

Waging War with a Gifted, Manipulative, and Self-Mutilating Adolescent: Some Clinical Thoughts

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I treat talented, troubled, troublesome, and tortured teens. These adolescents are alienated, angry, and act-out, so they need a structured, safe, and supportive environment to contain and control annihilative and sometimes death-defying acts. For me, psychotherapy becomes a war. Unless the psychotherapist is prepared to confront and attack by using any desperate and heroic ethical intervention necessary to destroy anti-social and self-destructive attitudes and acts, it is malpractice to become therapeutically involved. Unless the treatment agent accepts the awesome psychotherapeutic responsibility of annihilating **ALL** malignant material, like a cancer, that malignancy will metastasize and produce disastrous consequences. I view every adolescent as guilty until proven innocent. Fortunately, more than three decades ago, much to the chagrin of Glasser, I adopted a new treatment identity—i.e., gun fighter rather than the traditional therapist. For example, when parents were unable to prohibit driving or, in extreme cases, confiscate a car which the substance abuser drove at excessive speeds while intoxicated, I put sugar and salt in the engine, which destroyed the car. I contacted drug dealers, furthermore, to threaten them that if they did not stop selling drugs to my kids, I would dispatch someone to break their legs. I informed them that I had worked with mafia families who had voluntarily offered this kind of intervention. Wisely, I informed drug dealers that my job was to protect **MY** kids, not to incarcerate them. Several times, I persuaded my kids to speak with enforcement agents to introduce an undercover agent to the dealer. This undercover police officer would introduce a second who would introduce a third who would make the arrest. My intent was to protect my kid, the informer, because if his identity were discovered he could have been killed. One time, an agent refused to honor the agreement. I demanded a conference with the Commissioner of Public Safety. The agent denied having any conversation with me. I produced a tape recording, so the investigation was stopped.

This war analogy becomes more ominous. I know that if The John Dewey Academy fails to provide a corrective emotional experiences to help students begin to use (rather than continue to abuse) their talents, the ending will most likely be painfully tragic. If the adolescent is *lucky*, (s)he may be hospitalized. The other options are horrible: To be incarcerated, commit suicide, or be murdered.

The Intake Interview: Defining the Helping Relationship

During the intake interview with Josephine, an attractive and socially sophisticated adolescent, the sixteen-year-old tried to mesmerize and seduce me into believing that she was fine and that her problems would be self-correcting. Josephine attempted to convince me that she did not need residential placement. What this sixteen-year-old child did not know is that I have buried kids whom I loved and had the dubious honor of delivering eulogies for four. These experiences radicalized me.

Immediately, I loved this female's potential and the clinical challenges she presented—i.e., not being amenable to any treatment. I knew the stakes, as with most John Dewey students, were high. Either she would become a miraculous winner or remain a tragic loser. John Dewey students are doomed. Given their awesomely superior innate and intuitive intelligence, they can never be normal. Stated simply, they are too damned gifted in many ways. I enjoy playing this potentially deadly game with her because she was good—no, great! Josephine is articulate. Josephine is very likeable—no, loveable.

I permitted her to talk uninterrupted. She thought my smile was approval, but was wrong. I smiled because I knew she felt in control of the session as she had been with all psychiatrists. She gained pseudo-confidence because the number of doctors she had seduced was impressive. She was treatment savvy because she said the right words, but for the wrong reasons. I permitted this sham to last five or ten minutes by pretending to be impressed.

I changed my posture from slumping to sitting erect. I interrupted by inquiring, "Do you think I am so damned stupid to believe the shit you are saying? Well, little girl, let me tell you I am not amused because you try to insult my intelligence. Do you really think I am that dumb or that you are so damned slick? I have worked with your kind of kid longer than your parents have been alive! Do you have a reaction or a comment or do you want to leave? John Dewey is a voluntary school. All our graduates attend college. What is fucked up is that you will be admitted by a more prestigious college from John Dewey than from your former school! I warn you that, should you decide to stay and we decide to admit you, John Dewey will be the most stressful, terrifying, and painful experience you ever will have. If you want to play idiot games, remain a cute child,

or do not want to attend a great college, this 'ain't' [sic] the right place; but if you want to have real options when you grow up, then we are the best damn place in the world!" Even before responding, I knew that Josephine now realized who was in charge. Much to her parent's surprise, the little girl said meekly, "I want to stay." What a major victory for me. Rather than gloat or become confident I taunted her, "Why should we admit you?" In a matter of minutes, Josephine knew the "ole" man would be a formidable foe, which intrigued her for all the wrong reasons. I was prepared to wage war for the right reasons.

Josephine: A Reality Therapy Diagnosis.

Josephine appeared for an outpatient session. The psychiatrist, alarmed by her bleeding, called an ambulance to transport her to the Emergency Room. Eventually, she was taken to the pediatric ward, where she was placed on one-to-one *suicide watch*. Josephine was transferred to another facility for psychiatric inpatient treatment. There are explicit reports from the emergency room, which describe the severity of personal attacks. When released from the psychiatric ward, she was given the benign diagnosis of Mood Disorder. Incredibly, the psychiatric institution ignored the diagnosis of *suicidal ideation*. Visually, these extreme scars need no explanation. How can any psychiatrist diagnose an individual who mangles herself as having only a Mood Disorder? The *DSM-IV*, most assuredly, does not include serious self-mutilation in its diagnostic criteria for Mood Disorder!

With little effort, Josephine can create the illusion of "having it all." Externally, any grandfather or father would yearn to have Josephine as their daughter or daughter-in-law. But they would be wrong! Underneath the sweet and superficial smile, which camouflages hemorrhaging, is a lonely, confused, conflicted little girl who tortures herself physically.

After being hospitalized, predictably, Josephine was prescribed Lamactil, Klonopin, Seroquel, and Wellbutrin in an age that embraces the slogan probably proposed by a public relations specialist employed by big pharma—i.e., "better living through chemistry." When one learns, furthermore, that she has been hospitalized, there remains disbelief as to the seriousness of her condition. And finally, when one sees self-inflicted wounds on her legs, there are feelings of intense disgust. Three John Dewey Academy females have seen her legs: A psychiatrist, a psychologist, and a recovering self-mutilator whose self-inflicted wounds are ugly. Each reports that these wounds are grotesque and gruesome. While beyond the purview of this article, at this juncture, two plastic surgeons question whether surgery will be effective. A physical therapist fears that there is permanent nerve and muscle damage. The damage was so severe that Josephine needed crutches to walk and extensive physical therapy. While hospitalized, Josephine reports she was warned that this extreme kind of self-mutilation could be life threatening! Mood disorder,

indeed! She did escape, however, the favorite diagnosis "Adjustment Reaction to Adolescence."

The John Dewey Academy: A College Preparatory/Therapeutic School

Bratter (1993) writes that The John Dewey Academy is unique because its primary identity is as a school that provides individual, family, and group therapy for gifted adolescents who enter with negative self-concepts that Bratter *et al.* (2006 a & b), (2003), and Bratter (1989) describe. Most students were impulsive, with histories of extremely destructive and dangerous acting out patterns that generated these negative self-concepts. They need to establish stable identities while concurrently learning how to form positive interpersonal relationships.

The John Dewey Academy's therapeutic orientation is existential-confrontational. Students are forced not only to accept accountability for dysfunctional attitudes and acts but also to improve in a stressful, unrelenting, and uncompromising environment that demands educational excellence and personal integrity. Dewey nurtures the psychological, moral, and spiritual growth of students by creating conditions conducive to the (re)gaining of self-respect and integrity. The community insists that members become positive and productive by resolving intrapsychic and interpersonal problems while concurrently learning how to form mature interpersonal relationships. In a group setting that has escalating expectations for improvement, members relate to peers who offer insight and suggestions which provide the catalytic conditions necessary for self-exploration and change. Positive peer pressure is the primary and potent psychotherapeutic approach, which stresses empowerment. Students are *persons*, not *patients*. They are *perpetrators*, not *victims*. The treatment goal is to nurture psychological and moral growth. Gifted, creative, alienated, self-destructive, and angry adolescents respond positively to confrontation.

The Rejection of Psychotropic Medication

Breggin and Glasser (2003) were the first to reject the trend to medicate when they pronounced taking pills under medical supervision communicates the anti-therapeutic message "something is wrong with your brain, and you need a potent medication to function as 'normal.'" A decade and a half before others, Breggin (1991) attacked not only the biological theory of depression but also the use of older antidepressants to treat this "biochemical disease":

For years the dominant biological theory of depression, ...was derived from speculations on how and why medications...alleviate depression. One of the earlier groups of antidepressants, the monoamine oxidase inhibitors (MAOIs)... tends to increase the levels of available norepinephrine in the central nervous system...It was hypothesized that depression might result from the opposite-too little norepinephrine. Later studies showed some so-called

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. For example, some drugs that mimicked these biochemical effects did not seem to alleviate depression, and others that are thought to sometimes relieve depression have a wholly different biochemical mechanism. Furthermore, the supposed efficacy of the antidepressants...is much in doubt. (pp. 141-142)

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 their economic behalf.

Breggin was among the first to contend the myth of a biochemical disorder is precisely that--a malicious myth. Frighteningly, his second contention--that the only chemical disorder is the ingestion of psychotropic poisons that cause imbalances--has been ignored until recently (Breggin 2008a & b). Refusing to be silenced and often in the forefront of the fray, Breggin (2005) continued to confront the FDA when he criticized the agency for refusing to heed warnings of the increased harm posed by the SSRI antidepressants. He had exposed these risks more than a decade earlier.

Finally confirming conclusions that Breggin had documented since 1991, in 2003, the British equivalent of the Food and Drug Administration, the Medicines and Healthcare Products Regulatory Agency, notified the medical community that they must cease prescribing most SSRI antidepressants for the treatment of depression in children due to a combination of lack of efficacy and an increased risk of suicidality.

A year earlier, Connor (2004) commented, "The FDA released a statement regarding...Paxil for pediatric depression...[There] is a statement...that three well-controlled trials in pediatric patients with major depressive disorder failed to show that...Paxil was more effective than placebo. As far as I know these studies never have been published" (p. 127).

Brent (2004) observed that the "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).

Whittington *et al.* (2004) warned that children and adolescents are at risk to attempt suicide: "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).

As Breggin often has noted, 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 survival depends on this money. An editorial in *The Lancet* (2004), a respected and trusted British medical journal, concluded that research regarding selective serotonin reuptake inhibitor use "in childhood depression is one of confusion, manipulation, and institutional failure. Although published evidence was inconsistent...use of SSRIs to treat childhood depression by pharmaceutical companies and clinicians world-wide continues" (p. 1335).

Breggin has concluded that, while causing suicidality, the drugs do nothing to prevent it. Tihihonen *et al.* (2006) confirmed Breggin's contention, stating, "Despite extensive research, it has not been possible to demonstrate that the use of any antidepressant medication decreases the risk of suicide" (p.1358).

There can be no justification for the federal policy to pander to the corporations. Connor (2004) protested, "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).

The John Dewey Academy adheres to the same guiding principles as Breggin's critique of biological psychiatry-- i.e., drugs do more harm than good, and individuals need to learn to determine the course for their lives in more ethical and self-fulfilling ways. Psychopharmacologists' and biological psychiatrists' claim that intrapsychic problems are caused by metabolic disorders, genetic imbalances, and cellular deficiencies are refuted by The John Dewey Academy. Feelings of depression, pain, shame, inadequacy, and fear that overwhelm adolescents are caused by conscious dysfunctional, dishonest, destructive, and dangerous decisions, not by biological aberrations. When asked why they feel depressed or ashamed, students provide realistic explanations. The John Dewey Academy asserts that personality and affective disorders are rarely cured by medicinal approaches; no pill can teach self-respect or cure noxious narcissism, dishonesty, and anti-social attitudes. No psychotropic mood or mind-altering medication, therefore, is prescribed at John Dewey. Drug- and psychotropic medicine-free are viable treatment goals.

Breggin (1996) roils against the brain dysfunction assumption by exposing its counter-therapeutic message:

The biopsychiatric approach...reinforce[s] the patient's worst feelings and attitudes. The patient...feels helpless--at the mercy of forces beyond his or her control...Often the patient feels mentally defective. Unfortunately, the biopsychiatrist's approach will encourage the patient to think and act like a helpless victim of overwhelming forces, namely genetic and biochemical abnormalities...This further reinforces the patient's self-destructive helplessness (p. 4).

Breggin discusses the roles of empathy and love in the psychotherapeutic process. To love and be loved, Breggin (1997) contends, "is... to feel empowered--to feel in control of one's... spiritual state" (p. 78).

Breggin urged that psychotherapy attempt to empower those who seek help to become persons who "are active forces in their... lives." Rightfully, Breggin (1997) suggested that the sense of helplessness needs to be resolved:

Behind emotional psychological helplessness lies a subjective judgment about our...capacity to handle ourselves and our lives... As a healing person, nothing is more crucial than encouraging people to overcome... feelings of helplessness. Helplessness reflects a judgment... that nothing can be done... The alternative to helplessness is a feeling of self determination and mastery, the sense of taking control over one's... feelings and thoughts, and giving direction to one's life (pp. 72-73).

What makes "giving up" or quitting so debilitating is "when a feeling of helplessness... [increases, because the individual] may lose control in reaction to a seemingly slight frustration"(p. 73).

In philosophical terms, they have autonomy and are capable of self-determination... Because human beings must exercise free will... to survive and to prosper, they need...personal freedom... Approaches to deeply disturbed human beings should... respect their autonomy, independence and freedom... Empowerment involves self-understanding, moral encouragement through a caring relationship, and guidance toward... autonomous and loving principles of life... Deeply disturbed people should be viewed as... struggling to survive and to grow--as persons in conflict with themselves and with [others]. Healing comes through a combination of self-development and beneficial relationships (pp. 2-3, 7).

Breggin (1991) correctly identified this therapeutic challenge when he proposed that each person needs to "choose whether or not to overcome any hardship or oppression inflicted by the family, society, or psychiatry. Human beings retain... free will... Indeed, without the exercise of that flickering will, there is no hope... that is the helper's role, to encourage every hint of self-determination" (p. 45).

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).

Toward a Rational and Effective Treatment Approach: Compassionate Confrontation

While Glasser may disagree, three guiding principles of reality therapy form the core of compassionate confrontation. First: To encourage the youngster to evaluate behavior. Second: To force the youth to accept responsibility for conscious choices. Third: To help the teenager make a commitment to change constructively and creatively. Reality Therapy has been erroneously criticized as simplistic and superficial. One of the first advocates of this approach to therapy, Glasser viewed persons to be either responsible or irresponsible. Until gifted, deceitful, and

masochistic teens can be convinced to take control of their lives, these youngsters will refuse to change. Breggin (1991) correctly identifies the correlation of choice to treatment outcome when he writes "every individual must choose whether or not to overcome any hardship or oppression inflicted by the family, society, or psychiatry...indeed, [it is] the helper's role to encourage... self-determination" (p. 45).

No one denies that confrontation psychotherapy, at times, can generate much personal pain. Van Stone & Gilbert (1972) describe this pain generated by a self-help confrontation group as a psychotherapeutic orientation when these two psychiatrists write:

Each member... is... [confronted] with candid, personal facts regarding every observable behavior or attitude recognized by the group as being self-defeating or dishonest. If the member... attempts to explain or deny any observation, [s]he is ridiculed, browbeaten, shouted down, and insulted [when peers]... hammer away at the distorted ideas that he offers in support of his damaging behavior patterns. Intellectual insight or genetic self-interpretations are derided as an escape from responsibility for current behavior. Honesty, trust in the group, realistic self-assessment, appropriate emotional release, and changed behavior... are rewarded by sympathetic counsel and encouragement from... members (p. 585).

Sifneos (1991) warns the therapist who uses confrontation to be cautious but optimistic that this treatment orientation:

will [stimulate]...self-understanding...be beneficial to the patient. He must...be convinced that the patient [can]...withstand considerable stress...[Effective] confrontation must be based on the therapist's observation about a series of paradoxical behavioral patterns, contradictory statements, [self-destructive acts]; and by arousing the patient's feelings, it must motivate him to look at himself from a different point of view (pp. 374, 382).

Psychotherapy with gifted, manipulative adolescents who engage in deceitful, destructive, and dangerous behavior has two sequential phases. First: To *unlearn* and reject malignant attitudes and acts. Second: To *learn* how to become honest, responsible, and value self-respect as the *summum bona*.

Carkhuff & Berenson's (1972) four-decade-old definition remains relevant:

Confrontation helps the confronted understand: his strengths and resources, [and]...self-destructive behavior...It is directed at discrepancies...between what the client says and does...and between illusion and reality...It implies a constructive attack upon... unhealthy...illusions, fantasies, and life avoidance techniques...to create a reintegration at a higher level of health" (p. 171).

Complicating this seventeen-year-old's commitment to change is the fact that she knew her sentence at Dewey would be two and a half years, which for any adolescent feels like an eternity. Thus, there was no inducement to change quickly. Fortunately, I am impatient, so I escalated confrontations. What happened is that Josephine slowly began to trust, respect, and, yes, even like me.

After three months, I suggested that Josephine consider showing her scars to her parents. I knew secrecy would retard the recovery process. Being concerned about parental shock and overreaction when they saw the wounds, I demanded that two female Dewey staff attend. The Dean of Students and our consulting psychiatrist were there. When asked if I wanted to witness, I declined. I did not want to be a voyeur and, more important, I did not want to see the wounds. Josephine revealed her scars to the two Dewey staff members and to one of our students, a recovering self-mutilator. This act probably signaled that Josephine had determined she wanted to change. The conspiracy of silence had been shattered. Two months later, to my surprise, Josephine volunteered to show ugly and graphic color photographs of her infected wounds (which she had previously put on a website for self-mutilators) to the John Dewey community. I tried to discourage her, but she persisted. Though never seeing the pictures, I feared these self-inflicted mutilations would disturb peers. Josephine fetched the pictures, which she circulated. This ghoulish act lasted for an hour! My reaction when viewing these photographs? I was horrified that any intelligent person could intentionally hurt herself. These self-inflicted lacerations were more brutal than had she been attacked by a sadistic criminal mutilator. She had brutalized herself with an extreme self-hatred and vengeance. Josephine cleverly hid these extreme slashes from the world. Josephine had severed some muscle. She had acquired a scalpel with which to cut herself. The *piece de resistance* was that she inserted a needle to ascertain how deep the numbness was. The three inch needle broke and remained embedded in her leg. Her mother opposed removing the needle, but I prevailed. As I expected, it was simple surgery. These lesions are the ugliest and deepest that I have seen in a career which approaches the half century mark. I cannot explain the desperate pain caused by self-hatred acts. No person has such a high tolerance of pain to endure self-inflicted suffering. Josephine, indeed, was fortunate to survive this ordeal. Had Josephine been unlucky, she could have severed an artery, had her leg amputated from a class A infection, or died!

This adolescent's recovery has been facilitated by another self-mutilator who wore short sleeves to reveal ugly purple slashes. What needs to be noted is that others made significant contributions to Josephine's rehabilitation. Without peer input, this process would have taken longer or, more frighteningly, never happened. My role has been not only to confront but also to elicit and coordinate peer help.

CONCLUSION:

A Happy Ending

While there is tangible and compelling evidence that Josephine has miraculously transformed herself, I am reluctant to concede these changes are permanent. This seventeen-year-old confronts others and in so doing con-

fronts herself. She has become a respected, trusted, admired moral leader. If a gun were placed to my head and I was ordered to give a prognosis, I would respond that Josephine's prognosis has tentatively been modified to guardedly optimistic. I am in no hurry to celebrate because it is premature. I am in a clinical no-win quandary. If I trust prematurely and am wrong, I forfeit therapeutic integrity, but if I withhold approval I can retard/damage the treatment alliance. I intend to proceed slowly. If forced to wager today, however, I would bet huge sums that this young self-mutilator will graduate from a more prestigious college than most of her physicians whom, I contend, violated the Hippocratic Oath because they did harm by not only refusing to confront deliberate deceit but also prescribing potent psychotropic medicine when there was no evidence of the existence of a chemical imbalance! Simply stated, there is no psychotropic medicine that *cures* deliberate deceit or *produces* self-respect.

When I feel comfortable that Josephine is on solid ground, I will suggest she send copies of her article to those physicians who worked with this remarkable adolescent. My intent is not to wound or gloat, but rather to educate them.

Finally, I extend my appreciation to Jason Rosenfeld, who will hopefully be attending Columbia College next year, for his help in editing this letter.

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