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## Preliminary Observations and Reflections on Conscience Sensitive Group Therapy

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### Abstract.

**Objective:** This is the first in a series of articles to characterize and critically consider recently employed forms of conscience sensitive psychiatric treatment of children and adolescents.

**Method:** Modules were designed based upon domains of conscience functioning identified in empirical research and applied to recognized benchmarks for interventions in the treatment of psychopathology. Each module was designed to be sufficiently complete such that full participation from persons entering the cycle of modules at any point would not be compromised. One of the authors paired with interested, experienced therapists in existing programs to conduct and refine interventions in a group psycho-educational therapy format.

**Results:** Over one hundred and fifty hours of conscience sensitive psycho-educational group therapy were conducted in therapeutic loci within a well-established, community-based continuum of care. The therapeutic loci ranged from a child and adolescent psychiatry outpatient clinic to a closed youth residential setting and included adolescent psychiatric intensive outpatient and partial hospitalization programs. Number of participants in any module varied from one in the outpatient locus to fifteen in the intensive outpatient locus. Age of participants varied from school age to late adolescent. Formal intellectual testing was not uniformly available for participants. Most however appeared to be average intellectually. Each participant had, at minimum, an initial assessment by a mental health clinician yielding a DSM IV multi-axial psychiatric diagnosis. No restrictions were placed upon participants in terms of principal or secondary diagnoses or severity of impairment although all had sufficiently severe impairment to be deemed in need of the aforementioned current and standard psychiatric or psychosocial interventions. Length of time for each of the seven modules was permitted to vary according to the stability of the participant population. Individual modules conducted in the adolescent psychiatric intensive outpatient program were limited to one hour each, whereas some modules conducted in the residential and youth day school settings extended over several sessions held once weekly. Seven modules were eventually developed and refined to comprise a full course of conscience sensitive psycho-educational group therapy.

**Conclusions:** Each of the seven modules in its current stage of development and refinement is characterized in terms of praxis, but also considered critically in terms of treatment philosophy. Conscience sensitive group psycho-educational therapy can be conducted in child adolescent psychiatric therapeutic loci ranging from outpatient to closed residential programs. Constraining variables were encountered in the adolescent intensive outpatient program when census became large, and turnover rapid, in consequence of which the full cycle of seven modules conducted at a frequency of one per week could not be completed by many participants. This could be remedied by conducting sessions more frequently, perhaps two to three times per week, and offering a sufficient number of groups to ensure that the number of participants in each group does not exceed eight. In the outpatient setting, there were fewer referrals than had been hoped, perhaps because of limitations upon reimbursement for the total number and/or kind of therapeutic interventions, a condition which, in the local mental health community, favors individual psychotherapy over group psychotherapy. However, the possibility cannot be excluded that there have been referral biases or parental preferences in favor of groups with a more readily recognizable focus such as anger management or social skills over a novel, less familiar approach.

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**Key Words:** conscience sensitive, child and adolescent psychiatry, benchmarks for intervention, psycho-educational, group format.

## **Introduction.**

Current practice parameters for psychiatric assessment of children and adolescents (see outline form III E 9) specify that the parent interview should address, as part of the developmental history in the context of the family, "Conscience and Values":

- a. Assess conscience in terms of:
  - (1) Age appropriate development,
  - (2) Specific areas of harshness, laxness, or conflict;
  - (3) Effectiveness in helping child conform to expected family and community norms;
- b. Religious or ethical concerns;
- c. Goals and future aspirations:
  - (1) How realistic;
  - (2) How congruent with family's values and expectations.

A recursive procedure is embedded in the parameters pertaining to the child interview (see outline form IV C 4) insofar as the "[s]tructure of the child interview includes, as developmentally appropriate, in flexible order:

- ...
- (4) Major realms of functioning (as outlined in developmental history)
- ...

(American Academy of Child and Adolescent Psychiatry Practice Parameters, 1997).

The practice parameters are mute on the subject of how these tasks are to be accomplished and what occurs in actual practice is a current mystery. Older practitioners in child and adolescent psychiatry will recall the prior gold standard for the mental status examination of a child did not refer to 'conscience' per se, but to the psychoanalytic construct of superego, subsuming ego ideals and values, and their integration into the personality (Simmons, 1987). Some practitioners may be influenced by Kohlbergian cognitive developmental approaches to moral judgment (Gibbs, 1995; Gibbs, Potter and Goldstein, 1995; Lapsley, 1996; Wolff, 2002) They may then integrate their impressions of how a youth handles moral dilemmas hypothetically posed (or emerging in conversation) with historical data culled from the interviews of the parent and the child. Descriptors (examples may be found in Gibbs, et al.; 1995 and Lickona, 1983) may then be applied which are consonant, more or less, with formal stages in moral cognitive development. To the extent that the practitioner is attuned to moral emotionality, cognitive developmental descriptors may be supplemented by global impressions of empathic responsiveness (or the lack thereof) à la Hoffman (Damon, 1988; Hoffman, 1991; Lapsley, 1996; Wolff, 2002). Some clinicians may have been influenced by integrative perspectives represented in the literature (Navàez and Rest, 1995; Eisenberg, 1995). Still other practitioners may rely upon items endorsed by parents on dimensional ratings of youth psychopathology (e.g. The Child Behavior Checklist, Achenbach, 1985) or parent interview questions modeled upon such items. It is noteworthy that several of these items call for an interpretation of affect, for example: 'lacks remorse', and 'doesn't experience guilt after misbehaving.'

## **Conscience Sensitive Assessment and Diagnosis**

Stages of conscience formation and domains of conscience functioning have been identified based upon empirical research conducted in the 1980's with relatively advantaged youth of a Midwestern state, ages 5-17 (Stilwell & Galvin, 1985; Stilwell, et al., 1991; 1994; 1996; 1997; 1998). These stages and domains have also been found to have broader applicability to similar aged youth with adverse life circumstances in the form of maltreatment and natural catastrophe. Seriously, emotionally disturbed boys in a state hospital who had endured early maltreatment were apt to have more developmental delays in conscience formation and more psychopathological interference in conscience functioning than either their relatively advantaged counterparts or other seriously emotionally disturbed boys in hospital who had been

spared from the experience of early maltreatment (Galvin, Stilwell, Shekhar, Kopta, McKasson and Carl, 1997). In contrast, youth who survived an earthquake that devastated Spitak, Armenia in 1988 demonstrated a mix of accelerations in conscience formation and psychopathological interference in conscience functioning (Goenjian, Stilwell, Steinberg, Fairbanks, Galvin, Karayan, 1999). From these researches, as well as ongoing clinical and teaching experiences, evolved a theory of conscience, which can be distilled to three concepts: invariant hierarchical stages, interdependent domains and intrinsic values. The basic ideas of conscience sensitive psychiatric interview techniques built upon research experience with the Stilwell Conscience Interview (SCI) and conscience sensitive multi-axial diagnosis in maltreated children and adolescents have been put forth in this journal (Galvin, Stilwell, Adinamis & Kohn, 2001). A global assessment rating scale of psychopathological interference in conscience functioning has also been developed to assist in treatment planning (Stilwell, 2003).

### **Conscience Sensitive Treatment Planning and Treatment**

In general, one has the expectation that if competencies, delays and deficiencies are to be assessed in any particular developmental domain, the assessment is conducted for the sake of planning and carrying out effective treatment or providing necessary services. In accordance with this general expectation-even if 'conscience' is not explicitly mentioned- moral developmental interventions have indeed been included by many clinicians and clinical theoreticians among their therapeutic desiderata. As a first consideration, what has been written about raising and educating youth in a manner informed by moral developmental psychology (Berkowitz, 1997,1998; Coles, 1997; Damon, 1988; Lickona, 1983; Stilwell, Galvin and Kopta, 2001) and also what has been written about fostering moral philosophical development in youth -even in quite young children (Matthews, 1980, 1984, 1994) have *prima facie* applications to youth whose special psychiatric needs prompt clinical referral. The question must still be put: 'What is necessary to transform moral education into moral psycho-education for those with moral developmental delays or psychopathological interferences?' Aichorn's seminal work with 'wayward youth' (Aichorn, 1935), Kohlberg's 'just community' (Gibbs et al. 1996), Garbarino's recommended programme for 'lost boys' (Garbarino, 1998) are some benchmarks for projects involving youth with what, in current clinical parlance, have come to be termed *externalizing disorders*. As a very recent example, current practice parameters for the assessment and treatment of sexually reactive adolescents refers to attaining treatment goals relevant to victim awareness and empathy, values clarification and impulse inhibition (American Academy of Child and Adolescent Psychiatry Practice Parameters, 1999). However, comprehensive mental health centers, psychiatric services in community hospitals, and outpatient clinics do not only treat youth with externalizing disorders. These service lines may chiefly offer broad spectrum group therapeutic modalities including cognitive behavioral interventions, stress management, skill building, aggression replacement training, anger management, as well as psycho-educational interventions for a variety of disorders afflicting youth: externalizing, internalizing and combinations.

This is the first in a series of articles to characterize and critically consider recently employed forms of conscience sensitive psychiatric treatment of children and adolescents. The series, as envisioned, will continue by including further commentary on the subject of this article from co-therapists and applications of conscience sensitive psychiatry to individual treatment in the acute psychiatric hospital setting.

#### **Method.**

Therapeutic loci were selected within a well-established, community-based continuum of care.<sup>1</sup> Daylong workshops<sup>2</sup> were conducted by the authors for interested mental health clinicians to acquaint them with the Indiana University Conscience Project, with the following goals:

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<sup>1</sup> The authors gratefully acknowledge the in-kind support provided by St Vincent's Stress Centers Indianapolis, Indiana: Paul Lefkowitz, PhD., Clinical Director and Jerry Fletcher, M.D. Medical Director Child and Adolescent Psychiatry, Bev Berger, RN, Coordinator for Youth Day School, Partial Hospitalization and Intensive Outpatient Programs, Mimi Brittingham, MSN, CS, LMF, Site Coordinator for Meridian Youth Child and Adolescent Psychiatry Outpatient Services, Marjorie Cline LCSW, and Julie Martin MS, LMHC; Children's Bureau Incorporated Retreat : Jon Bennett, Senior Vice President, Janet

- 1) To provide them with direct personal experience of a secular, psycho-biologically based examination of conscience using an adapted version of the SCI developed for coursework in Conscience Centered Professional Ethics (Galvin, Gaffney, Stilwell and Abram, 1997)
- 2) To review with them research findings summarized in the above **Introduction**
- 3) To discuss previously employed clinical applications of the SCI to assessment and treatment planning and,
- 4) To lay the groundwork for conscience sensitive group therapy.

Preliminary discussions of applications of Conscience Theory to treatment had been the object of a special interest group, the Conscience Study Group at Pleasant Run Incorporated, which convened regularly at a community based residential treatment center.<sup>3</sup> Several ideas for therapeutic tasks embedded in the modules emerged from these discussions. The modules were designed based upon domains of conscience functioning. The pertinent question set from the SCI is identified for each module in the **Discussion** section below. Applications were made to recognized benchmarks for interventions in the treatment of psychopathology. Each module was designed to be sufficiently complete such that full participation from persons entering the cycle of modules at any point would not be compromised. One of the authors paired with interested, experienced therapists in existing programs to conduct and refine interventions in group psycho-educational therapy format.

## Results.

Over one hundred and fifty hours of conscience sensitive psycho-educational group therapy were conducted in therapeutic loci within a well-established, community-based continuum of care. The therapeutic loci ranged from a child and adolescent psychiatry outpatient clinic (cumulative N= 13, age-range 12-14 years old) to a closed youth residential setting (cumulative N=28, age range 9-17 years old) and included a semester based youth day school (cumulative N= 14, age range 7-16 years old), adolescent psychiatric intensive outpatient (cumulative N= 40, age range 12-18 years old) and partial hospitalization (cumulative N=31, age range 13-18 years old) programs. Number of participants in any module varied from a single participant in attendance in the outpatient locus to fifteen participants in the intensive

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Meeker, Program Manager, Julia Bradshaw, Therapist; and the Indiana University School of Medicine Conscience Project, Meg Gaffney, M.D., Director.

<sup>2</sup> Workshop at St. Vincent's Stress Center (Day School and IOP), 5/21/01, conducted with Meg Gaffney and Barb Stilwell.

Guests Rita Kohn and Neal Wilkey.

Workshop at Children's Bureau Incorporated 1/30/02:

with Meg Gaffney, Barbara Stilwell

and Guest: Sandy Laramore Ferraro.

<sup>3</sup> As Clinical Director of Pleasant Run, *Kim Haga, PhD*, directed that Dr. Tom Battocletti's Work/Study Group be reorganized to consider how conscience could be incorporated in treatment. Participants in these various groups included I.U. Conscience Project members and several PRI clinical, administrative and support staff united in their interest in conscience, in alphabetical order: *Tom Battocletti, Sue Brown, Janet Carlson, Kanasha Crawford, Meg Gaffney, Matt Galvin, Gayle Harrell, Cynthia Holloway, Erron Kelly, Rae Lynn Kelly, Rita Kohn, Kinzua LeSuer, April McWilliams, Brenda Melton, Mary Jean Pies, Maroline Ritter, Deborah Stamper, Monte Stevenson, Barb Stilwell, Sue Walker and Neal Wilkey*. The nursing contingent among these participants, Ms. Stamper, CNS, Ms. Kelly, RN and Ms. Harrell, RN, and Dr. Wilkey, a fourth year psychiatry resident at I.U. began with Dr. Galvin the task of developing a format for conscience sensitive psychoeducational group therapy. The first group was brought to premature closure when, after 134 years, Pleasant Run was obliged to close its doors.

outpatient locus. Formal intellectual testing was not uniformly available for participants. Most however appeared to be average intellectually, some appeared to have above average or borderline intellectual functioning and only a few were classified as mildly mentally handicapped by testing from their schools. Each participant had, at minimum, an initial assessment by a mental health clinician yielding multi-axial psychiatric diagnoses per The Diagnostic Statistical Manual IV (APA, 1994). The community-based continuum of care has a specialized program for primary diagnosis of adolescent substance abuse, which was not included in the study. No restrictions were placed upon participants in terms of their principal or secondary diagnoses or severity of impairment although all had sufficient severity of impairment to be deemed in need of the aforementioned psychiatric or psychosocial interventions. Length of time for each of the seven modules was permitted to vary according to the stability of the population in the therapeutic setting. Individual modules conducted in the adolescent psychiatric intensive outpatient program were limited to one hour each, whereas some modules conducted in the residential and youth day school settings extended over several sessions held once weekly. Seven modules were eventually developed and refined to comprise a full course of conscience sensitive psycho-educational group therapy.

## Discussion.

For purposes of this discussion, each module will be described separately in terms of the SCI questions and therapeutic tasks employed. Meta- (moral)-psychological (or moral philosophical) considerations that have arisen are presented in the context of each module as it is characterized in praxis.

**Psycho-educational Group Therapy (CST-Group TX)**

- seven interchangeable modules
- closed groups may lengthen the number of sessions for each module
- in open groups, modules are each one hour
- participant observation from youth care workers

**CST-Group TX (cont'):**

- process issues are made part of the examination of conscience
- modules are designed according to domain
  - each module has a unique question set to be covered in discussion
  - each module has a specific therapeutic task to be completed
  - each module has an intrinsic value to be identified

**CST-Group TX Foundation Work**

- personal matters: thoughts, feelings, values, choices, behaviors
- circle of confidentiality (respect for autonomy)
- participation (contributory value)
- regulation of self disclosure (respect for privacy)
- respect for other's disclosures

A Youth Care Worker's Conscience



This image of conscience was rendered by a youth care worker. She explained the elements in writing:

- "1) Cross because Christ is the center of any decision (Christian upbringing).
- 2) Parents' disapproval (or teachers, bosses, etc).
- 3) A clear conscience lets me sleep well
- 4) A clear conscience lets/helps me see the beauty in nature and others.
- 5) If I intentionally make a wrong choice, nothing good will come of it and could invoke the wrath of God, others, or anger towards myself.

**First Module: An Exercise in Moral Imagination**  
**SCI Questions 1, 2, 11.**<sup>4</sup>

What considerations stand in favor of:

- 1) posing the questions  
    *“Have you heard the word **conscience**?”*  
    *“What does it mean?”*
- 2) penetrating to the heart of the matter by asking,  
    *“What does the word mean to you, personally?”*
- 3) giving the instruction,  
    *“Describe your own conscience,”*
- 4) then making an assignment to:  
    *“Use your imagination and draw a picture of your conscience.”*

**CST-Group TX: 1<sup>st</sup> Module**  
**The Question Set**

- general and personal definitions of conscience
  - written down before any discussion
  - alternative interrogatories and directions according to cognitive level
  - assurances that responses will not be treated as incorrect

Why couple these interventions with the two-fold assurance that there is no expectation of correct or incorrect answers and that there will be no preferred definition revealed and promulgated after discussion? Why imply that the personal definition is superior to a conventional definition? Is this done in an effort to adhere to some form of moral relativism?

The Möbius strip is sometimes offered as a representation of how the mind-body ‘problem’ (in its most contemporaneous form, the phenomenon of consciousness) may be resolved (or dissolved). When traced, the apparent inside of this loop is found to be continuous with the apparent outside. The Möbius strip is offered as mute testimony to false dichotomy. On this view there is no inside or outside—simply one ‘side’, not otherwise specified. Analogously, it is argued, mental state (interior, inner state, subjective) descriptions and brain-state (exterior, objective) descriptions falsely dichotomize a monistic reality, not otherwise specified (Hofstadter, 1979; Trimble, 2002; Schiller, 1982). This argument from analogy, while appealing to the imagination, falters. For one thing, a genuine alternative to taking either an inside-out approach or an outside-in approach eludes description. Allowing ‘in’ to vanish altogether is the chimerical goal of the eliminative materialist program. For most, this is a disagreeable process that, consistently applied without boundaries, would eliminate goal directed investigation into brain states and eventually the eliminative materialist *program*, itself, insofar as programs are executed according to goals and objectives (i.e. outcomes of valuational processing). For another thing, the Möbius strip yields the secret of its nature only after its loop appears to have been fully traversed. The loop that is variously and inadequately described by brain states and mental states, including consciousness, does not seem susceptible of such a roundtrip. There is not anything like an epiphany, an ‘Ah-hah!’ experience: “I had thought I was on the inside looking out but now methinks I am on the outside looking in.”

Whatever else is said of it, conscience is a form of consciousness. It is moralized consciousness. As a form of consciousness it is bound to draw subjective experience into the definition. Without the subjective experience represented any attempted definition of conscience is suspect. Who is more expert about the unique contours of conscience than the person to whom it belongs? True, the outward signs of conscience like the outward signs of other forms of consciousness can be described objectively by others. By virtue of experiences with others, which, by the way, already require subjective correlation, and perhaps also by virtue of empathic responsiveness, which requires inter-subjective resonance, one person is able to draw inferences about the conscience of another person. However, the inferential enterprise in which the subjective account is rejected or reduced produces scant information in comparison to the inquiry that aims to engage the moral personhood of another. The inferential enterprise that does not take into account the other’s moral personhood is impoverished in more ways than just the low yield of clinically relevant data. An opportunity for healing or flourishing is missed. If a conventional definition is externally imposed, the subsequent description of inner states of conscience can still be elicited but will lack meaning for the person of conscience. On the other hand, each invitation to conceptualize conscience generates a new and viable definition allowing the person to compose the good life in narrative form, to make of the diverse domains of personhood a moral whole. When a person is asked to describe the inner states of conscience, to compare and contrast these with received knowledge about the word, that person has an invitation to

<sup>4</sup> The SCI is available at this URL, [shaw.medlib.iupui.edu/conscience](http://shaw.medlib.iupui.edu/conscience)

See: Stilwell, B. (2003): Trauma, moral development, and conscience functioning. **Conscience Works: Theory, Research and Clinical Applications** 2 (1): Appendix A.

exercise moral imagination, to render an account of mindfulness that includes, literally, the moral of the person's life-story thus-far.

Far from beginning with an unconstrained moral relativism or value neutrality in the service of value clarification, the facilitators' first questions uphold values intrinsic to conscience: respect for autonomy and respect for **meaning making**. Even so, it is not until conscience drawings are requested that the persons of conscience are certain that what is being truly encouraged are their individualized conceptualizations. Once they are asked to draw, they are closer to allowing themselves free rein to treat conscience metaphorically. They are encouraged to bring moral imagination to bear on the composition of moral being. Discussions of concepts are enlivened.

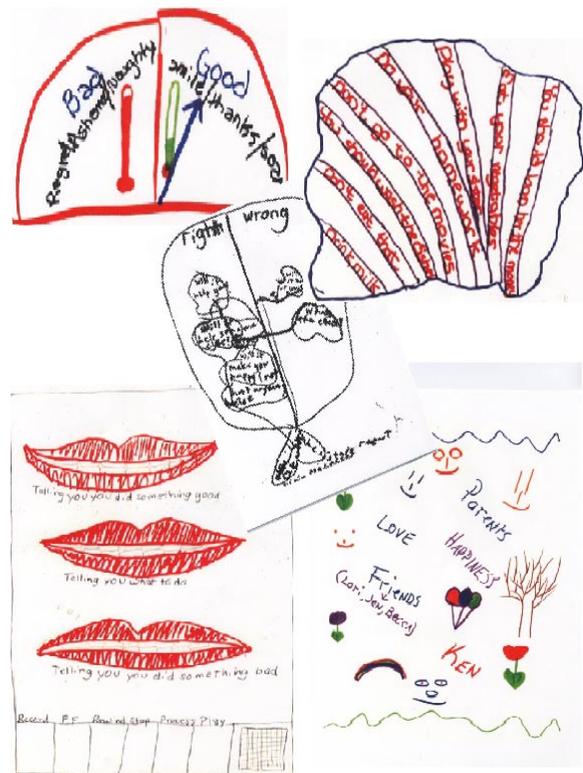
**CST-Group TX: 1<sup>st</sup> Module**  
**The Conscience Drawing**

- The Image of Moralized Consciousness
  - requested prior to any discussion of the written definitions
  - associations encouraged

### The Composite Conscience.

Each group has been different. Nonetheless, most participants have listened to one another sufficiently well that they readily produce a composite conscience identifying at least some of the domains recognized from our empirical research with advantaged children. They use cognitive and/or emotional and/or valuational, and/or volitional and/or relational descriptors. Key words are identified from the discussion, and made visual on the board. The key words are then organized according to the known domains and a first approximation of the group's composite conscience is made. In the event that a particular group does not represent a domain, the relevance of the missing domain for other groups can be the subject of supplemental remarks by the facilitators. After preliminary discussion, when age-appropriate to use, the 15-minute video **Conceptualization of Conscience** (Stilwell et al., 1990) can be shown. It is best to put the video in pause mode after each set of drawings to elicit discussion from the group before listening to the recorded analysis. Often, group participants make many pertinent observations approximating to the theory of stages of conscience development. This realization can be revisited in subsequent conversations about delays in conscience formation and psychopathological interference in conscience functioning.

The goal is to introduce the notion of stage development without pursuing it to the point that participants engage in staging (and/or 'upstaging') one another. Rather, once the group composite conscience is characterized, the notion of *contours of conscience* can be raised with the aim of fostering tolerance (and eventual celebration) for diversity in moral lives.



Clockwise from the top left: conscience images with salient contours in moral emotional, moral valuational, moral attachment and conceptual domains. Center drawing: moral valuation and volition.

Sometimes it is helpful to explicate and illustrate how the inner states participants describe are intimately connected but not reducible one to another. Called for are brief, consistent and gently applied

correctives to our folk psychology which limits itself only to the more familiar terms *thoughts* and *feelings* mirroring a dualistic academic psychology which often names only *cognitions* and *affects*, respectively. Efforts to smuggle in moral psychology in the guise of ‘social–cognitions’ and ‘social–emotions’ because of embarrassment over moral language, notwithstanding, there exists a gap that can only be closed by explicit use of terms like ‘conscience’ in moral psychobiology. An illustration of this gap follows:

One university professor approached after the authors had conducted a workshop on conscience centered professional ethics. She had enjoyed our workshop, she said, but related ruefully that in her academic department, “We avoid the idea of conscience like the plague.” Her department, we learned, was ethics.

Moral philosophy is not the only discipline in which some regard the word conscience with disfavor. Not so long ago, the emergence in therapeutic conversations, including supervisory experiences, of modal modifiers characteristic of moral language, e.g. ‘shoulds’ and ‘shouldn’ts’, were regarded by psychotherapists as signs of at least faulty cognition if not compulsive psychopathology. We, who matriculated in professional schools in that era, may have more or less successfully expunged from our clinical dialects any use of *shoulds* or *shouldn’ts* so that we would not be accused of inconsistency when we directed our patients to eschew the same words. We may even have found means to convey our healing values through circumlocution or non-verbal legerdemain. After so many years of this, we may now find ourselves in the position of being more embarrassed by moral language than by explicit sexual language. A worthy aim is to desensitize persons, including ourselves as therapists, to a freer use of moral language. It can be pointed out that we commonly *evaluate* our own and others’ thoughts and feelings or that they come framed with a valence. *Re-framing* is above all else a valuational enterprise.

Adding valuational to cognitive and affective description enriches the psychological characterization of complex inner states. Despite this enrichment, the proposed psychological explanation has not yet acquired the rudiments that make it adequate. In some psychological explanations, choosing--volition--itself is left as embarrassingly unaccountable. Volition, like valuation, is irreducible and has its place in an adequate psychology of inner states.

At this juncture, it is not uncommon to have the first opportunity to characterize defenses operating against conscience activity even at the level of language. It may be remarked, for example, how we prefer to say, “I made a mistake,” instead of “I did something wrong,” or how we like to disguise and dismiss our moral approval of right and good actions with the aesthetic remark, “That’s cool.” Participants have generally appreciated when we as counselors acknowledge our tendency to conceal our moral values in language about this or that lifestyle choice being healthy or unhealthy, that or this behavior being adaptive or maladaptive. The question may be raised, “What about the tenet of our professions to be non-judgmental?” The response may be given that striving to be non-judgmental is not the same as striving to be value-neutral. Simply stated, “I expect to find something-many things in fact- to approve about you as a person of conscience.” Simply stated, “I will make no effort to conceal that I uphold a set of values known as *healing values* that I believe are built upon the bedrock values of conscience itself.”

### CST-Group TX: 1<sup>st</sup> Module Extraction of the Intrinsic Value

- Conceptualization of Conscience/ Moral Imagination as a moral psychological domain
- **Moral Meaning Making** as the intrinsic or bedrock value associated with the domain
- The Allure of Value

### CST-Group TX: 1<sup>st</sup> Module Intrinsic Value: Meaning

- strengthening the domain
  - exercising moral imagination for achieving moral health (e.g. Shelton)
  - opportunities to identify moral issues (Right vs. Wrong)
  - opportunities to identify moral dilemmas (Right vs. Right)

**Second Module: Moral Connections**  
**SCI Questions: 6, 7, 9, 10, 12, and 13.**

**The Moralized Time-Line**

**CST-Group TX: 2<sup>nd</sup> Module**  
**The Question Set**

- early moral memories
- who has cared the most about your conscience?
- moral mandate attributions



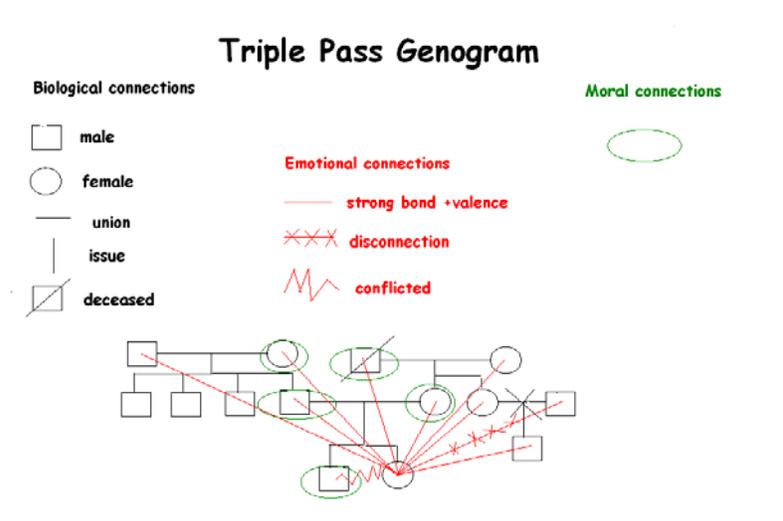
**CST-Group TX: 2<sup>nd</sup> Module**  
**The Moralized Time-Line**

- retrieving memories of disapproval
  - (depression makes it easy)
- retrieving memories of approval
  - (depression makes it hard)
- changes in how appraisals are appraised
  - (overvalued devaluations)
- attaching importance to an attachment figure
  - (changes in the lifespan)

The questions posed include the Moral Attachment Questions from the SCI. The first delve into early memories of approval and disapproval and an invitation to evaluate each in terms of the effect upon the person, the moral lesson imparted. In the individual mental status examination, three out of three items may be readily retrieved by a person in testing of immediate recall, and relatively value neutral events, such as what was had for breakfast, from recent memory. However, a person of conscience subject to depression, to dissociation or to low self-esteem concomitant with other conditions such as the experience of childhood neglect, is apt to have impoverished early, remote and recent memory for experiences of approval. Be prepared. The assignment to retrieve moral memories may prompt recollection of maltreatment experiences or harsh, punitive treatment. A person with disruptive behavior disorder is apt to have less difficulty retrieving recent experiences of disapproval, but may still have difficulties retrieving early memories of appraisal of any sort or may dismiss the question by conveying the information, “I’ve never had the experience of approval only disapproval.” These are all opportunities for psycho-educational interventions regarding psychopathological interference. In particular, the notion of depression as a valuational as well as a mood disorder may be introduced, in passing, with agreement to defer in-depth discussion until the appropriate module. Therapeutic opportunity also emerges when pushing back the **Moralized Time Line** beyond more recent memories of approval to more distant ones, diverting the participants from depressive cognitive pathways. Of course embedded in the moral memory is the experience of moralized attachment.

**The Triple-Pass Genogram**

Figure 1:



Moralized attachment is approached more explicitly in the assigned task of constructing a triple pass genogram. The conventional symbology of genograms is first taught to older participants. The first pass elucidates biological connection and disconnection using standard genograms and offers another opportunity to describe how biological conditions may be a threat to conscience formation and functioning. Biological conditions may be heritable or may consist of environmental modulation of genetic expression as, for example, in the transduction of stress responses to adversity into depression.

**CST-Group TX: 2<sup>nd</sup> Module**  
**The Triple Pass Genogram**

- teaching the symbolic notation
- first pass: biological connections
- second pass: emotional connections
- third pass: moral connections
- reconstruction of the genogram for the group
- intergenerational transmission of values

The second pass elucidates emotional connection (affiliative and conflictual aspects each represented) and disconnection (including loss). Emotional attachments are depicted by rays emanating from the proband symbol. Participants often develop their own notations and this practice may be encouraged. However in cases where individualized symbology is not forthcoming or where uniformity is preferred for the sake of communication, the double bond and the lightning flash zigzag are serviceable to represent close and conflictual relations, respectively. These lend themselves metaphorically to making the homework assignment, at the conclusion of the module, to strengthen a connection or to smooth out some of the rough edges in a selected attachment relationship.

The third pass elucidates moral connections. Moral connections may be conceptualized according to the SCI questions “Who cares most about your goodness? About your badness?” For younger children, the use of successive family kinetic drawings can be used:

- “First draw a picture of everyone in the family doing something”;
- “Next, draw a picture of what happens in your family when you’ve done something good”; and
- “Now draw a picture of the family when you’ve done something bad.”

The intergenerational transmission of values can also be subject to drawing: assign participants to “Draw a picture of how a person in your family shows s/he cares about your goodness” and, *mutatis mutandis*, assign the mirror task with respect to badness. Each participant is invited to reconstruct the genogram for the group. The observing participants may be engaged in interpretation and summarization of what they learn about each other’s family trees and the intergenerational transmission of values. Often the focus can be shifted to the proband as an actual or potential moral connection for others in the family. The intrinsic value of **connectedness** can usually be elicited in discussion of the question, “What value is a person upholding as s/he strengthens this domain of his/her conscience?” Or, “What do we think is important when we try to strengthen this part of conscience?”

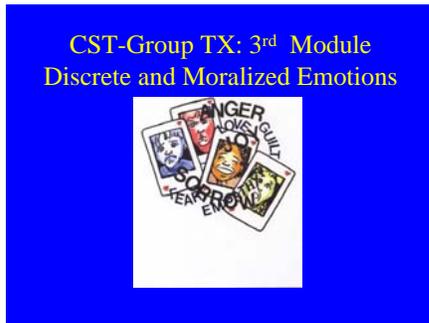
**CST-Group TX: 2<sup>nd</sup> Module**  
**Extraction of the Intrinsic Value**

- Moralized Attachment
  - a moral psychological domain
- **Connectedness**
  - the intrinsic or bedrock value associated with the domain

**CST-Group TX: 2<sup>nd</sup> Module**  
**Intrinsic Value: Connectedness**

- strengthening the domain
  - strengthening an existing connection
    - when the spatio-temporal connection is intact
    - when the spatio-temporal connection is lost
  - reckoning one’s moral worth to another person of conscience
  - establishing a new moral connection

### Third and Fourth Modules: Moral Emotions. SCI Questions: 3, 4, & 5.

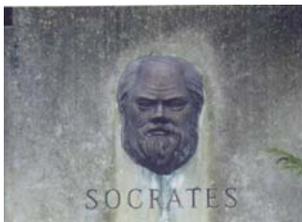


Ethical perspectives on the promontories of life's beginning (reproductive values) and life's end (end-of-life values) put these boundary conditions in bold relief. The moral peaks and valleys are readily recognized, albeit exceedingly daunting to traverse even (especially?) in one another's company. Moralized emotionality is apt to run high on all sides of the salient issues. The danger emerges at every turn that those whose beliefs differ will be treated as less than persons of conscience. Those who differ may even, in extreme cases of intolerance, forfeit inclusion in their antagonist's ambit of conscience. Many of us, for this reason, learn to shun moral

precipices, actively avoid the conditions we fear will eventuate in crises of conscience. Similarly, persons of conscience often succeed in ignoring the call to moral adventure and right-doing. In the event, it may take the efforts of others (more conscientious in some specifiable regard) ranging anywhere from mild suasion to fire-and-brimstone exhortation to *raise our consciousness* that the issues are indeed inescapably moral ones.

On the other hand, negotiating the terrain of day-to-day life does not seem to require frequent consultation of moral map and compass. Doubtless, the opportunities for right and wrongdoing are ever in abundance. However, the internal compass of conscience reliably works at preconscious (procedural/tacit/implicit) levels, at the level of virtuous (or, at the least, counter-vicious) habituation, such that wide deviations from permissible pathways trigger its anticipatory guidance. When deliberate excursions from permissible pathways are made for the sake of misadventure, moral awareness is triggered, moral emotion is aroused, albeit with the very real possibility of temporary denial of the one and suppression of the other. However, for some, conscience has a way of nagging and spoiling a person's resort to creature comforts. It may be appreciated through literature that, for some, conscience scorned becomes palpable, externalized in some concrete form, for example as a revenant, a haunting apparition or an illusory sensory experience. Many adolescent participants will be familiar with Edgar Allen Poe's story **The Tell-Tale Heart** (Poe, 1989) or Lady MacBeth's monologue about the damn spot (Shakespeare, 1971). Usually much less dramatic, the nagging conscience is a conscience in cognitive mode. It may be unaccompanied by any somatic experiences of which to speak. This could be alexithymia. It could also be a normal variation in the human condition. On the other hand, absent concern about wrongdoing being discovered by others, absent anything at all except the perception or the possibility of wrongdoing, some participants are apt to endure robust gut reactions or other psychophysiological changes. For still others, conscience is recognized as residing at the heart in part because of its way of inflicting emotional hurt and altering mood.

#### The Ring of Glaucon Questions



Imagine now that two such rings existed and the just man put on one, the unjust the other.... To begin with the unjust man. [With his ring on,] he must operate like a skilled professional- for example, a top-class pilot or doctor, [who] must be perfect in his wickedness; he must be able to commit the greatest crimes perfectly and at the same time get himself a reputation for the highest probity, while if he makes a mistake he must be able to retrieve it, and if any of his wrongdoing comes to light, be ready with a convincing defense.... Beside our picture of the unjust man let us set one of the just man... 'Who wants to be and not seem good.' [With his ring on, the just man] is not allow[ed] to seem good.... No, [he is stripped] of everything except his justice...[is given] an undeserved and lifelong reputation for wickedness, and [made to stick to] his chosen course until death....

(Rendered from passages 359a-361d in the Prelude to Plato's **Republic**: the story of Glaucon's rings)

**Rings of Glaucon**

- Moral Emotions I
- Internal Anxiety
  - 'What happens inside when you've done something bad?'
    - First Ring of Glaucon: 'if no one knows?'
  - 'What happens inside when you've done something good?'
    - Second Ring of Glaucon: 'if no one knows?'

**CST-Group TX: 3<sup>rd</sup> Module  
The Question Set (cont')**

- Moral Emotions I:
- External Anxiety
  - 'What happens (on the) outside when you've done something good?'
    - Second Ring of Glaucon: 'if no one knows?'
  - 'What happens (on the) outside when you've done something bad?'
    - First ring of Glaucon: 'if no one knows?'

The Ring of Glaucon questions, posed at this juncture, are devised to elicit discussion of anxiety, mood alteration and somatic correlates of conscience functions. Revisited in the context of valuation, the Ring of Glaucon questions illuminate internalization. The psycho-educational opportunity is usually present for discussion of temperament, diversity in the experience of discrete moral emotions and the variety of conscience contours.

With respect to temperament and conscience, a basic knowledge of Grazynska Kochanska and her colleagues' work is essential. In early work, Kochanska identifies two developmental processes important in conscience formation: the development of the tendency to experience affective discomfort, guilt, and anxiety associated with wrongdoing and the development of behavioral control, the ability to inhibit a prohibited action.

With respect to discrete emotions, Izard's work is a good starting place. The essential points to make are that each discrete emotion has a characteristic facial expression, a neurobiology, and a correlative subjective experience. 'How Are You Feeling today?' charts, more or less derivative from Izard's seminal investigations, have become ubiquitous in clinical settings and classrooms. They have even found their way onto refrigerator doors in magnetized miniatures. *Nota bene*, many charts perpetuate confounds between conditions (e.g. depression, cognitive states), attitudes (valuational states) and emotions. In the exercise, adolescents as well as children are provided copies of the faces evincing various emotions. They are asked to use one color to code the emotions that are experienced when they have done something good and someone knows it. They select a second color to code emotions associated with undisclosed, undetected (perhaps perceived as unappreciated) good deeds. Another color is selected to code emotions that are experienced when they have done something wrong and someone knows it. A fourth color is used to code moral emotional responses to undisclosed and undiscovered wrongdoing. Alternatively participants may be asked to identify what they consider moral emotional responses typical of others versus their own actual responses.

**CST-Group TX: 3<sup>rd</sup> Module  
Discrete and Moralized Emotions  
(cont')**

- pictured emotions identified in association with right-doing by oneself, by others
- pictured emotions identified in association with wrong-doing by oneself, by others

Empathy is bound to come up both in terms of 'too-much' and 'too-little.' Hoffman's developmental approach may be helpful to have in mind. The relationship of empathy to guilt is an important didactic point to make that sets the stage for a *re-valuation* of moral emotions (references for Kochanska, Izard, and Hoffman are included in the bibliography).

The re-valuation of moral emotions begins with the question of what one person of conscience might wish for another in terms of *emotional well being*. Participants are asked to identify moral exemplars who have pursued goodness at the expense of health and happiness as well as persons who might be seen as healthy but who have repudiated the good life. The complex relations obtaining among the concepts of happiness, health and goodness come to light. The intrinsic value of

**Empathy:**



- resonating with the biology of emotion and listening to its biography
  - guilt as an empathic response
  - initial exercise in empathy
    - 'How do you tell when someone is hurt?'
    - 'What happens inside you when you recognize harm done?'
  - psychopathological interference with moral emotions

harmony or equanimity and the motivational allure of goodness apart from so-called positive emotions are likewise topics for discussion.

**CST-Group TX: 3<sup>rd</sup> & 4<sup>th</sup> Modules**  
**Intrinsic Value: Balance**

- re-evaluation of moral emotions

Q: What is the nature of emotional well-being?

A: Full range of human emotion  
 Congruence of human emotions  
 Adaptive regulation of human emotion

**The Worth of So-called Negative Emotions**

- good even if they don't feel so good
- guilt tolerance (it is a form of empathy after all)
- under- and overvaluation of moral emotionality
  - “he keeps smiling when I punish him”
  - “she doesn't have remorse”
- guilt induction vs. guilt as punishment
- regulation of empathic arousal
- suspension of moral reactivity

### The Letter of Apology

**CST-Group TX: 4<sup>th</sup> Module**  
**The Question Set**

- Moral Emotions II:
  - reparation and healing
    - reparative mechanisms
      - forgiveness
      - gratitude
    - healing measures
    - defense mechanisms

**CST-Group TX: 4<sup>th</sup> Module**  
**The Letter of Apology**

- may be an exercise in moral imagination
- identification of critical elements
  - identification of harm done
  - ownership of harm
  - expression of regret
  - amendatory proposal
- identification of extraneous and vitiating elements

This is another exercise in moral imagination. It is helpful to make the imaginary aspect of this exercise explicit. Discussion revolves around essential features of the letter, recognition of harm done, owning the harm done, an expression of sorrow, and an offer to make amends. Extraneous, particularly exculpatory inclusions are often identified by other participants. The discussion that ensues often revolves around forgiveness. The relationship between forgiveness and gratitude brings the group back to the awareness that any discussion of moral emotional responsiveness is not confined to amendatory, reparative and healing strategies but also includes taking stock of ways of replenishing and ways of flourishing.

**CST-Group TX: 3<sup>rd</sup> & 4<sup>th</sup> Modules**  
**Extraction of The Intrinsic Value**

- Moral Emotional Responsiveness
  - a moral psychological domain
- **Equanimity/Harmony/Balance**
  - the intrinsic or bedrock value associated with the domain.

**CST-Group TX: 3<sup>rd</sup> & 4<sup>th</sup> Modules**  
**Intrinsic Value: Balance (cont')**

- strengthening the domain
  - developing a repertory of reparative strategies
    - seeking forgiveness and being forgiving
    - restitution
    - gratitude
  - healing strategies
    - solitude
    - time for reflection

**The Fifth Module: Moral Valuation**  
**SCI Questions: 8, 12, 13, and 14.**

**CST-Group TX: 5<sup>th</sup> Module**  
**The Question Set**



- do's and don'ts
- attributions in value keeping
- derivations in value making
- intergenerational transmission of family values revisited

**Rings of Glaucon revisited:**

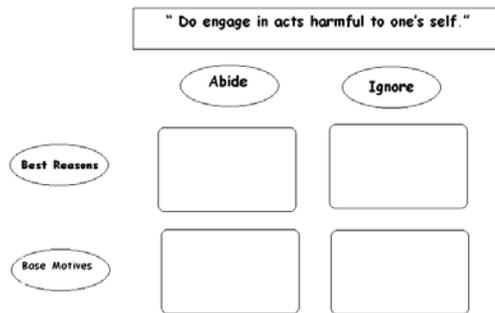
- do's and don'ts absent approval/disapproval

Moral mandates in the form of *do's* and *don'ts*, *should's* and *shouldn't's*, *ought's* and *ought not's* are culled from the moral consciousness of the group. Sometimes a moral mandate will be expressed in terms that are so valuationally thick they admit of little discussion and even less disagreement. Such a moral mandate may be a candidate for universality among Right vs. Wrong statements or may express something akin to a tautology. In one group, "Don't be cruel to animals" was generally accepted without much comment. When the valuationally thick term 'cruel' was underscored and the (still uncomfortable but less valuationally thick) term 'harmful' substituted, a lively discussion drawing in most participants ensued.

**The Valuation Matrix**

**CST-Group TX: 5<sup>th</sup> Module**  
**The Valuation Matrix**

- eliciting best moral reasons
  - to abide by the moral mandate
  - to ignore the moral mandate
- baser motives
  - to abide by the moral mandate
  - to ignore the moral mandate



**The Valuation Matrix**

How are the values that undergird the moral mandates made explicit? One way is to specify the mandate and then construct a two by two grid: *best reasons* and *base motives*, divided in a column and *abide by the rule* and *excuse/ignore the rule* occupying a row. We have called this the Valuation Matrix. Older youth often demonstrate recognition of the term 'matrix' owing to their exposure to the film featuring Keanu Reeves. A few are able to define the term. Responses recorded in **both** the *best reasons* cells are reframed as values. Work promoting moral reasoning can be conducted by blocking one reason in favor of eliciting a more altruistic, albeit weaker, one. For example, if the best reason provided by one participant is to avoid trouble with the law, her moral imagination might be engaged by posing the first Ring of Glaucon question slanted now towards valuation rather than moral emotion, "What if you were very sure you would not be caught doing x, what would your best reason be then?" Not only are values identified but also, in this manner, the concept of moral dilemma (genuine Right vs Right considerations) may first emerge and gain recognition from the group. If the concept of moral dilemma does emerge, then the litmus tests for Right vs Right issues (à la Kidder) are germane to further discussion. Groups may struggle with contra-distinguishing moral reasoning from sophisticated rationalization. They may also

identify defense mechanisms other than rationalization operating to prevent the full recognition of a moral issue. Consideration of baser motives may issue into discussion of psychopathological conditions that interfere with the ability of persons of conscience to retrieve best reasons (or summon up will power to act upon them, which will be the subject of the next module on Moral Volition). The Valuation Matrix allows for appreciation that there exists a value-motive gap. Clearly, sometimes the strongest motive for abiding by a rule is not after all the best reason. However, put another way, encouraging best reasons to acquire strength at the expense of baser motives is one definition of moral growth.

### The Valuational Triangle

**CST-Group TX: 5<sup>th</sup> Module**  
**The Valuation Triangle**

- authority derived/attributed
- peer derived/attributed
  - manipulations from media and the mall
- self derived/attributed

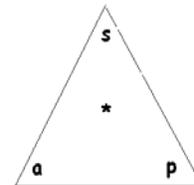


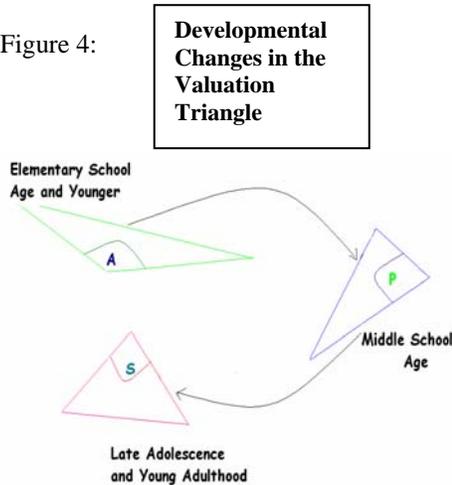
Figure 3:

**The Valuational Triangle**

Some moral mandates in the composite group conscience will have already emerged in the module on Moralized Attachment as rules for life based upon the intergenerational transmission of values. This is an important modality for **value-keeping**. Other mandates derive from **value-seeking** among peers. Still others may be **values-in-the-making** contra-distinguished in origination from either authorities or peers. These latter may have most to do with self-development in a self-centered sense (e.g. egoism, enlightened self-interest) or in a non-selfish sense (e.g. eudaemonism). {Indeed an interesting digression may be set in motion by the question: ‘Are the intrinsic (bedrock) values of conscience attributable to self in a eudaemonistic sense?’} However, the matter becomes quite complex when considering who or what each moral mandate regards- its pertinence, to whom it is attributed, its degree of internalization irrespective of its origins, and its actual psychodynamic derivations irrespective of attribution. The moral philosophical distinctions among intrinsic, instrumental, contributory and originative values are applicable with greater intricacy, greater subtlety than may have been appreciated formerly (Nozick, 1981). While *attributed* in origin to the self, some moral mandates may nonetheless be authority or peer *regarding*. Often rules about peers are *derived* from peer relationships, but there may be scaffolding provided by external authority figures. So it makes sense to discuss such rules as *peer regarding* as well as *authority derived*. A rule may also have become so *internalized* that the scaffolding provided by external authority figures has been disassembled in all but moral memory. The person (facilitator or other participant) mindful of such complexities in moral psychology is apt to strike a deeper aporia.

For the sake of many other participants, the facilitator should be prepared to clarify just what information (with respect to derivation, origination, pertinence, degree of internalization or attribution) is being requested when the list of mandates is reviewed and labeled by group participants with **A** for ‘Authority’, **P** for ‘Peer’ and **S** for ‘Self’. Having made this point, it remains to be said that, from the developmental perspective at least, the visual aid of the Value Triangle is probably most useful to depict internalization. In this heuristic device, the person of conscience is represented in the center of the triangle. Vectors represent the direction of internalization, externally supported acquiescence or perhaps, oppositely directed, repudiation. The scalene triangle with its obtuse angle occupied by Authority-regarding mandates is gradually transformed into one in which Peer- regarding mandates demand a more generous allotment of degree. With further maturation, the triangle becomes equilateral with evenly distributed moral mandates speaking to elder-worth, other-worth and self-worth, virtually all being owned by the subject with varying requirements for external conscience supports. Participants are encouraged to construct personal valuational triangles based upon their personal sets of moral mandates.

Figure 4:



**CST-Group TX: 5<sup>th</sup> Module  
Intrinsic Value: Worthiness**

- the allure of value is motivational
  - but akrasia is also a possibility
- closing the motive-reason gap in behalf of moral growth
- elevating moral dialogue and ethical discourse
  - crediting others with best reasons
  - suspending moral reactivity to the baser motives of others

**The Sixth Module: Moral Volition  
SCI Question: 15.**

**CST-Group TX: 6<sup>th</sup> Module  
Moral Volition**

- autonomy
- agency
- advocacy

**CST-Group TX: 6<sup>th</sup> Module  
The Question Set**

- awareness of growth and change
- enlarging the ambit of conscience

The didactic component of this module is to present the casuistical approach to moral dilemma resolution. An indispensable reference is Rushworth Kidder’s **How Good People Make Tough Choices** (1996). In the previous module on Valuation, the Valuational Matrix was introduced. It now becomes the basis for choosing among alternatives, upholding values in creative tension. The emphasis here is on the act of choosing, distinguishing it from consequential, alternative and means-end cognitive activities or even lexical ordering. Anticipate that the group may include a participant who, in the best tradition of William James, is concerned with the philosophical/ meta-psychological issue of free-will vs. determinism (Bricklin, 1999). Neuro-biologically sophisticated persons may be aware of Libet’s problematic electro-encephalographic findings revealing that action potential precedes awareness of choice (In: Libet, Freeman et al., 1999). Adolescents may recount recent films dealing with this subject (e.g. **Minority Report**, 2002).

The discussion may be allowed to take such turns, but lengthy treatment of these subjects may detract from the more clinically relevant issue of psychopathological interference in agency and accountability. A familiar pattern has been simply to engage in a discussion of the concept (if not the actual term) *akrasia*, arriving at an appreciation for the sense of such assessments as “I knew it was wrong but I did it anyway.” In this vein, it is possible to lay emphasis upon phrases introduced by participants such as “struggling with my conscience.”

**CST-Group TX: 6<sup>th</sup> Module  
Intrinsic Value: Freedom**

- accountability
- matching privilege with responsibility

The task for participants is to relate success experiences. Each is to identify a moral event in which he or she has successfully resisted an urge to wrong-doing. Each is to identify a moral event in which he or she overcame resistance to performing a good deed. Another exercise aims to enhance appreciation of agent-assisted internalization. It involves Moral Imagination and the Valuational Triangle. Participants are asked to predict which of their “A” moral mandates will become “S” moral mandates within a year. Conversely, participants may be asked to identify which mandates are most likely to resist internalization. The value matrix can then be applied to the mandate in question with the aim of fostering appreciation for the values upheld by the mandate and critical self-examination for the motives and reasons for keeping it at arm’s length.

**CST-Group TX: 6<sup>th</sup> Module Task**

- successful resistance to an antisocial impulse
- overcoming resistance to a prosocial impulse

**The Seventh Module: Delays in Conscience Formation and Psychopathologic Interference in Conscience Functions.**

**CST-Group TX: 7<sup>th</sup> Module**

- Developmental Delays
  - disruptive behavior disorders
  - attention deficit hyperactive disorder
- Psychopathological Interferences
  - depression
  - post traumatic stress disorder
  - obsessive compulsive disorder
  - substance abuse

Our groups have been heterogeneous with respect to diagnoses, conditions of advantage and conditions of adversity. Yet participants have been able to engage with one another in identifying ways in which conscience can be strengthened and ways in which it can be weakened. How does a person compose a morally meaningful life, one in which moral imagination is vibrant? How does a person honor connectedness in the form of moralized attachments? How does one attain equanimity and balance in moral emotional life? How does a person become active in reconfiguring the valuation triangle? How does one look beyond autonomy and even agency (with accountability its constant companion) to advocacy for others? How does one go

about the business of upholding the plurality of intrinsic values which conscience generates, especially when there is tension or conflict among them? Participants have ideas about how to respond to these queries. They have likely reflected, and possibly even expressed themselves already, on some or all of these questions as they emerged in the previous modules. Through contrast and comparison with the individual consciences of peers and co-facilitators, or with the composite conscience of the group, they have to lesser or greater degree identified their own distinctive contours of conscience. They have to lesser or greater degree appreciated that moral perspective and moral decision-making are markedly influenced by which contours are most salient. Perhaps this or that participant has even made a beginning at appreciating the relative competencies and weaknesses residing among the domains of her or his individual conscience.

More specific comments will emerge out of the specific psychopathologic experiences of the participants. Co-facilitators may find various approaches helpful. One approach is simply to invite discussion as to how conscience can be mobilized with respect to substance abuse, maladaptive sexual behaviors, anger management, suicidality, and the like. Another approach is to actually engage participants’ consciences directly, chiefly by means of previously described devices: valuational matrices and triangles. A co-facilitator adopts the strategy of taking any psychiatric benchmark topic *x*, modifying it, and transforming it into a mandate (which may or may not be seen as *moral*). A valuational matrix is constructed, allowing for the adumbration of best reasons and strongest motives for abiding by the mandate, and, on the other hand, for ignoring or resisting it. For example, suicidality is rendered as the amoral mandate: “ Do engage in acts harmful to one’s self.” The lower left hand cell is apt to fill up quickly with the flotsam and jetsam of depression, of maltreatment, of post-traumatic stress disorder, *inter alia* -- psycho-biological conditions that leave in their wake compromised or threatened conscience functions in the domains moral emotional responsiveness, valuation and volition. Like effects of loss and disconnection upon moral attachment may be recorded, witnessed and validated here.

### Supplemental Exercises.

The facilitator of groups conducted in residential settings or school-term-long day-programs may wish to coordinate efforts with the special education teachers<sup>5</sup> in their settings. Poe's **Tell-Tale Heart** has already been mentioned as lending itself to discussion in the module Moral Emotional Responsiveness. Younger group participants were asked to read or listen to **The Thanksgiving Visitor** (Capote, 1996) and select one of the three principal characters (Buddy, his Friend, or Odd), make inferences about the character as a person of conscience and discuss their ideas. The filmed version of the 1960's musical **Oliver!** also provides opportunities to make character studies (Oliver, Artful Dodger, Fagin, Sykes and Nancy) in terms of the domains of conscience and, in particular, potential trajectories from adverse events (loss, neglect, physical abuse, exposure to domestic violence) earlier and later in life. For older children and adolescents we have used the film version rendered by Bille August from Victor Hugo's **Les Misérables** (1998) in the same manner.

### Conclusions and Limitations.

For the preliminary observations and reflections put forth in this study, the point of departure was consideration of the AACAP Practice Parameters for the Psychiatric Assessment of Children and Adolescents with respect to conscience formation and functioning. In earlier work (Galvin et al, 2001), conscience sensitive interview technique and diagnostic formulation were characterized. Conscience sensitive interview technique and diagnostic formulation, respectively, have been proposed, as ways to conduct and understand psychiatric evaluations in accordance with the practice parameters. Recognizing that assessment is propaedeutic to treatment, the authors have posed these questions:

- 1) Can conscience sensitive treatment be conducted in today's different mental health environments?
- 2) If so, what would it look like?
- 3) Will it have universal applicability across the age-span of youth and the spectrum of developmental psychopathology? What about IQ considerations?
- 4) What form(s) could/should parent or other adult involvement take?
- 5) Does conscience sensitive treatment work?

Our response so far to question (1) is: 'Yes, conscience sensitive group psycho-educational therapy can be conducted in child adolescent psychiatric therapeutic loci ranging from outpatient to closed residential programs.' However, constraining variables were encountered in the adolescent intensive outpatient program when census became large, and turnover rapid, in consequence of which the full cycle of seven modules conducted at a frequency of once per week could not be completed by many participants. This could be remedied by conducting sessions more frequently, perhaps two to three times per week, and offering a sufficient number of groups to ensure that the number of participants in each group does not exceed eight. In the outpatient setting, there were fewer referrals than had been hoped, perhaps because of limitations upon reimbursement for the total number and/or kind of therapeutic interventions, a condition which, in our local mental health community and perhaps elsewhere, favors individual psychotherapy over group psychotherapy. However, the possibility cannot be excluded that there have been referral biases or parental preferences in favor of groups with a more readily recognizable focus such as anger management or social skills over a novel, less familiar approach.

In response to question (2), each of the seven modules in its current stage of development and refinement has been characterized in terms of praxis, but also considered critically in terms of treatment philosophy.

Our impressionistic response to question (3) is 'So far so good!' with respect to an age-span between 7 and 17 and psychiatric disorders of mood, anxiety, and behavior and, even schizophrenia after

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<sup>5</sup> In this regard, the author is indebted to Ms. Julie Noel and Ms. Sharon Tolle, both teachers in the Washington Township Metropolitan School District, Marion County, Indiana.

acute stabilization. With appropriate modifications, we envision applicability in children with developmental disorders and mild mental retardation.

Regarding question (4), involvement of grown-ups, there are these considerations. In the residential and day-school groups, the educator-clinicians engaged with other persons to examine conscience and seek out the intrinsic values that will govern strengthening exercises for each of its domains. In these settings, there was participation in the group by youth care workers. Staff were encouraged to adopt the conscience language and methods introduced in the group to engage the young persons of conscience in their charge on a one-to-one basis, to help them declare themselves intentionally, "I will do *x* as specified in my treatment plan for the sake of *y*". Assigned tasks emerging from these one-to-one encounters may, for example, be applying a social skill *for the sake of connectedness*, practicing expressions of remorse *for the sake of balance*, accepting 'unfair' consequences for ambiguous behavior *for the sake of respecting authority*, or, *for the sake of autonomy*, taking the next step towards a higher privilege level consonant with demonstrated responsibility. One exciting possibility is to operate a parallel group for the grown-ups, parents or mentors, covering each module with a slant towards parenting or mentoring as the youth proceeds through the same module in the conscience sensitive psycho-educational group therapy format. This summer, we are beginning a pilot project that will involve first year medical students in their introduction to clinical medicine course pairing with children and adolescents in a residential program. As in past years, the medical students will be guided through parts of the I.U. Conscience Autobiography for Health Care Professionals (Gaffney et al, 2002). However in the anticipated pilot project, the medical students will have their discussions in tandem with key conscience sensitive psycho-educational group therapy modules conducted for the youth in residence.

Question (5): How best to study outcome? The goal of psycho-education is to foster a better understanding of the nature of a psychological condition. When the condition is subject to developmental delay and/or psychopathological interference, then there are additional goals to understand the nature of the disorder and its treatment. Hence measurable outcomes from moral psycho-educational interventions could be obtained from testing the expansion of a person's fund of knowledge with respect to the broad range of normal moral development and moral developmental psychopathology. At a minimum, the educator might expect that a person could, in age-appropriate language, identify the domains of conscience and how conscience formation and conscience functioning might be affected by, for example, depression. Behavioral change can be measured. It is notoriously difficult, however, to correctly attribute the behavioral change to a specific component of treatment. Gibbs et al (1995) make this point in their review of "the most impressive study to date of the remediation of moral developmental delay" conducted by Arbutnot and Gordon to evaluate their four month program entailing small-group discussions in 1986. While the experimental subjects of this study showed gains in both moral judgment and in behavior as measured by disciplinary referrals, tardiness, and grades, the techniques were multifaceted, promoting group cohesion, mutual caring and social skills training. The multifaceted approach relying upon integrated treatment modalities makes it hard to know which ingredient (or is it the blending of ingredients?) that is essential. Indeed, the same study by Arbutnot and Gordon, although its title, "Behavioral and cognitive effects of a moral reasoning development intervention for high-risk behavioral disordered adolescents," indicates emphasis on the moral psychological domain, is adduced as evidence for the efficacy of cognitive problem solving skills training (Kazdin, 1987). A person's profession that she changed her behavior "for the sake of *x*" can be characterized and staged. This could be accomplished by pre- and post- intervention use of one or another version of the SCI. The extent to which a behavioral change can be attributed to any expressed "for the sake of *x*", to moral purpose, to best reasons as opposed to base motives is not so easily accounted. Moreover, given the possibility of sleeper effects, the benefit may not be easily detected in early measures of treatment outcome. Nonetheless, if possible, outcome *should* be studied, keeping in mind, that in part, what defines growth as a person of conscience is the deliberate effort she puts forth to make the highest values of which she is capable also her strongest motives.

A final point: a persuasive argument might be made that a conscience sensitive approach, *prima facie*, adds value to any established treatment modality, be it psychodynamic, cognitive behavioral or interpersonal, be it in group or individual format. Together with an *evidence-basis* there is also an *ethics basis* for the practice of child and adolescent psychiatry. The educator-clinician practices transparently in accordance with professional healing values derived from the intrinsic values of conscience and transformed by the profession. Desired outcomes for patients cannot be reached just any way at all; there are deontological constraints for even the most dyed-in-wool consequentialists among us. Moreover, from

the ethical standpoint, some ways may be better than others, irrespective of the relative strength of their evidence bases. The benefit of conscience sensitive psychiatric treatment may not be discerned as readily in treatment outcome as in how a virtuous practice is shaped.

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