

Changes in adolescence demand new treatment approaches

Developments such as those described in the preceding section present new challenges for therapists. Friedman (1991) warns “the perils of adolescence as a developmental stage have been increased during the past decade” (p. 363), thus necessitating a more active-directive treatment approach. The mass media has extolled “drug usage, sexual freedom, ... and an anti-work ethic” (p. 364). Many adolescents engage in dangerous behaviors from which they are unable to extricate themselves.

They cannot navigate between the Scylla of excessive rigidity and the Charybdis of passive gratification. For them, effective psychotherapy requires a therapist who is willing to help them develop skills in navigation by recognizing the dangers from both sides....The therapist may have to stand firm against such influence with adolescent patients. He may have to do so with vigor and force when the adolescent’s inner life is enforced by authority figures who define autonomy in passive, regressive fashions (pp. 364, 365).

Another approach

We contend that pathological beliefs and dysfunctional behaviors can be changed. We agree with Breggin (1991), who states, "By refusing to diagnose or to label people who already feel rejected and humiliated, we welcome them back to the human community and promote humane, respectful, and loving attitudes toward them" (p. 46). As do Mowrer (1961), Ellis (1962), and Glasser (1965), we reject the psychoanalytic approach because we believe that focusing on learning and growth in the present are key aspects of a successful treatment. Adolescents can transcend their pasts. As Patterson et al. (2005) propose, the individual "cannot...control conditions [by] which he is confronted. but can control his responses....[The person] is responsible for his responses, his choices, and his actions" (p. 466). Another way is to look at depression as a realistic response to self-destructive behavior.

As we have indicated, most entering students arrive with multiple psychiatric diagnoses, most often including a depressive spectrum disorder. Depression, common during adolescence, can be a product of self-destructive behavior and antisocial attitudes, which lead to "self-criticism, self-contempt, self-deprecation, self-doubt, self-punishment...seeing the worst in [one's self]; by...low self-esteem; and by accompanying feelings of failure, inadequacy, worthlessness, embarrassment, guilt" (Driscoll, 1989, p. 104). Driscoll fails to note that poor conscious choices are at the root of this teenage malaise. In addition to decreasing future options, these adolescents have destroyed relationships with family and friends. They feel, as a result, alone and betrayed. They trust no one. While they are indeed depressed, their problems cannot be cured with medication.

Between clinical depression, attributed to a metabolic deficiency, and reality-based despair exists a profound difference, although the surface symptoms may be quite similar. Kids know they have compromised their futures, so depression is a realistic reaction. When asked why they feel depressed, gifted adolescents can articulate and provide substantial, realistic explanations. Due to poor conscious decisions, they have imprisoned themselves in a lose-lose labyrinth. Thus begins the cycle of hopelessness, helplessness, and demoralization—hardly prerequisites for constructive and creative change. These adolescents believe they are damaged goods. They stop daring to dream that they can rebuild their lives, thus intensifying their despair. Is it any wonder they resemble patients with mood disorders?

Converting anger and shame into proactive behavior: A treatment challenge

Viewed in this light, the primary cause of depression is a toxic, self-induced attitude that is compounded and perpetuated by dysfunctional behavior, resulting in feelings of pain, shame, fear, inadequacy, and self-loathing. Underneath the thin layer of depression exists an intense rage. The sources of this rage are voracious

entitlement needs, a self-serving sense of injustice, and a full retreat into the role of the victim. The clinical challenge is to redirect this anger/rage into positive, productive, and proactive activities. Gans & Weber (2000) contend "shame is an important emotion that... [group] leaders...overlook, often to the detriment of their groups.... Attention to shame requires clinical judgment, proper timing, countertransference awareness, and a primary obligation to the needs of the members of the group" (pp. 393, 394). Nathanson (1987) discusses the centrality of shame in adolescent development. Kaufman (1989) asserts, "no other affect is more disturbing to the self, none more central for the sense of identity. In the context of normal development, shame is the source of low self-esteem, diminished self-image, poor self-concept....Shame...produces self-doubts and disrupts... security and confidence" (p. vii). Helping students recognize that guilt and shame result from irresponsible and/or illicit acts is an effective treatment tactic, because this pain creates the incentive to change.

It can be salubrious when the therapist states, "I understand why you suffer, because what you did is hurtful and hateful. If you change your behavior, you will feel better about yourself." An intense group experience forces these adolescents toward accountability and also toward a true comprehension of the correlation between current acts and attitudes and outcomes and consequences. The clinical challenge is to help adolescents ameliorate noxious feelings by discovering positive behavioral options. When behavior becomes congruent with a positive value system, adolescents gain self-respect. In contrast, we note that sympathy can prolong the homeostasis which mires individuals in self-imposed depressive states.

Restoration of hope: The most potent cure for depression

To ameliorate despair, the teenager needs to be convinced that change is possible. Adolescents arrive at Dewey demoralized because they know their acts have destroyed future options. A significant number have refused to study since elementary school, and have even been school avoidant. Of course, it is impossible to hide from the transcript, a black and white confrontation in and of itself. These students lack the incentive to work because they know the best they can do is a fourth- or fifth-rate college. We believe that until the student feels there is a modicum of hope that the future can indeed improve, the person will not study. Hope, therefore, becomes the primary catalyst for change.

During the intake interview, the applicant is told that all our graduates attend college and most are accepted by the most competitive institutions of higher learning. Outside the president's office where the interview occurs, are two plaques which contain the names of graduates and the colleges they attended. Alexander & French (1946) note:

Like the adage, nothing succeeds like success, there is no more powerful therapeutic factor than the performance of activities....No insight, no

emotional discharge, and no recollection can be as reassuring as accomplishment in the actual life experience in which the individual has failed. Thus the ego regains that confidence which is the fundamental condition, the prerequisite of mental health. Every success encourages new trials, and decreases inferiority feelings....*Successful attempts at productive work, love, self-assertion, or competition will change the vicious cycle to begin one; as they are repeated, they become habitual and thus eventually bring about a complete change in the personality* (p. 40, italics added).

Elsewhere in this volume, Bratter discusses the power of the impact that the therapeutic act of advocacy has on the restoration of hope.

Life after JDA

Graduation from high school, in our society, starts the transition to young adulthood. High school seniors enjoy status and security and may thus be a bit reluctant to close the final chapter of adolescence. For most adolescents, going to college is exciting but also frightening and threatening, because it means starting again, being at the bottom, and knowing no one.

JDA seniors participate in a year-long weekly senior group that maximizes the probability of success. By this time the members have participated in approximately 1,000 hours in other groups, so they know each other well. Our senior experience is divided into five sequential components: a) bonding with classmates to build a support network after graduation; b) coping with pressures of confronting peers to improve themselves, thus encouraging the internalization of proactive values; c) becoming moral leaders and responsible role models; d) training juniors to assume positive leadership roles and saying good-bye to them; and e) gaining the courage of convictions to resist the myriad of self-destructive activities at college. Students discuss and ponder real issues such as, "What do I say if my roommate wants to use the room as either a brothel or drug den?" This decreases significantly the probability of becoming a casualty or dropout.

Outcome data

The dropout rate from JDA since its inception is less than twenty-five percent. If a student chooses to leave, the school works with the family to find the adolescent another residential program, because the school is committed to forcing the student to "grow up."

Table 7.1 shows a list of the colleges attended by JDA graduates. More than seventy percent of JDA graduates graduate from college. More than a third make the dean's list at college. At least a third attend graduate school. Ten percent are either attending or have graduated from law schools. In the new millennium, less than ten percent of Dewey graduates have dropped out. Equally significant, less

Table 7.1 Colleges John Dewey Academy graduates have attended

Antioch College	Grinnell College*	Spelman College*
Babson College*	Hamilton College	St. John's College
Barnard College*	Hampshire College	SUNY-Binghamton
Bates College*	Haverford College*	SUNY-Purchase
Bennington College	Hobart College*	Syracuse University*
Bentley College	Indiana University	College of Visual Arts,
Berkshire Community College*	Kalamazoo College	Martin J. Whitman School
Boston College	Kenyon College	of International
Boston University	Lemoyne College	Management, S.I.
Brandeis University	Manhattanville College	Newhouse School of
Brown University*	Mary Washington	Public Communication
Bucknell University*	University	Trinity College*
Carleton College*	Mount Holyoke College*	Tufts University*
Clark University	Muhlenberg College*	Tulane University
Centre College	New York University Tisch	Union College*
College of the Holy Cross*	School of Arts*	UCLA
Columbia College*	Northwestern University	University of Chicago*
Columbia University*	Oberlin College*	University of Hartford*
Connecticut College*	Ohio Wesleyan University*	University of Hawaii
Cornell University*	Parsons School of Design	University of
Eckert College	Pepperdine University	Massachusetts*
Embry Riddle Aeronautical University	Pitzer College	University of Miami
Emerson College	Queens University	University of Michigan
George Washington University*	(Canada)	(Honors Program)
Georgetown University*	Rollins College	University of Oregon*
Glendon College of the University of Toronto (Canada)	Rensselaer Polytechnic Institute*	University of Rochester*
	Sarah Lawrence College	University of Santa Clara
	Scripps College	University of Tampa
	Skidmore College*	University of the Redlands
		Vassar College*
		Wellesley College*
		Wheaton College
		Williams College*

* Denotes Dean's List

than ten percent of this school's alumni resume psychotherapy or take psychotropic medication as adults.

Both interesting and significant is the fact that there is little staff turnover. Most staff members have doctorates. A majority of the faculty have been at the school for at least a decade.

Conclusion

In summary, the John Dewey Academy provides a positive educational and emotional experience that promotes:

- Maximizing the making of constructive and creative choices
- Formulating realistic intermediate to long-term educational, personal, and professional goals and the strength to achieve them
- Individuation and separation from the family
- A proactive self-identity
- Forming mature and positive interpersonal relationships
- Strength to be assertive and moral
- The opportunity to (re)gain self-respect
- The incentive to be good and decent
- A resilience to learn and survive inevitable painful fears, failure, and rejection
- An optimistic outlook about one's self and capacity to succeed at tasks considered important
- A desire to change rather than remain complacent
- The ability to take control of one's life by making conscious, responsible, and proactive choices
- The courage to shatter restricting boundaries of innocence and ignorance which characterize immature thinking

Given the energy, enthusiasm, and creativity of adolescents who yearn for novelty, self-destructive acts may signal the "rites" of passage from childhood to adolescence in our society. The nature of this rebellion changes for each generation, but teens still seek personal identities, and they still battle their conflicting needs between desire for the security of dependence and the struggle for independence and separation from the family. Youth continue to rebel by hurting themselves and those who love them. When convinced it is in their best interest, however, they work diligently to achieve success at those tasks they consider important and stimulating.

References

- Alexander, F. & French, T. (1946), *Psychoanalytic Therapy*. New York: Ronald Press.
- Applebaum, S. A. (1977), Objections to diagnostic psychological testing. In *Diagnosis and the Difference It Makes*, ed. P. W. Pruyser, New York: Jason Aronson, pp. 161–174.
- Bratter, T. E., Bratter, C. J., Maxym, C., & Steiner, K.S. (1998), The John Dewey Academy, a moral caring community: An amalgamation of the professional model and self-help concept of the therapeutic community. In *Community as Method: Modified Therapeutic Communities for Special Populations and Special Settings*, eds. G. De Leon, & J. F. Zeingfus. Westport, CT: Greenwood Publishers, pp. 179–194.
- Breggin, P. (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 Press.
- Dennis, W. (1992), *Hot and Bothered: Sex & Love in the Nineties*. New York: Viking Press.
- Ellis, A. (1962), *Reason and Emotion in Psychotherapy*. New York: Lyle Stuart.
- Friedman, H. (1991), Confrontation in the psychotherapy of adolescent patients. In: *Confrontation in Psychotherapy*, ed. G. Adler & P. G. Myerson. Northvale, NJ: Jason Aronson, pp. 349–367.

- Gans, J. S., & Weber, R. L. (2000), The detection of shame in group psychotherapy: Uncovering the hidden emotion. *Intl. J. Group Psychother.*, 50:381–396.
- Giddens, A. (1991), *Modernity and Self Identity*. Stanford, CA: Stanford University Press.
- Glasser, W., (1965), *Reality Therapy: A New Approach to Psychiatry*. New York: Harper & Row.
- Harris, J. (2005), The increased diagnosis of “juvenile bipolar disorder”: What are we treating? *Psychiat. Serv.*, 56:529–531.
- Kaufman, G. (1989), *The Psychology of Shame: Theory and Treatment of Shame-Based Syndromes*. New York: Springer.
- Meeks, J. E. (1989), Diagnosis and psychotherapy of adolescents. *Highland Highlights* 2:2–6.
- Mowrer, O. H. (1961), *The Crisis in Psychiatry and Religion*. Princeton, NJ: D. Van Nostrand.
- Nathanson, D. (1987), *The Many Faces of Shame*. New York: Guilford.
- Patterson, K., Grenny, J., McMillan, R., & Switzer, A. (2005), *Crucial Confrontations: Tools for Resolving Broken Promises, Violated Expectations, and Bad Behavior*. New York: McGraw-Hill.
- Pruyser, P. W. & Menninger K. (1976), Language pitfalls in diagnostic thought and work. In: *Diagnosis and the Difference it Makes*, ed. P. W. Pruyser. New York: Jason Aronson, pp. 11–28.
- Rose, J. (2004), The residential care and treatment of adolescents. In *From Toxic Institutions to Therapeutic Environments: Residential Settings in Mental Health Services*, ed. P. Campling, S. Davies, & G. Farquharson. Gaskell, UK: Royal College of Psychiatrists, pp. 219–226.
- Sperry, L. (1995), *Handbook of Diagnosis and Treatment of the DSM-IV Personality Disorders*. New York: Brunner/Mazel.
- Szasz, T. S. (1961), *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New York: Harper.
- 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. *Lancet*, 369:1341–1345.

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