

Progress in Conscience-Sensitive Psychiatry: Assessment, Diagnosis and Treatment Planning

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Abstract: Study of the relationship between episodic or continuous moral malfunctioning and psychopathology is an undeveloped field in child and adolescent psychiatry. An empirically derived theory of conscience provides a normative base from which to launch such studies. This work reviews five normative stages of functioning within five domains of conscience: conceptualization, moralization of attachment, moral-emotional responsiveness, moral valuation, and moral volition. Current professional guidelines for the doctor-patient relationship, psychiatric assessment, diagnostic categorization, and treatment planning address conscience functioning sometimes directly, sometimes indirectly, and sometimes not at all. A case report is provided to illustrate progress already made in conscience sensitive clinical psychiatry. Further advances may begin with consideration of proposed hypothetical models, comporting with recent research, which describe progressive impairment involving both delay and deviancy in conscience functioning. **Conscience Works**, An On-line Periodical: *Theory, Research and Clinical Applications*, 2006, 2 (1): 5-30

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Nota bene: Documents fully designated by title in the text, which appear in bold with underlining, are currently available on this same website. In the case illustration, arrows and/or yellow highlights have been used to designate material derived from a conscience sensitive clinical approach to psychiatric evaluation.

Introduction

Given that child and adolescent psychiatry has an important and ever enlarging share in the stewardship of wayward youth, the tasks can be identified: how to predict, assess, treat, and prevent moral collapse or failure- but then the question must be raised: in order to complete these tasks, what tools are at hand? Does child and adolescent psychiatry have an adequate conceptual base for examining the moral aspects of psychic structure in children and adolescents? Does it have adequate language and methodology to identify and articulate value deficiencies and distortions? If not, how might such tools be acquired?

The goals of this article are:

- to ground discussion of conscience in general concepts relating development, health, disease, and morality;
- to review five empirically-derived domains of conscience and their course in normal development;
- to highlight how current guidelines for the doctor-patient relationship (and how this is taught), psychiatric assessment, diagnostic categorization, and treatment planning do or do not integrate examination of conscience functioning;
- to consider a case report that illustrates the current state of the field in conscience sensitive psychiatry;
- to present hypothetical models of conscience impairment; and
- to apply these models to the illustrative case.

General Concepts Relating Development, Health, Disease, and Morality

Development

The human brain develops through complex patterns of differentiation and integration stimulated by interpersonal experience and recursive processes (Siegel, 1999). When properly nurtured, most forms of development reach an optimum level, after which functional maintenance becomes the ongoing concern. Within limits, human beings have the capacity to influence various kinds of development in themselves and others. Most parents, teachers, and professionals involved with children are motivated to cultivate moral sensitivity in children. Children demonstrate a natural moral impulse in the second year of life as they begin to place personal actions, outcomes, and reactions of others into good and bad categories (Kagan, 1998). Thereafter, interactive moral learning opportunities between children and trusted adults are everyday occurrences (Hoffman, 2000).

Aberrant Development, Disease, and Morality

Genetic variations, inherited or mutant, have an impact on development in ways that range from interesting differences to life-threatening diseases. Environmental influences, supportive or traumatic, also have an impact on development with effects ranging from precocious maturation to disorder. Developmental differences may be expressed as deficits, excesses, or altered trajectories, including evolutionarily advantaged ones. Diseases are health-impairing conditions.

When a child presents an adult with something that isn't working right—a toy, a body part, or someone's meanness, most adults want to help correct the situation. Desire to make something "right" in response to someone else's needs or wrongs initiates the growth of moral sensitivity within relationships—relationships between parent-child, teacher-student, doctor-patient, friend-friend, community-member, etc. The easier the correction, the less frustrated the moral response.

Isolated functional deficits or health-impairing conditions, e.g., cleft palate, deafness, or blindness, readily arouse the collective conscience of a community to provide special programs and treatment. Extensive physical impairments in individuals whose minds remain alert and creative also inspire moral-emotional responsiveness. Such individuals, e.g., the late Christopher Reeves or Michael J. Fox, become welcomed advocates for public awareness, political influence, and fund raising for research of targeted conditions. Individuals who have multiple impairments may also occasion consciousness raising- or more accurately *conscience-rousing*- discussions and decisions concerning quality of life.

Mental deficits or disorders may be evaluated passionately or indifferently, depending on our sense of connectedness to those affiliated, the power of others' advocacy on us, and the possibilities for improvement or cure. Families who are burdened by mental illness among their members are eager to turn others' indifference into educated acknowledgment and support for treatment, assisted care-giving, and research. Those who have been victimized by others' mental disorders are passionately motivated to secure protection, prevention and treatment—in that order. People with conditions known to elicit negative moral judgments, e.g. alcoholism, sexually transmitted disease, or antisocial personality disorder, may be judged quite harshly, indeed, punitively. Negative moral judgments may be related to the degree to which afflicted individuals or their caretakers are held responsible for the conditions and any resulting harm. Alternatively, negative judgments may be related simply to the shame of association.

Disease, in the form of psychopathology, readily engages psychiatrists to respond to those afflicted with a sense of responsibility, care, and fairness. Thus, the systematic studies of etiology, treatment, access to treatment, outcome, and prevention are diligently pursued. Scientific methodology keeps clinicians and researchers disciplined and rational while constantly challenged by peer review and public opinion. In contrast, psychiatrists' attitudes about mental health and development, including moral development, are often submerged in an insufficiently examined belief that if psychopathology were eliminated or controlled then developmental processes would proceed normally.

Defining Conscience and Its Domains

In 1982 the authors began developing a semi-structured interview to assess personal understanding of conscience in children and adolescents who were free of psychopathology, learning difficulties, or major trauma. No *a priori* hypotheses were established. Grounded in clinical experience, the investigation was empirical and exploratory. Questions were chosen because they were intuitively relevant to mental development, health, disease, and morality. These questions now comprise the **Stilwell Conscience Interview** (Stilwell, 2003a). In addition to many clinical interviews, one hundred twenty five research interviews of normal children and adolescents were collected, read, and rationally analyzed. Five domains of conscience were identified, each one related to the moral aspects of a different category of human experience: attachment, emotion, cognition, volition, and moral meaning-making. Conceptualization of conscience was considered to be the anchor domain, while moralizations of experiences in other psychological categories were considered to be contributory domains of conscience. They were named: moralization of attachment; moral-emotional responsiveness; moral valuation; and moral volition.

Five stages were identified within each domain for part of the life span, ages five through seventeen. Standard research methodology established inter-rater reliability and construct validity for the domains and stages. The results were published one domain at a time (Stilwell and Galvin, 1985; Stilwell et. al., 1991; 1994; 1996; 1997 and 1998). A parenting book integrating the five domains was then published (Stilwell et. al., 2000). The following paragraphs review the five domains while **Tables 1-5** summarize the developmental highlights of the domains within each of the five stages.

Table 1: The External Stage Conscience

Domains	External Stage (6 and under)
Moralization of Attachment	Parent-child empathic responsiveness generates bi-directional sense of oughtness.
Moral-emotional Responsiveness	Positive emotions become linked to sense of goodness.
Moral Valuation	Moral expectations emerge from daily routines.
Moral volition	Willpower is directed toward commitment to restraint.
Conceptualization	The conscience is perceived in terms of action scenarios with elders in which right and wrong behaviors are punished or praised.

Table 2: The Brain-Heart Stage Conscience

Domains	Brain-Heart Stage (7-11)
Moralization of Attachment	Disciplinary practices shape moral tone of parent-child relationship.
Moral-emotional Responsiveness	Anticipation of negative emotional response to wrongdoing emerges; rudimentary processes of reparation and healing emerge.
Moral Valuation	Some moral rules are constructed from consequential learning; others are internalized directly as mandates of elders.
Moral Volition	Willpower is directed toward mastery of skills and demonstrating sufficiency in the pursuit of goodness.
Conceptualization	The conscience is perceived as a storage site for moral rules.

Table 3: The Personified Stage Conscience

Domains	Personified Stage (12-13)
Moralization of Attachment	An internalized and often “anthropomorphized” conscience supplements the moral authority of elders.
Moral-emotional Responsiveness	Initiative characterizes the pursuit of virtues and undertaking of reparative actions after wrongdoing.
Moral Valuation	Rules are interpreted in light of the dynamics of maintaining good relationships.
Moral volition	Willpower is directed toward the pursuit of specific virtues.
Conceptualization	The conscience is perceived as a “someone” for dialogue regarding moral issues.

Table 4: The Confused Stage Conscience

Domains	Confused Stage (14-15)
Moralization of Attachment	Independence from parental moral authority is facilitated by attraction to idols and ideals in the culture.
Moral-emotional Responsiveness	Emotional reactivity over conflicts of loyalty intensifies.
Moral Valuation	Conflicts over moral issues between self and authority, self and peers, and self with self prompt “weighty” moral processing.
Moral volition	Willpower is directed toward idealism.
Conceptualization	The conscience is perceived as struggling to integrate various sources of moral authority.

Table 5: The Integrating Stage Conscience

Domains	Integrating Stage (16+)
Moralization of Attachment	Image of becoming a moral authority for progeny emerges.
Moral-emotional Responsiveness	Emotional comfort with making individualized moral choices emerges.
Moral Valuation	Being true to oneself becomes a dominant value.
Moral volition	Willpower is directed toward “personal best” moral choices.
Conceptualization	The conscience is perceived as an entity that incorporates the concept of good within evil and evil within good.

Also see: [Clinical Vignettes](#) (Stilwell, 2005b).

A General Definition of Conscience

Metaphorically speaking, conscience is the moral heart of the personality. How does this heart come to be? Beginning with a biologically prepared impulse to sort experience into good and bad categories in early childhood (Kagan, 1998), conscience develops as an intrapsychic structure that stores the oughtness messages from life’s lessons about good and bad, right and wrong. Within most individuals, understanding of goodness and badness, the objects of conscience, grows in increments of organized meaning under the guidance of moral nurturance, experience, and development.

Goodness is first experienced through the satisfaction of needs. Bedrock values, the most basic forms to apprehend goodness, are engendered in the process of having needs both met and unmet. Thus, an infant’s need for human attachment engenders a value for *connectedness*; the need for emotional regulation engenders a value for *harmony*; the need for goodness itself engenders the logical structuring of value-laden experiences (*value-sensitive rule making*); the need to act and restrain engenders the value of *autonomous will*; and the need to coordinate experience into a meaningful whole generates the synthesizing value of *moral meaning making*. These bedrock values guide life’s first expectations and obligations. As domains of experience are further moralized through nurturance, development, and the challenge of making moral sense of life’s experiences, value connected expectations and obligations become increasingly differentiated and integrated.

Moralization of Attachment

The personhood of conscience evolves from empathic responsiveness within parent-child dyads as mutual demands and expectations become connected to the desire to please and to be pleased. As the child conforms to parental expectations (and the parent responds to the child’s needs), security within the relationship is enhanced; non-conformity and unmet needs stress the

relationship. The resulting *security-empathy-oughtness bond* becomes the interpersonal core of the conscience mental representation (Stilwell et al, 1997)

Moral-Emotional Responsiveness

The emotional power of conscience evolves as parental demands and expectations become values around which the child's emotions are regulated (Stilwell et al., 1994). The content of what it means to be good (pleasing behaviors) takes form in relationship to feeling good (feeling pleased or satisfied). An *am good / feel good* state of moral-emotional equilibrium motivates the developing child to inhibit prohibited behaviors and to engage in pleasing, pro-social behaviors. Feelings of goodness or badness are tied to the body's physiological processes, which, in turn, signal the person when moral-emotional equilibrium is disturbed by behavior the individual deems to be bad or wrong. Reparation and healing processes (e.g. forgiveness) are then learned and practiced to restore moral-emotional equilibrium.

Moral Valuation

The value-processing power of conscience is initiated when the child begins to use cognitive skills to actively evaluate parental demands and expectations in the face of her own needs and desires. As the child moves into the larger community, values governing three types of relationships become important: values governing her relationship to authority; values governing her relationship to peers; and values governing obligations to herself. It is within this valuational triangle that moral dilemmas arise and must be resolved. All cognitive processes are activated: language—now to frame moral choices and challenges; memory—what precedents are applicable; reasoning—what logic can be applied; moral judgment—what cumulative valuation will guide action. Uncertainty, fallibility, and bad choices foster moral justifications—psychological defense mechanisms centered on moral issues. Through the valuation process the growing child gradually learns about moral complexity.

Moral Volition

The will power of conscience evolves as the child's capacity for action and restraint, attention and effort, are moralized in the process of exercising autonomous will (Stilwell et al, 1992). Living involves both willed and unwilled behavior. Evolutionarily prepared dual abilities to act before thinking and think before acting (LeDoux, 1996; Libet et al., 1999) lead to behaviors as diverse as life-saving actions or impulsive, self-defeating "stupidities". Even when humans think before acting, pre-conscious factors—biological drives, emotional arousal, relationship loyalties—may combine with situational cues and demands to mar or enhance moral choice. As the child grows in ability to use consequential feedback and deliberate self-assessment, she grows in ability to be in charge of her moral actions.

Conceptualization of Conscience

The power of conscience as a whole evolves as the child synthesizes moral meaning from the domains of moral attachment, moral-emotional responsiveness, moral valuation, and moral volition. Conscience is the moral organizer in each person's autobiographical journey, a moral governor at the heart of the personality. Children have great facility to both draw and define their conscience when the language of inquiry is adjusted to their cognitive abilities. Five discrete stages of synthesis can be identified before the age of 18 (Stilwell & Galvin, 1985; Stilwell et al., 1991).

Current Integration of Conscience Domain Concepts in Child and Adolescent Psychiatry

In the Doctor-Patient Relationship

The ethical nature of the doctor-patient relationship is grounded in centuries of thoughtful practice (Bloch et al., 1999). Moral responsibilities specifically related to children's physical and psychological needs have emerged in recent decades. Child and adolescent psychiatry affirms principles of responsibility toward children and adolescents through its Code of Ethics and various practice parameters. We acknowledge that children have rights that may be in conflict with claimed rights of parents or society. When abuse or neglect is involved, proper reporting must be done. In the midst of family conflict or litigation, our professional loyalty is focused on the healthy development and well-being of the child.

With limits fully stated, we pursue confidential treatment relationships with our child patients. We honor legal custodial rights in the release of information. We provide young patients with development-appropriate explanations for any treatment, including medications. Although they cannot legally give consent for treatment or research protocols, children's assent is enlisted in honor of their autonomy. We advocate for children's rights to a full range of mental health treatments of sufficient duration with health maintenance organizations. Because our loyalty to children's mental health includes the entire community of children, we serve as consultants to government and private organizations concerned with value-deficient community practices that threaten to harm children or adolescents. As individual practitioners we honor legal and moral principles in pragmatic ways according to the functioning of individual conscience.

In educational encounters with learners in every year of medical school and residency, psychiatry educators are in a unique position to provide the moral developmental psychological structuring that has long been missing in ethical discourse. Conscience sensitive medical (including psychiatric) education becomes apparent when medical educators (especially those in psychiatry) assist persons of conscience in understanding and undertaking the process of becoming professionals of conscience. Teaching programs organized around the **Indiana University Conscience Autobiography for Health Care Professionals** that stimulate awareness of the individual professional's conscience functioning have been designed to improve how physicians in general and psychiatrists in particular handle moral complexity, paradox, and conflict (Gaffney et al., 2002; Gaffney et al., 2005; Galvin et al., 1999; Galvin and Stilwell, 2005).

In Clinical Assessment

Current practice parameters for psychiatric assessment of children and adolescents (American Academy of Child and Adolescent Psychiatry Practice Parameters, 1997, 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)....

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, inviting speculation. Practicing child and adolescent psychiatrists may rely on cumulative clinical experience, commonly held mores, personal moral perspectives, and global impressions when assessing "*age-appropriate development of conscience and values*" in young patients. 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). In this tradition, what was required was discernment of unconscious derivatives, for example from drawings, play or storytelling (Gardner, 1986), from which could be inferred superego processes. "*Specific areas of harshness, laxness, or conflict*" alludes to a psychodynamic relationship between different components of the personality, harking back to Freud's model of superego, ego, and id. It also alludes to abnormal developmental trajectories: harshness possibly related to punitive rearing experiences; laxness to neglectful ones; and conflict to confusing ones. The authors agree that conscience has dynamic influence within the personality. However, conscience theory makes two important distinctions. First, conscience is defined as a fully conscious construct. It is a person's working summary of moral meaning that he or she has constructed from retrievable moralizing experiences. Second, what make living with conscience dynamic are perturbations in development and experience. Retrieved memories and current experiences are focused and interpreted differently as development progresses or regresses. Furthermore, fallibility in both self and conscience is integral to the reality of moral complexity. When new moral issues come into awareness, value processing reshapes the character and content of conscience. Working with conscience is a dynamic, bi-directional, maturing process wherein reality is continuously being re-grounded in moral meaning.

Even though child psychiatrists' memory banks may contain knowledge of moral development learned in undergraduate courses, focused lectures during medical school or residency, or personal reading, they are uncertain of its applicability in clinical settings where patients seem to be "all over the place" in their development and functioning. Thus, recollections of Piaget's heteronomous and autonomous stages (Piaget, 1932/1956); Kohlberg's stages of pre-conventional, conventional, and post-conventional moral reasoning (Kohlberg, 1981); Hoffman's stages of empathy (Hoffman, 2000); or even Erikson's epigenetic stages of ego development (Erikson, 1963) grow rusty from troublesome application. Application is troublesome because many young patients' developmental trajectories are so intertwined with psychopathology that attempts to define, describe, or stage them are confusing. The terminology fails to capture the essence of many patients' unusual combinations of normal moral impulses and psychopathology. "When I steal, I always steal for my buddy, too; he does the same for me."

Some practitioners may be influenced by post-Kohlbergian cognitive developmental approaches to moral judgment (Gibbs, 1995; Gibbs, Potter and Goldstein, 1995; Lapsley, 1996; Wolff, 2002, Seligman et al, 2005) 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, Seligman, Berkowitz, Catalano, et al., 2005). Some clinicians may have been influenced by integrative perspectives represented in the literature (Navàez and Rest, 1995; Eisenberg, 1995). Some may have gleaned insight on how to proceed based upon reading narratives of moral encounters (Aichorn, 1935; Coles, 1997; Garbarino, 1999, 2006; Hubner, 2005) or even moral philosophical encounters (Matthews, 1980; 1984; 1994). 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.'

"Effectiveness in helping child confirm to expected family and community norms, religious or ethical concerns, goals and future aspirations" addresses the restraining influence of conscience but not its proactive power. It does not address virtuous striving. Conformity is one honorable way of pursuing goodness. Virtuous striving evokes a creative connection between conscience and self. Clinical assessment needs to tap into children's morally creative urges—their own style of seeking goodness and correcting wrongness in their world—as well as their success or failures at conformity.

The authors' own formulation of conscience development may be problematic for the clinician. Even though this empirically-derived theory is broken down into five domains and five stages within each domain, each relevant to categories of experience common to defining psychopathology, colleagues continue to be puzzled and respond with comments like, "That's very interesting, but how does it apply to patients?" The reaction is understandable. When a patient demonstrates a combination of aberrant conscience development combined with spurts of even more serious conscience mal-functioning associated with stress, psychopathology, or environmental circumstances, retreat to the more familiar categorizations of the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) (APA, 1994) provides conceptual security.

In Categorizing Mental Disorders

Years of open-ended clinical interviews and play sessions with children and their families regarding such complaints as inattentiveness and distractibility, shyness and fearfulness, interpersonal warmth and distance, unhappiness and irritability, stubbornness and meanness, etc. preceded the tightly constructed system of diagnostic categorization that exists today. Psychiatrists all agree that the system is not perfect but, at least, facilitates uniformity in communication and provides a paradigm for testing of hypotheses. Similar to self and conscience, we psychiatrists and our categories are fallible.

Historically, the psychiatrist's approach to the moral realm of patients' lives has been wisely cautious. We have preferred to understand rather than to judge, to medicalize rather than moralize, to form working alliances rather than paternalize, and to deliberately avoid devaluing our patients' belief systems. Although behaviors that clearly violate the right of others and society are diagnostically labeled and acted upon, impairment is not described in terms of domains of conscience. Deficiencies in the moralization of relationship obligations, emotional responsiveness, reasoning, will-power, and the conceptual organization of oughtness associated with conduct-disordered behaviors are not delineated.

Unable to completely adhere to a value-free orientation in psychiatric nomenclature, our profession "lumps together" behavior that is obviously value deficient in the diagnoses, conduct disorder and antisocial personality disorder ("...a pervasive pattern of disregard for and violation of the rights of others...failure to conform to social norms..." APA, 1994). The separate categorization for youth and adults allows for optimism about possible corrections along the trajectory of moral development: disordered conduct in childhood or adolescence may not progress to antisocial personality disorder. Other diagnoses suggest a more limited type of value deficiency. Examples include some of the impulse-control disorders (e.g. kleptomania, pyromania). DSM-IV does not list a sexual impulse-control disorder. Neither does DSM-IV have a specific place for incorporating such organically based conditions as brain damage to the ventro-medial frontal lobes that Damasio and his colleagues (Anderson, 1999) have identified as being specifically related to impairments in social and moral behavior.

Criteria for Cluster B personality disorders—borderline, histrionic, and narcissistic—(DSM-IV, pp 645-661) identify unstable emotional, reasoning, and action patterns but also implicate moral difficulties in the form of various excesses and deficiencies in the valuation of self and others. Taken together the disorders allude to a general deficiency in moral grounding. Afflicted individuals are not able to integrate the good and the bad—the right and the wrong—in themselves and the world in ways that consistently tolerate the negative while holding to the positive. The description of Dissociative Identity Disorder (DSM-IV, p 487) also alludes to faulty conscience development as different value deficiencies or assets characterize the different personality states. The diagnosis, socialized conduct disorder, which disappeared after DSM-III, presented a mixed picture. It was defined as a condition in which a person demonstrated a pervasive pattern of disregard toward the "impersonal" other, while remaining loyal and true to a select group. For an overview of current nosology from the perspective of maltreatment see:

Conscience Sensitive Diagnosis of Maltreated Children and Adolescents (Galvin et al, 2001).

A subtle moral respect for human fallibility or “growing pains” exists in DSM-IV’s time and impairment requirements for labeling a set of symptoms as a mental disorder. Emotions may rise and fall, thoughts may lose their logical structure, behavior may go awry, and interpersonal rifts may occur without meeting the frequency, duration, or intensity requirements to be labeled psychopathology. These weighting requirements imply that children and adolescents’ lives (and those of adults, too) are expected to contain some distress, unhappiness, and error. In fact, in moderate amounts, these perturbations enhance the development of tolerance in us for each other. Distress, unhappiness, and error force moral maturation out of the loss of innocence. They impel fine-tuning in the differentiation of good and bad; create lessons out of mishap and tragedy; inspire the investment of energy into creative goodness, and prepare individuals to anticipate a future filled with uncertainty and, occasionally, morally uncharted waters. Parenting and grand parenting are not just reruns of development from a third-person perspective, but opportunities to master what was missed on the first-time pass through in growing up. Distress, unhappiness, and error also beset a profession and its professionals in their moral maturation.

Slowly but surely, a developmental perspective is being built into child psychiatry’s diagnostic system. Research of conditions as diverse as schizophrenia and conduct disorder demonstrate different impairment trajectories related to the chronological age at which the disorders first appear (Werry et al., 1991; Lahey et al., 1998) A chronological timetable is, of course, different from a developmental one. Conscience is a developmental construct that, in normal children and adolescents, correlates well with age. Healthy development leads to moral functioning that is connected, harmonious, value-balanced, and thoughtfully chosen. Unhealthy conscience development leads to a variety of escalating impairment patterns, currently not susceptible of description because psychiatry does not have the necessary agreed-upon concepts and language.

Conscience Sensitive Nosology: Conceptual Models of Conscience Mal-development or Malfunctioning

The interaction of *sick* and *bad* is perennially perplexing. Child and adolescent psychiatry needs operational and testable conscience concepts—borrowed, adapted, or created—that connect directly with or work alongside the assessment and treatment of psychopathology—in a developmental or epigenetic way. Necessary steps include (1) translating conscience concepts into domain-specific descriptors that track the course of aberrant trajectories of conscience and (2) analyzing how these aberrant trajectories do or do not correlate with singular or co-morbid Axis I or Axis II psychopathology and other associated factors. A model of psychopathological conscience functioning needs to be built domain-by-domain, diagnosis-by-diagnosis, circumstance-by-circumstance.

An early effort to provide such a model resulted in the **Global Assessment of Psychopathologic Interference in Conscience Functioning** (Stilwell, 2003c). In this undertaking we authors developed a deeper appreciation of interactions of psychopathology and conscience mal-functioning, i.e., the interaction of the “sick” and the “bad”, involving factors both distinct and overlapping. The essential lesson from the experience was that conceptual models relating conscience mal-development or malfunctioning to psychopathology could be organized along lines of progressive impairment. Similar to impairment associated with psychopathology, conscience impairment may involve such factors as density and severity of stressors, intensity of stress reaction, age of onset, duration of disturbance, and biological correlates and predispositions. Measurable factors related to conscience functioning alone include an individual’s general sense of oughtness and moral bonding to others; intensity of emotional reactions to self-defined right or wrongdoing; effectiveness of reparations and healing in the restoration of moral-emotional equilibrium; characteristics of personal value-sensitive rules for living; the distribution of personal values between authority, self, and others; degree of virtuous striving; response to moral complexity and wrong-doing in the world; and sense of moral efficacy.

In Guiding Treatment

Brent and Kolko (1998) define psychotherapy as “a modality of treatment in which the therapist and patient(s) work together to ameliorate psychopathological conditions and functional impairment through focus on the therapeutic relationship; the patient’s attitudes, thoughts, affect and behavior; and social context and development.” We authors contend that ameliorations of value deficiencies, imbalances, and distortions followed by the moral consolidation of therapeutic gain should be an additional goal in psychotherapy, especially during the formative years.

Injecting a moral focus into psychotherapy need not conflict with current modalities or techniques. Domains of experience that are already the focus of psychotherapy, i.e., relationships, emotions, cognition, and behavior, are also domains of conscience. Respect for patients’ belief systems does not preclude highlighting the moral aspects of their lives. In fact, a disservice may be done if moral issues are not addressed. Psychotherapy with non-psychotic adults generally focuses on change in coercive relationships, pathological guilt and anxiety, devaluative thinking and judgment, and excessively conforming or impulsive behavior. When adult patients change, they often experience a new sense of freedom. Therapists may feel like rejoicing with them in celebration of this freedom. However, freedom from old entrapments brings new responsibilities, each one requiring a new consolidation of moral meaning. Psychotherapy is incomplete if patients are not encouraged and given tools for morally organizing lessons learned from change. Self and conscience must grow in synchrony. Improved psychological adjustment mandates re-consolidation of conscience.

In contrast to adults, change in children or adolescents is often synonymous with development itself. As therapists “catch” change and development in the act, they are eager to capitalize on the child or adolescent’s newly emerging potentialities. Development brings its own resources: new curiosities and perspectives on relationships; new capacities for expressing and regulating emotions; new interests in organizing ideas; new value consolidations; new opportunities to act autonomously. Conscience-sensitive therapy can help a child or adolescent organize these emerging potentialities into morally meaningful guidelines—guidelines that ground their lives in the pursuit of goodness. See: **Preliminary Observations and Reflections on Conscience Sensitive Group Therapy** (Galvin et al., 2005).

Case Report

In accordance with HIPAA regulations adopted as part of its governance, the agency which had been involved with the following case requested that all identifying information including the location of the subject of this report and dates of admission to other facilities be expunged from the record. To ensure fidelity to the case, all dates will be indicated in reference to the date of the admission for example, ‘one week prior to admission (PTA).’ The reader may better gauge progress in conscience sensitive psychiatric assessment in the last eight years by comparing a previously published case report (Ammerman and Galvin, 1998).

Identifying Data:

“Kent” was a thirteen year eleven month old boy referred to The Youth Program by his caseworker at his home county’s Office of Family and Children and by the coordinator of his services from the “CAP Project” (hereafter referred to as the C. Project, a state supported project which secures and ensures the least restrictive available treatment setting for its clients).

The Reason for Referral was “ Seeking short term placement for stabilization, process[ing] grief and loss issues [and improving] anger management.”

Chief Complaint as registered by Kent: “ The only problem I have is the anger problem and I’m working on it.”

History of Present Illness.

Kent’s living arrangements PTA had been in a succession of therapeutic foster homes in which he had been placed. Kent himself estimated he had had over 30 foster home placements, including respite homes, although the aggregated referral information made mention only of the therapeutic foster homes, of which there were four. Among the documented reasons for one of his relocations among the therapeutic foster homes was that, in one case, the therapeutic foster parents had lost their licensure, in another case the foster father had “ an untreated mental illness” and engaged in “substantiated abuse” not otherwise specified. Upon inquiry about his maltreatment during the first psychiatric interview, Kent was angered and snapped, “ I don’t care! Why do you care?” Kent had also been at the guardian’s home and in two secure residential care programs comparable to The Youth Program.

Past Psychiatric History.

PTA Kent had been in at least seven psychiatric hospitalizations including two intermediate-stay state psychiatric hospitalizations. PTA Kent had been diagnosed, at various times, as having Intermittent Explosive Disorder; Bipolar Disorder, not otherwise specified; Oppositional Defiant Disorder; Attention Deficit Hyperactive Disorder (ADHD), combined type; and Major Depressive Disorder. Previously employed psychoactive medication trials as determined from aggregated referral information included: fluoxetine, bupropion, lithium, valproic acid, dextroamphetamine salts, and methylphenidate. In the course of his life, he had two state psychiatric hospitalizations, separated by an acute psychiatric hospitalization. He had been in process of transfer from the first state hospital, which was remote from his family, to another within the same locale as The Program, closer to his family, but did not show up at the hospital facility designated to receive him. Instead, he had apparently returned to live with his family. He soon required an acute psychiatric hospitalization, which eventuated in his transfer to the state hospital within the locale.

At the time of his admission to the first state psychiatric hospital he was taking bupropion, valproic acid and risperidone. He was still taking these medications at the time of his admission to the second state psychiatric hospital. In addition he was taking Ritalin. During the hospitalization his Ritalin was adjusted upwards, an attempt was made to reduce his Risperdal out of concern that it might be causing akathisia manifesting behaviorally. His Depakote was titrated up to generate a high therapeutic level of valproic acid. Wellbutrin SR was increased maximally. At best these medications seemed to help Kent “settle into the academic setting.” Higher doses of risperidone were resumed. Consideration was given to adding a selective serotonin reuptake inhibitor (SSRI) for his obsessiveness, which was not otherwise characterized. His treatment plan at the second state psychiatric hospital, which had a fully accredited hospital school, focused upon academic performance by providing a small,

structured classroom, a behavioral level system to reinforce academic and classroom performance including attendance, completion of daily assignments and homework, working in small groups and participating in alternative outings. Kent's treatment plan also targeted covert behavioral problems by establishing positive contingencies relative to time-outs which followed non-compliant behaviors; proposed work with the family to identify a lesser restrictive setting; promoted activities of daily living, grooming, hygiene and self help skills; and monitored for depressive symptoms, emergence of auditory hallucinations, excessive worries, and distorted thinking. While medications were continued at the time of discharge, the separation summary did not reflect robust effects. The separation summary identified "some signs possible hypomania" mostly in the form of silliness and grandiosity, but "not the mood shifts that had been seen at [the last acute psychiatric hospital]." The diagnoses at the time of discharge from the second psychiatric state hospital were Oppositional Defiant Disorder, Attention Deficit Hyperactive Disorder, Bipolar Disorder, not otherwise specified and Learning Disorder in Reading. At discharge his Mental Status Examination (MSE) was significant for inappropriate affect. His Global Assessment of Functioning (GAF) at admission was 40. His Discharge Assessment of Functioning was broken down into Components, according to the practice at the youth services of the state hospital at that time: social 42, family 41, academic 38 and psychiatric symptomatology: 46.

Past Medical History.

Aggregated referral information included some developmental history. In a past parent interview, his mother had denied use of substances of any kind during the pregnancy. He was delivered 3 weeks prior to his mother's due date. There was fetal distress, not otherwise specified and jaundice at birth that required 2 weeks in the hospital. He required an apnea monitor for 6 weeks. At 8 months of age he required hospitalization for dehydration. He walked at 11 months and accomplished toilet training by 2.5 years old. At 8 years of age he was hit by a car and was struck on the head but there were no details about loss of consciousness, concussion or any neurological sequelae. He had an EEG and CT scan of the head performed. These studies were normal. He had normal thyroid functions as well as CBC, differential, platelet count, comprehensive metabolic and lipid panel.

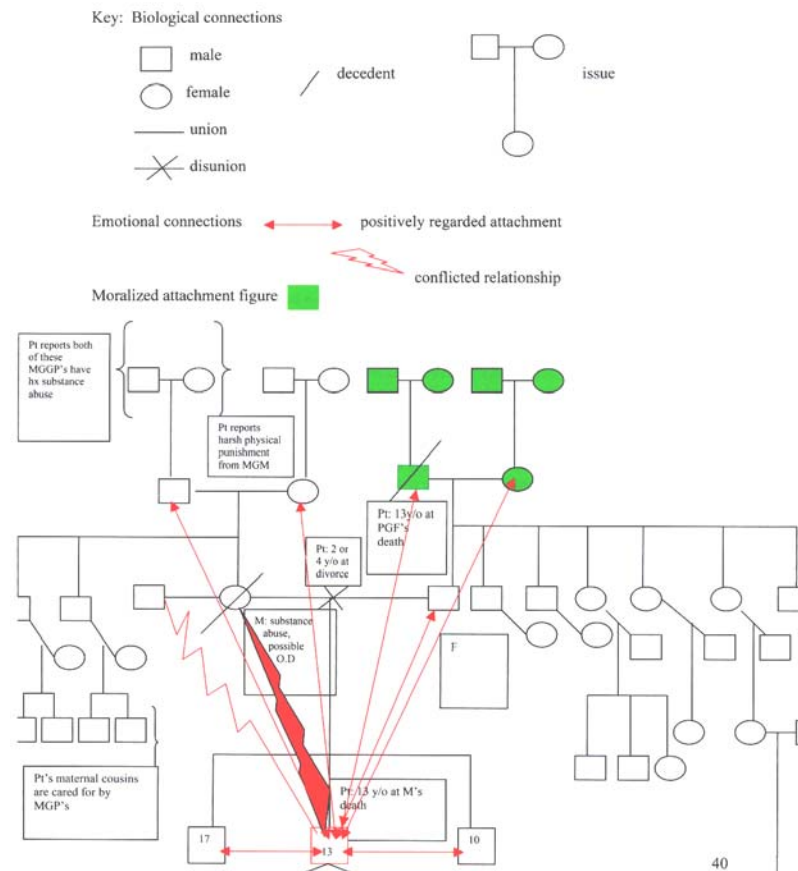
Substances. Aside from tobacco, which he did not favor enough to use habitually, Kent's substance use included trying marijuana. He also admitted to huffing gasoline once two years PTA.

Family and Social History.

A family tree was constructed with Kent during the second psychiatric evaluative session when he was more cooperative and self-disclosive. The technique employed involves three passes over the material. The first two passes are familiar efforts to identify biological connections, genetic vulnerabilities and losses (supplemented with reference of the event in question to the patient's personal time line), emotional connections and disconnections.

The third pass is an inquiry about moral attachment figures (e.g. "In your family, who cares most about whether you lead a good life?" and "How has this person tried to teach you right from wrong?")

Figure: Kent's Moralized Genogram



Available information indicated that Kent's mother dropped out of school in her junior year of high school in order to marry Kent's father. They were married 8 years. According to referral information, Kent's biological parents were divorced when he was 4 years old (according to Kent he was 2 years old at the time). Kent believed his mother's substance abuse began after the divorce. His parents continued to live together after the divorce, until 5 years PTA. At about the same time that Kent's father was diagnosed with a chronic debilitating illness. Kent recalled that, up until the time his parents parted, there were scenes of high expressed emotionality and domestic violence in which they threw things at one another. He stated that responsibilities for cleaning up after these altercations and taking care of the younger children devolved to him. Indications from both Kent and from the record were that he subsequently lived with his mother and/or members of her family as well as at other

times with his paternal grandfather. He professed to have a positive attachment to his maternal grandmother but recalled that his maternal grandmother would “beat” him with a wooden paddle. He harbored a belief that his relatives from that side of his family owed him material goods. In particular, he believed “a four-wheeler” that once belonged to him was sold to purchase guns to which he laid claim. He resided with family friends at age 7 for six months because he ran away from his mother’s home. His mother had left Kent with these friends while she went to visit her family. It was during that time, while she was away, that he was first psychiatrically hospitalized by consent of these same friends to whom she apparently had given power of attorney. He resided with his father for a nine-month period five years PTA because he had been too aggressive at home with his brother. At the time of Kent’s admission to The Youth Program his biological mother was incarcerated. She had given history at one point of being physically abused by her mother. Kent made inconsistent allegations that his mother was physically abusive but consistent allegations that she was negligent and emotionally abusive towards him. Kent further alleged that her partner, whom he called his stepfather, “Beat me with a belt with spikes.” Kent attested that marks were left. He said he was about 6 years old at the time. During Kent’s second state psychiatric hospitalization, when Kent was 9 years old, it was known that his mother had custody of all three of her boys. She was described in the separation summary as difficult to engage in family work and hospital staff recorded their suspicion that she was diverting controlled substances sent home for Kent during home visits. She removed Kent from the hospital against medical advice. Kent recalled he lived with her for a couple of months after his release from the state hospital but that she sent him to live with his paternal grandfather while his brothers continued to reside with her. Kent declared with bitterness this division occurred “--because they [his brothers] were special.” Kent indicated that he subsequently lived with his grandfather 3 or 4 times but that his mother would “pull me out” each time, because, as he understood the matter, of custody disputes she had with Kent’s father. At some point, she was charged with diversion of prescription drugs including medications prescribed for Kent. During her incarceration, her other sons were placed together in a foster home where they continued to reside at the time of Kent’s arrival at The Youth Program. During the time of C. Project involvement, Kent’s mother signed consent for Kent’s adoption but not for the adoption of his brothers. She was not approved by the county Office of Families and Children for either visiting Kent or contacting him on the telephone. Kent’s biological mother died 1 week after Kent’s arrival at The Youth Program. She had been released from prison whereupon she returned to her mother’s home in a neighboring state. Kent stated his belief that she overdosed on street drugs shortly after her release from prison. Her death occurred between Kent’s first and second psychiatric interviews at The Youth Program. At the second interview, he professed to be glad about her death. Kent’s father was still living. While he too signed adoption consent, he was granted approval for phone contacts with Kent, as were Kent’s paternal aunt and paternal grandmother. Kent’s father did not finish high school. It was reported he remained unemployed due to his condition, which has also left him wheelchair bound. He had suffered a recent stroke.

Personal History.

General. Kent remarked: “ In my life--didn’t have much attention. I lived in the country. Did what I wanted.” Upon inquiry about risk taking behaviors, Kent conveyed, with relish, the information he engaged in “daredevil stuff.” It was difficult to establish the position of (let alone corroborate) the events he described on his personal timeline. The misadventures he recounted included at age 6 shooting a bee-bee gun at his brother: “[It] hit him in the buttocks and went six inches up, bounced off his bone. [It’s] still there. Nobody can get it out.” He also related driving his father’s red mustang, “--at 70 miles an hour, ramping it and wrecking it.” He said he enjoyed engine operated vehicles and hunting. He said he enjoyed guitar and drums.

Education. In the aggregated referral information, his IQ had been reported to be 91 but the method of determination was not specified. His most recent achievement at school was reported to be no further along than 3rd or 4th grade level in all subjects. In 7th grade he received an out of school suspension (OSS) for threatening to strangle his teacher. In 8th grade he had “difficulties with his teachers,” not otherwise characterized and was attaining F’s at the middle school he attended at the time. While at the most recent therapeutic foster home, he was enrolled in an alternative program in a different middle school. There he received services for his previously diagnosed Reading Disorder and other services under an Emotionally Handicapped (EH) designation. Kent reported 6 or 7 OSS’s, mostly for stealing or for smoking tobacco on the grounds. He insisted that only one of these OSS’s was for fighting. He related he was provoked to fight when a peer made fun of his grandfather.

Religion. Kent identified himself as Christian. Asked about whether he perceived himself closer or further apart from God in the last year, he responded: “Last year--close. This year He’s not around and doesn’t want to help me.” Kent nonetheless continued to engage in prayer. Kent specified he made prayer requests of God to see his grandfather. He spontaneously added, “ But I also worship the devil ‘cause I know he’s real. Kent continued, “[B]ut if you’re not careful, the devil can take control of your body-- like he [did with me and] made me steal and smoke.” In the second interview, in the context of discussing his mother’s unexpected death, he said: “I was shocked. I wished my Mom was dead and 2 or 3 days later she died. God probably thought I needed it [reference to Mother’s death]. She hadn’t been much good in her life. If she didn’t ask Jesus into her life when she died she probably went to ‘H-E-Double Hockey Sticks.’”



Conscience Functioning

[Information conveyed by Kent in response to selected questions from the **Stilwell Conscience Interview**]

Conceptualization of conscience. Kent conceived of conscience as “in my head.” He said: “ I know right from wrong very well. I just don’t choose to do it. Sometimes it will tell me ‘Don’t grab or steal it.’”

Moralized Attachment. In the first interview, Kent’s response to this question set was to identify attachment figures who, he believed, concurred with him that he did not require pharmacological interventions to help him control his anger. There was an expression of anger in the presence of a staff person immediately after the first interview in which Kent remarked to the staff person “[The psychiatrist] asked me about my anger and about my grandfather who died” (actually no questions were posed in the first clinical encounter about his reactions to his grandfather’s death). In the second interview, he constructed his triple pass genogram (see Figure). He described a strong emotional attachment to his paternal grandfather who died when Kent was thirteen. Kent could not be sure exactly when, remarking it happened one or two Thanksgivings ago. As can be seen from Kent’s genogram, although deceased, PGF remained a principal moral attachment figure: “ He taught me ‘Don’t hurt yourself,’ how to shoot a gun in defense, use knives in defense, how to hunt, not to get into a garage without permission, start lawnmowers with the right key--everything a parent would.” Kent said he used to help wait on customers in a gun shop where his grandfather worked. Kent’s earliest memory of approval was retrieved from 13 years of age. He related how he found a wallet at the mall, turned it in at an information desk where the man was already making an inquiry about his lost possession. The man, as well as Kent’s father, approved. Kent said he received a monetary reward of one hundred dollars. Kent exhibited a longer memory for disapproval. The earliest such memory was from 6 years of age when Kent took a guitar to school against his father’s wishes: “ I broke the whammy bar.” Asked how he reacted to the event, Kent said he threw his older brother around. Asked what made him respond that way, Kent explained, “ He don’t weigh that much plus he was really tired.” Kent indicated he was generally more apt to disapprove than approve of himself.

Moral Emotional Responsiveness. In the first clinical encounter with the psychiatrist, Kent was not responsive to inquiry into changes in his inner states in response to right- and wrong-doing. In the second interview, he conveyed the information that when he engaged in doing something he considered to be right or good, he had an urge “to jump for joy.” When he engaged in wrong-doing, he experienced “guilt over my whole body,” a mood change in which he felt he would cry, with somatically experienced concomitants of shaking legs, hands, and an “upside down stomach.” An example of when he had this kind of moral emotional reaction was when he stole \$267 dollars at his school.

Moral Valuation and Volition. Kent adduced some rules for living: “Don’t steal,” “Don’t smoke,” “Don’t Drink,” “Get married after 21 years old and stay in the relationship 3-4 years” beforehand, and “Do what parents say.” In the first interview, Kent related he was subject to homicidal urges, but would not act on them. At that time, Kent insisted that the sole reason he didn’t kill his mother “with a shotgun” was because he would go to prison. When challenged to think of any other reasons to resist his urge to kill his mother, he adduced none.

Mental Status Evaluation

Appearance, Attitude and Behavior. On first encounter, Kent appeared a moderately built youth of stated age, with tousled brown hair, facial freckling and an uncertain complexion prone to mild acne. There were no readily discernible genetic markers, or abnormalities of cranium or facies such as elongation, hypertelorism, abnormal pinnae, or shallow philtrum. His height was 5’51/2’’ and weight 143 lbs. There was no evidence of abnormal involuntary movements in the form of tics, extra pyramidal symptoms (EPS) or dyskinesia. While not in a state of extreme or even moderate psychomotor agitation, he immediately made known his annoyance that the interview would be conducted and became more impatient as the nature of the interview (i.e. expressly that it would involve personal questions about his thoughts, feelings, values and choices) and the rule of confidentiality governing the interview were described to him. He professed disinterest and resisted making anything more than curt, minimally informative responses that nonetheless were laden with anger. However, he also gave the impression he was monitoring and modulating the tone of his voice as if to avoid exhibiting too much disrespect. He was guarded and averted his gaze from the interviewer. He made no threatening or intimidating gestures.

On second encounter three weeks later (a period of time remarkable for the loss of his mother), he was attired casually in his pajamas (it had been declared pajama day at The Youth Program); he was much more relaxed, engaging, cooperative and self-disclosive. However, he was not composed and exhibited marked fidgetiness. He endorsed having longstanding problems sitting still.

Mood and Affect: On the first encounter, the prevailing mood was irritability and the chiefly expressed emotion was murderous hatred of his mother. Otherwise he was guarded in describing emotions, especially pain and sadness at the loss of his grandfather, which he disclosed indirectly to staff only after the first psychiatric interview was formally over. His affective range appeared markedly constricted and dominated by hostility and suspicion. Elements of what have been termed ‘instrumental anger’ as well

as 'reactive anger' were evident. On the second encounter he described a fuller range of emotion including excitement, enthusiasm, "guilt" and joy but his affect remained generally superficial and did not always resonate with the emotional experiences he recounted. Some of his accounts of sensation-seeking exploits and a considerable monetary reward garnered for good behavior were grandiose in content if not in the affect that accompanied their rendering. The contrast in moods from one clinical encounter to the next did suggest mood lability, mild to moderate in severity.

Thought Processes. On both clinical encounters, he responded to most questions without indicating any confusion about their meaning. His responses were mostly pertinent to the questions posed. There appeared to be mild impairment in his ability to sequence events along his personal time-line. The impairment was more pronounced when the events subject to inquiry involved adverse experiences. He was more generously informative about his inner states during the second encounter but also exhibited more pressure, mild to moderate in severity. He endorsed having subjective experiences of cognitive accelerations, as well as difficulty paying attention. He recalled having trouble talking out of turn and receiving correction from his teachers more frequently than his classmates. He also declared, "I space dream." He had difficulty describing this state further in terms of level of awareness of his surroundings, duration, and frequency or similarity to dissociation or thought blocking.

Thought Content. He denied current hallucinations. On the second interview, he acknowledged past experiences of hearing voices--none recently-- and clearly distinguished these from his experience of conscience functioning, previously described. He endorsed having intrusive imagery from an earlier adverse experience, but only one: his pet dog getting hit by a car while he was working on his go-cart. He would not directly respond to questions about suicidality (ideas and intent) on the first interview, denied current suicidality on the second interview but at that time did disclose having had a suicidal urge at admission. He identified worrying whenever his foster parents or his caseworker would come to see him later than he expected. He identified tossing and turning at night. He reported having frequent nightmares such as one about running over his grandfather with a train as well as others about zombies and monsters. He indicated a significant level of distress attributed to his nightmares. He asked for medication to help eliminate them. He denied specific phobias including fear of the dark and fear of being alone. He endorsed having preoccupations with repetitive character about the loss of his grandfather and having homicidal fantasies with repetitive character about his mother.

Sensorium: he was alert and oriented in three spheres.

Concentration: He could not do serial 7's; emitting a groan when presented with the task and exclaiming he had difficulties with math.

Immediate memory: he was able to retrieve 3 out of 3 items without cue-words.

Recent memory: was unimpaired for verifiable events occurring within the milieu since he had arrived.

Remote memory: he was able to retrieve memories from after age 6. His ability to consistently present a time-line of personal events was impaired. Note has already been made that he retrieved memories of disapproval from earlier in his life span than memories of approval. Memories with other, non-moral, positive valences such as those for exciting activities on his own and agreeable experiences with his grandfather were retrieved from younger ages. Inquiry into memories of adverse experiences elicited heightened arousal, marked verbal resistance and defensive posturing.

Calculations. With encouragement, he subtracted 7 from 20 correctly. For Kent the task was moderately effortful.

Fund of Knowledge. A sample of writing from a privilege request he made showed poorly formed printing. He spelled "l-e-a-f-t" for "l-e-f-t," "p-o-r-v-ed" for "p-r-o-v-e-d" and "n-o-u-t h-e-n" for "n-o-t-h-i-n-g." He knew the current President but none before. He knew about the war in Iraq and remembered "the Twin Towers" vividly.

Intellect appeared to be low average to average with disability. He tended to be concrete, but was able to describe simple inner states.

Judgment: He clearly engaged in consequential thinking about acting on his homicidal fantasies. He indicated that anticipation of imprisonment effectively allowed him to resist acting upon his homicidal urges. The caution he exercised in observing limits on disrespectful behavior in the first encounter with the psychiatrist was not induced by warning from external authority (suggesting a measure of cognitive control over emotions). On the other hand, his recent history of out of school suspension and runaway behavior attested to his being subject to impulsiveness, if not being persistently impulse-ridden. He had a history of accidents. He described himself as a risk-taker but denied any encounters with legal authorities. It was suspected there might have been more legal involvement, perhaps informal, than appeared in the referral information.

Insight was impaired. Initially, he admitted only to "an anger problem" which he was "working on," by himself. Subsequently he admitted to nightmares for which he wanted symptomatic relief. He readily admitted to preoccupations with his losses. He actively resisted expression of any emotion but anger and in general minimized the importance of his recent relational disconnections. Upon inquiry, Kent provided no information about his perception of benefit intended or conferred -- or any side effects experienced -- in response to past or current medication trials. It was clear that his understanding of the nature of his disorder(s) and the various medications used in treatment was largely uninformed.



The psychiatric evaluation of Kent was conducted in a conscience sensitive manner, relying upon interview techniques that engaged him not only as an historian of his present illness and the subject of a mental status examination but also as a developing person of conscience, albeit subject to moral developmental delays, deviations and psychopathological interferences. Kent was asked specifically about his conceptualization of his conscience, moral attachments, moral emotional responsiveness, as well as moral valuational and moral volitional experiences. In the course of the interview there were also many opportunities to elicit his moral valuational and moral emotional responses to salient events in, and influences upon, his life and successes he had had in making choices that he regarded as good or right. As Kent's history attested, he had become a serious and persistent mental illness layered in complexity. Kent's case has been presented in such a way as to demonstrate that conscience sensitivity does not compromise or supplant established and/or evidence based theories and techniques in the field of psychiatry. With respect to interview time, review of aggregated referral information, interdisciplinary collaboration and length of documentation, Kent's assessment and treatment planning would not look out of place in many therapeutic residential treatment centers or intermediate stay psychiatric hospitals. However, conscience sensitive evaluations and treatment plans need not be as long as the ones conducted and elaborated on behalf of Kent. In an acute psychiatric setting, for example, they may be quite focused, as we have attempted to illustrate in previous work, **Conscience Sensitive Psychiatry: Clinical Applications: Retrieval of Life Affirming Values** (Galvin, Fletcher and Stilwell, 2005).

Biopsychosocial Formulation.

The genetic vulnerabilities in Kent's case were:

- 1) The genetic contribution to the condition of ADHD;
- 2) Other aspects of genetic endowment which could constitute a diathesis for disruptive behavior disorders, for example, recently researched functional polymorphism in the gene encoding the neurotransmitter-metabolizing enzyme monoamine oxidase A as a putative moderator of the effect of maltreatment on antisocial behavior (Caspi, McClay, Moffitt, et al., 2002)
- 3) Very probably a *temperamental* factor that is associated with sensation seeking or risk-taking (although his exploits may be exaggerated as compensatory grandiosity); there is also the possibility of intergenerational transmission of anger dyscontrol mediated partially by a heritable factor;
- 4) A maternal and possibly paternal history of substance abuse.

There is no clear-cut history of bipolar disorder on either side of Kent's family but it would not be surprising if either or both parents struggled with depression and mood instability.

Perinatal vulnerabilities. Although apparently not exposed to substances during the pregnancy, Kent had more difficulties than most babies in his perinatal course.

Attachment in infancy was threatened by Kent's hospitalizations. In the preschool and school age years, Kent's attachment experiences were badly compromised by disruptions, a chaotic upbringing and, in later childhood, by multiple out of kinship placements.

Childhood injuries. He sustained a head injury of unknown severity when a car hit him early in childhood. However his central nervous system appeared to have been grossly intact two years later when he had an unremarkable EEG and CT scan.

Neuropsychobiological sequelae of maltreatment experiences endured in early childhood in any given case are a matter of speculation. In L. Terr's (1991) terminology 'a type II' traumatic experience endured over time may also predispose to 'type I' reactivity consonant with the diagnoses of Post-Traumatic Stress Disorder (PTSD). Kent was recipient of "a double whammy" with acuity superimposed upon well-established chronicity. In D.O. Lewis' (1992) apt terminology, Kent was likely to have acquired 'intrinsic neuropsychiatric vulnerabilities' perhaps as part of genetic endowment (e.g. Caspi et al., 2002), perhaps incurred in the perinatal period but enlarged and compounded by maltreatment, resulting in impairments that compromised effective modulation of aggressive and violent impulses. Adverse life experiences might have altered and modulated genetic expression. The biological aspects of stress experienced over time might have, in R. Post's (1992) terminology, been transduced into the biological condition of depression or even, more speculatively, something resembling childhood bipolar disorder (during periods of highly intense stress) but more appropriately described as emotional dysregulation (under conditions of less intense stress). Stress responses including those from glucocorticoid and noradrenergic systems interacting with the developing nervous

system have implications for synaptic connectivity, neurotransmitter system maturational trajectories, and neurotransmitter enzymatic activity, some or all of which may figure in prefrontal-limbic functions correlated with adaptive executive and other psychological functions which pertain to cognitive control of emotions and effective use of working memory. Trauma effects upon the hypothalamic-pituitary-adrenal axis, locus coeruleus, amygdala and hippocampus, among other structures may manifest in hypervigilance, distractibility, autonomic hyperarousal as well as diminished empathic responses and constricted affective range.

From the standpoint of *developmental psychopathology*. During several developmentally sensitive periods, Kent occupied a position of extreme vulnerability on 'the continuum of caregiver casualty.' Several developmental domains were affected by rejection, abandonment, disruption of surviving attachments, loss of biological and foster parents' functionality and maltreatment experiences. There had been too many aggravating and too few protective factors in Kent's life. Sustained progress along a normal developmental trajectory was arrested. Psychopathological interference (P.I.), which took the form of 'background rage' compounded by mistrust, altered his trajectory into a deviant course. Not only were Kent's cognitive and emotional developmental domains affected, Kent also exhibited delay in conceptualization of conscience, inadequate moral attachment experiences, impairment and severe constriction in moral emotional responses including what might be termed deficiencies in 'guilt management' and an impoverished repertory of reparative and amendatory strategies, difficulty sustaining life affirming and life respecting values and, lastly, persistently and seriously impeded progress from an autonomous position (distorted, however, by oppositional defiance) to that of an accountable moral agent.

Psychodynamic considerations: The acute psychosocial stressors PTA were the death of Kent's paternal grandfather and the minor stroke of his father, which, together with Kent's behaviors at the time resulted in limitation of Kent's contacts with his father during the latter's recovery. Kent's adjustment to the therapeutic foster home, which earlier had appeared promising for permanency, was destabilized. Kent regressed. His behavior deteriorated and he engaged in acting out and running away as maladaptive coping devices, or defense strategies, which had served him often in the past. Another unconscious defense mechanism employed by Kent was 'splitting,' evident in override idealization of his paternal grandfather and demonization of his mother. On the Defensive Functioning Scale in DSM IV, Kent appeared to operate mostly between the disavowal level and the action level.

Loss of objects, loss of control of objects, and avoidance of a harsh and punitive superego figured among Kent's core conflicts. PTA he had experienced the loss of functional parenting from biological and socially designated parent figures. PTA he had experienced the existential loss of his grandfather. Following admission to The Program, he experienced the existential loss of his mother but preserved the hostile-dependent attachment relationship he had had with her by intermittent denial of her death. Events truly beyond his control overwhelmed his customary attribution style in which he externalized the locus of control in his life. This prompted compensatory grandiosity in various forms, for example his belief that he killed his grandfather or that God had destroyed his mother on Kent's behalf. His perception that he killed his grandfather, verbalized to his therapeutic foster parents PTA and erupting in nightmarish dreams after admission were also consonant with conflict arising from superego activity.

Societal considerations. Kent's lot had been to move from caregiver to caregiver, from school to school. It is a matter of speculation whether earlier interventions to assist Kent's parents to engage in sustained, firm, consistent parenting, earlier removal from them if this engagement did not appear possible, and, in the event, earlier development of a permanency plan for his adoption would have ameliorated the enduring adverse circumstances of Kent's life.

Strengths. Kent had competencies. The account of his intellectual abilities available at the time of this case report, although very incomplete, did not suggest mental retardation. The absence of covert violating behavior from the more recent chronicle of Kent's school and foster family life and a legal record relatively clear of violations of the rights of others (as opposed to violations of major age appropriate norms and rules which were documented) was promising. There was evidence of positive regard for some biological and foster family members (as well as his caseworker), which may have reflected some preservation of Kent's capacity for attachment. While there were delays and P.I. in the developmental domains of conscience, he also demonstrated preservation of functionality in several domains. Kent was not yet so demoralized that he had eschewed pro-social impulses or repudiated the image of himself as a person of conscience.



Conscience Sensitive Enrichment of the Bio-psycho-social Formulation

There were delays and deficiencies in conscience development as well as psychopathologic interferences in conscience functions. These included a conceptualization of conscience only one stage beyond the "external conscience" of the pre-schooler. Kent's conceptualization was an example of the "brain-heart conscience" that, among advantaged children, is more commonly found in early school age than in early adolescent years. He had compromised moral attachment reflected by difficulty retrieving moral memories, identifying moral exemplars among, or making moral attributions to, adult caregivers. He had moral emotional

disequilibrium, markedly diminished capacity for forgiveness and general lack of skill in amendatory and reparative strategies. Moral volitional impairments were in part attributable to his impulsiveness and his overvaluation of autonomy manifest as compensatory grandiosity and oppositional defiance. Moral valuational deficits included disregard for the rights of others and major age appropriate norms and rules when stressed and affectively dysregulated, a developmental psychopathologic condition predisposing him to meet Axis I criteria for Oppositional Defiant Disorder or Conduct Disorder, depending on the level of structure with which he might be provided. It was unclear at the time whether he would engage, as he had in the past, in covert violating behaviors while in a structured environment.

DSM IV Diagnoses

Axis I. Victim of Neglect of Child (995.5)

Victim of Abuse of Child (995.5)

Possible History of (Undiagnosed) Reactive Attachment Disorder (313.89)

Probable History of (Undiagnosed) Chronic PTSD (309.81): secondary to exposure to domestic violence and maltreatment experiences.

Acute PTSD (309.81): met criteria: A, B (1), (2), (4), C (1), (5), (6), D (1), (2), (4), E, F.

Disruptive Behavior Disorder, NOS (312.9): in past, but not in last 12 months, had met criteria for Conduct Disorder, Childhood-Onset Type: A (5), (8), (11), (12), B, C; currently met criteria for Conduct Disorder: A (14) and A (15) and four or more of criteria A, as well as criteria B and D of Oppositional Defiant Disorder (313.81). He might not have met Criterion C for Oppositional Defiant Disorder.

Mood Disorder, NOS (296.90): note that he would have met the criteria usually proposed for Childhood Onset Bipolar Disorder and historically was diagnosed as having Bipolar Disorder type II. Depressive symptoms were definitely present.

Bereavement (V62.82): in complicated form.

History of ADHD, combined type (314.01). Rule out refractory ADHD: there might have been a full complement or only residual symptoms refractory to current pharmacotherapy, however adequate treatment of Kent's PTSD and Mood Disorder was deemed necessary before making this diagnosis.

Reading Disorder (315.00)

Axis II. At least five of the nine criteria were met for **Borderline Personality Disorder**. Kent's young age mediated in favor of indicating its presence in the form of **Traits**. There were other Cluster B traits which at Kent's age were subsumed by the Axis I diagnosis. *Developmental psychopathology* suitable for informal inclusion on Axis II, associated with the forms of maltreatment to which Kent had been exposed (encoded on Axis I) and which Kent still exhibited included: cognitive effects such as reduced mean length of utterances, impoverished inner state language, interpretation of ambiguous stimuli as threatening, poor self-other differentiation, impaired cognitive control of emotions; emotional effects such as 'background rage,' general mood and affective dysregulation, empathic blunting; mistrust of authority figures and negative effects in terms of peer relations.

Axis III: Possible susceptibility to neuroleptic induced akathisia.

Axis IV: Problems with primary support group: abandonment, maternal criminality and incarceration, paternal illness, loss of paternal grandfather, loss of mother, shifting caregivers; problems related to social environment: multiple hospitalizations and residential placements, educational problems.

Axis V: CGAF: 30 HGAF: 45



Differential Diagnostic Considerations Among Subtypes of Conscience Functioning Disorder

Up to this point in our progress report, the authors have attempted to portray how conscience sensitive psychiatry is currently being practiced. We now take a tentative step beyond the state of the art to propose and, consider with the reader, in the case of Kent diagnostic criteria for Conscience Functioning Disorder (CFD).

Conscience functioning can go awry in many ways. The current diagnostic categories of oppositional defiant disorder (ODD; 131.81), conduct disorder (CD; 312.8), disruptive disorder not otherwise specified (CD-NOS; 312.9), impulse-control disorders not elsewhere classified (312.34; 312.32; 312.33; 312.31; 312.39; 312.30), and child or adolescent antisocial behavior (V71.02) describe end-product behaviors that imply problems in the moral pursuit of goodness and rightfulness. The general descriptions of these diagnoses (e.g. “pattern of negativistic, hostile, and defiant behavior” or “basic rights of others or major age-appropriate societal norms or rules are violated”) imply conscience dysfunction but do not include the context in which the disorders emerge. No diagnostic category captures impairment due to a hyperfunctioning conscience (e.g. obsessional concern about rules; indecisiveness about moral action).

CFD with seven subtypes is proposed. One subtype, obsessional conscience disorder, describes impairment due to hypersensitivity to moral concerns. The other six subtypes describe progressively impairing disorders that include context (acute precipitating factors, enduring adverse circumstances—biological or environmental), chronicity, and severity of impairment. This dimensional, developmental, and relationally focused approach to categorization assumes an interactional model of brain development and experience. It is designed to be helpful in prognostication and treatment. Since conscience domains emerge from underlying brain/mind systems, CFD invites research into brain mechanisms or endophenotypes. It does not negate accomplished research into conduct disorder.

On what Axis should CFD be encoded?

Considering that conscience is a core feature of personality, it is logical to code CFD on Axis II. However, a transaxial approach to understanding CFD comorbidity may present patient problems most accurately. Consider the following scenarios:

- (1) Axis I diagnoses such as PTSD, depression, anxiety, adjustment disorder, and substance abuse may precipitate a lapse in conscience functioning which would be recorded as: *conscience functioning disorder, disrupted type, acute*.
- (2) Being a victim of maltreatment (Axis I, 995.5) may precipitate chronic PTSD, depression, and anxiety as well as *conscience functioning disorder, deviant type, chronic*.
- (3) Characterological weakness expressed as *conscience functioning disorder, deficient type* or uncoded Axis II traits in combination with environmental stress may precipitate an Axis I diagnosis such as adjustment disorder or dysthymia.
- (4) *Conscience functioning disorder, impoverished type, chronic, severe* evolves into adult antisocial personality disorder.

Maintaining a multi- as well as a trans-axial approach to describing how various types of developmental psychopathology result in or emerge from conscience functioning disorders adds specificity to the system.

In Kent’s case the following types of CFD might be considered. For all seven types and suggested dimensional clinical and research queries for each type see [Conscience Functioning Disorder \(Stilwell, et al., in process\)](#);

XXX.2 Developmentally Delayed Type

A. Context:

One or more underlying brain/mind systems is impaired, resulting in *delayed* conscience development. With adequate moral environmental structure and support the individual still seeks goodness and rightfulness but does it in ways

characteristic of a younger child. The condition may be comorbid with Axis I Pervasive Developmental Disorder, Axis II mental retardation, etc.

B. Conscience Dysfunction Characterized by at least 4 of the following:

- (1) general immaturity in moral awareness
- (2) minimal or sporadic resistance to authority
- (3) desire to please others intact or exaggerated
- (4) distressed when rules are not or cannot be followed literally
- (6) protracted need for adult supervision on matters of right vs. wrong, good vs. bad

Using conceptualization of conscience stage as a guide, specify the delay as mild if one stage behind age expectation; moderate if two stages behind, or severe if three stages behind conceptual expectation for mental age. [Expectation: External stage (six years and under); Brain/Heart stage (seven to eleven years); Personified stage (twelve to thirteen years); Confused stage (fourteen to fifteen years); Integrating stage (sixteen years and older).

XXX.5 Disrupted Type

A. Context: The individual has been traumatized in ways that upset trust in the moral foundation of his or her world (e.g. extreme betrayal by others; war; natural disaster, etc). The individual's rearing may or may not be morally supportive. This disorder is likely to be comorbid with Axis I PTSD, depression, and anxiety.

B. Conscience dysfunction is characterized by three of the four following:

- (1) severe confusion about the moral foundation of life
- (2) sporadic participation in antisocial behavior for which the individual has no logical explanation
- (3) sporadic participation in antisocial behavior that the individual does not remember
- (4) a sense of futility about ever feeling like a good person again.

Specify age of onset of disorder.

Specify time since exposure to trauma.

Specify as acute if disorder has been present for 3 months; chronic if longer.

Specify impairment in the moral realm (disrespect for authority, self, or others) as mild, moderate, or severe.

XXX.6 Deviancy Type

A. Context: The individual has been chronically traumatized by a morally unsupportive and unstructured environment (e.g. abuse, neglect, abandonment, impoverishment, etc.).

Brain/mind systems underlying conscience development may or may not be impaired. The condition may be comorbid with Axis I depression, bipolar, ADHD, anxiety disorders.

B. Conscience dysfunction is characterized by all of the following

- (1) extreme dominance of survival values and strategies
- (2) aggressive and paranoid reactivity to the slightest offense by others
- (3) trust is limited to a very few individuals (e.g. one's own gang.)
- (4) hostile stance toward authority

Specify age of onset

Specify social, academic, or occupational impairment as moderate or severe.

XXX.7 Impoverished Type, Chronic, Severe

A. Context: With or without a morally supportive environment, brain/mind systems that organize the conscience clearly do not function in ways that support the pursuit of goodness and rightfulness as defined by society. All domains of conscience functioning are affected.

Conscience dysfunction is characterized by all of the following:

- (1) Trust and empathy between child and attachment figures are chronically impoverished.
- (2) Emotional responses (sadness, guilt, shame) to what society deems moral behavior are impoverished.
- (3) Values are exclusively self-serving and cognitive processes are used to justify the rightfulness of this stance.
- (4) Will power is used to intimidate or control others in the service of self.

(5) Conceptualization of conscience lacks evidence of personal moral meaning.

Treatment Planning.

Kent's most immediate needs were for:

- i) Safeguards, currently in place, to be sustained in order to protect Kent from his dangerous, risky and self-injurious behaviors;
- ii) Identification of an acute psychiatric hospital and safe, expeditious transfer to that facility if Kent's level of acuity were to rise. Frequent interventions more restrictive than therapeutic holds or need for injections prn for severe agitation were to be among the indications for transfer to the acute psychiatric service at the community hospital. Current pharmacotherapy was to be maintained with minimal adjustment, if possible;
- iii) Concurrent therapeutic work in order to support Kent in a complicated bereavement process and to acquire skills in dealing with his anger (and other emotions not so readily apparent);
- iv) Prompt evaluation of Kent's position along the continuum of caregiver casualty, with a determination of whether removal from the most recent foster home was irrevocable from the standpoint of the foster parents and/or the C. Project and/or the OFC;
- v) Efforts to protect and strengthen connections (salutary to Kent's well-being) with biological family members.
- vi) Continuation of his education.

Kent's intermediate (short-term) needs were for:

- i) External support and direction while he internalized safeguards in accordance with management plans for suicidality, violent impulses, and elopement impulses;
- ii) Differential pharmacotherapeutics for ameliorating disabling affective and cognitive conditions specified according to a personalized algorithm informed by Kent's past responses to psychopharmacologic interventions;
- iii) Proposed alterations in pharmacotherapy in accordance with processes of informed consent from Kent's legal guardian and informed assent or refusal from Kent;
- iv) Psychological assessment if not conducted in the last two years.
- v) Psycho-educational evaluation if not conducted in the last three years.

Among Kent's longer-term needs are:

- i) Sustained involvement by a single coordinated provider-group operating within a continuum of care ranging from the current therapeutic residential program to a therapeutic foster family inclined towards permanency. The highest degree of confidence in Kent's readiness for movement should first be attained by the interdisciplinary team before Kent would be subjected to any efforts to 'step-down' to lesser restrictive settings;
- ii) Contingent upon the outcome of meeting "immediate need (v)," and "longer-term need (i)" above, eventual reintegration into a therapeutic foster home with a permanency plan and community including school and outpatient psychiatric and psychotherapeutic interventions
- iii) Inclusion of mentoring as part of the disposition plan.

Treatment Plan.

At admission consent for treatment was obtained from the legal guardian (the OFC caseworker). Initial assessment of Kent's behavioral acuity and potential for self harm favored continuation in the lesser restrictive residential treatment setting rather than referral to the acute psychiatric inpatient unit for youth in a community hospital where the consultant psychiatrist maintained active admitting privileges (assessment of behavioral acuity was ongoing throughout Kent's stay). The initial treatment plan was established with suicide, escape and assault precautions; visitor and contact list established in accordance with OFC requirements as communicated by the caseworker; authorization was given by the consulting psychiatrist to continue medications prescribed prior to admission; and Kent was designated to have a firm supportive therapeutic approach from staff (replaced by a matter of fact approach when Kent engaged in escalating oppositionality). Kent was enrolled in school. School records were requested and an educational assessment by the special educational teacher at The Youth Program was begun. Kent was engaged in the milieu therapy at basic responsibility and privileges status (Kent was oriented to the level of privilege system and policies regarding restrictive interventions in place at The Youth Program). Kent also participated from the point of his arrival in process group therapy and individual therapy with the social worker. Early family work included monitoring of foster family contacts and keeping Kent informed of his biological family's plans for his mother's funeral. The Program also designated a staff person to coordinate social services provided by the county OFC caseworker and the C. Project case manager. Kent's case manager visited Kent 15 days after his arrival at The Youth Program, a week after his mother's death. Kent was excited to have

the visit. Physical examination was conducted, and immunization and TB skin testing records reviewed by the pediatric MD and RN, respectively. Findings were unremarkable.

Therapeutic Modalities

I. Psychopharmacologic Interventions

At the time of this case report there were still gaps in the account of Kent's pharmacotherapy. Summaries of the residential placements and history from the most recent prescriptive authority, it was hoped, would shed light on specific questions such as why valproic acid was discontinued and which, if any, mood stabilizers were used in its place. Additional history of medication trials was deemed highly desirable for establishing entry points on the various algorithms of differential pharmacotherapy for Kent's aggression, mood regulatory disorder and ADHD.

Conscience-Sensitive Psychoeducation.

However, there were other concerns besides collecting missing data. A therapeutic alliance had not yet been established and Kent had strongly indicated his anti-medication sentiment. It was thought Kent might be more amenable to medication if he could be engaged in a conscience-sensitive psycho-educational intervention which highlighted how biological conditions were likely to present barriers to a person of conscience attempting to direct his willpower to use existing coping skills (or acquire new ones) for the sake of life affirming and respecting values, which however, precisely because of the same biological conditions, had eluded his best efforts to retrieve and apprehend. To honor his autonomy Kent also needed a more important role in determining efficacy. It was considered unlikely that Kent would be able to have a period entirely medication free in which he might be observed prospectively while in the residential setting. Still, while awaiting responses to inquiries for more information about previous medication trials, there would be an opportunity for baseline assessment in which minimal adjustment of medication would occur to determine frequency and severity of target symptoms not susceptible to the psychoactive medications being then employed. In Kent's case, treatment team members were to monitor reactive-affective-defensive-aggressive outbursts and self-injurious behavior that comprised one target symptom cluster, mood lability, anxiety and depression another cluster, and readily apparent inattention, impulsiveness and hyperactivity still another cluster. Kent was to be enlisted as one of the informants on rating the response of target symptoms to medication. To supplement his weekly global impressions, either formal rating scales or a visual analog were to be employed.

HPI and MSE findings favored continued use of an atypical neuroleptic at least temporarily for the purpose of 'fuse-lengthening.' Kent's dose at the time of admission to The Youth Program (risperidone 0.5 mg per twice per day) was not nearly as high as his peak dose 5 years earlier (risperidone 5.5 mg per day), which, at one time, was apparently associated with akathisia induced behavioral symptoms. Neither on MSE nor physical examination at The Youth Program had Kent shown signs of any abnormal involuntary movements, which would have militated in favor of discontinuation. Kent had taken risperidone in the past and although robust effects had not been attributed to it, efforts in the state hospital to reduce the dose were eventually reversed on the grounds of behavioral deterioration. In view of these considerations, the tapering and discontinuation of risperidone intended by the OP psychiatrist was countermanded. It was hoped that supportive therapy and consistent limit setting afforded to Kent in the structured setting of the residential treatment center combined with the medications would be sufficient to stabilize aggressive behaviors directed at himself or others. If not, consideration would be given to a cross-titration of another atypical neuroleptic (such as quetiapine, ziprasidone or aripiprazole, assuming these had not already been used) against risperidone, according to the rationale that they might also contribute to 'fuse-lengthening.' Olanzapine might also be used, and for adults already had an indication for mood stabilization, but the undesirable weight gain associated with it as a side effect might exceed that of other atypical neuroleptics. The conjectural nature of the intended off-label use of any of these atypical neuroleptic warranted specific mention in the informed consent process.

A mood stabilizer was likely to be required. Topiramide was discontinued (as intended by the OP psychiatrist) since, at 25 mg per day, it was not likely to confer benefit either as a putative mood stabilizer or as an agent to counteract weight gain associated with atypical neuroleptics (the weight gain associated with mirtazepine might have influenced the choice of topiramide as much as the association of this side effect with atypical neuroleptics). In order of preference, alternative mood stabilizers were: carbamazepine, valproic acid re-challenge (depending upon what was learned about the reason for its discontinuation), and lithium carbonate which had been tried before but might be given another trial since there was no data about efficacy or levels attained in Kent's case. Lamotrigine was a last choice because of the increased incidence of Stevens Johnson Syndrome in the pediatric population in comparison to the adult population. As in the case of the atypical neuroleptics, the same considerations for informed consent applied.

Kent was taking mirtazepine at admission. It was surmised that mirtazepine was selected from among the antidepressants for its sedative effects, since Kent's sleep pattern had long been disrupted by nightmares and restlessness. In any event, Kent did not discern mirtazepine as conferring any benefit. The one request for symptomatic relief Kent made was for suppression of his nightmares. It was therefore decided to discontinue mirtazepine in favor of the alpha 2 adrenergic agonist

clonidine with the intention it would reduce autonomic hyperarousal, shorten sleep latency and suppress nightmares. It was understood that the antidepressant and anti-anxiety effects conferred by the mirtazepine might be lost. Therefore, a different medication for depression and anxiety might be required. Atomoxetine, structurally similar to an antidepressant, exerts noradrenergic effects reminiscent of desipramine. While it might be hoped that atomoxetine would confer benefit for anxiety and mood disorders, it was not indicated for either. Kent had previous trials of fluoxetine and bupropion. Additional records, once acquired, might indicate that sertraline has been tried already. If not, sertraline would be a reasonable choice and would be as compatible as other SSRI's, in terms of its serotonergic effects--and perhaps more compatible than other SSRI's in terms of competition for cytochrome P450 enzymes--with atomoxetine.

Kent had previous trials of psychostimulants from each of the two major families and had also a trial of bupropion at adequate doses in combination with the stimulant methylphenidate. Atomoxetine seemed a reasonable choice at the time but at his weight, 143lbs, Kent probably needed a higher dose, twice what he had been taking.

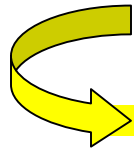
II. Psychotherapy, to be conducted by the social worker, reinforced in the milieu, reviewed weekly in interdisciplinary team meetings and approved by the psychiatrist, was proposed as follows:

- A. Exploration of Kent's existential losses, i.e. paternal grandfather and mother;
- B. Identification of his current stressors, e.g. Kent's undesirable movement further along 'a continuum of caregiver casualty' most recently in his disconnection from his current foster family;
- C. Attaining understanding of Kent to engage in psycho-dynamically informed supportive psychotherapy, in which the therapist might use indirect communication or therapeutic metaphor to respond to Kent's representations of core conflicts;
- D. Working within the perimeters of defense mechanisms developmentally available to Kent in order to help him identify:
 1. His self-defeating behaviors,
 2. Faulty cognitive habits, as well as
 3. His misattributions of empowerment (or lack of empowerment).
- E. Engagement in goal-setting, acquiring and/or applying problem solving skills (e.g. consequential, alternative and means-end thinking) in achieving the objectives approximating those goals; and
- F. Specific anger management techniques.

III. Milieu therapy conducted by the youth service workers and supervised by the coordinator of The Youth Program was proposed to include behavioral interventions that would:

- A. Reinforce adaptive autonomous behavior via
 1. Engagement of Kent as a member of his treatment team responsible for self monitoring progress towards his goals and for initiating requests for removal of precautions and addition of privileges
 2. Assisting Kent in recognizing choice-points and practicing self-efficacy within the range of acceptable options.
- B. Reinforce accountability via
 1. Provision of external control in the form of precautions as required; removal of precautions contingent upon Kent's demonstration of consistent absence of and/or resistance to urges to engage in behaviors dangerous to self or others PLUS:
 - a. Kent's completion of suicidality management plan
 - b. Kent's completion of violent-impulse management plan
 - c. Kent's completion of runaway-impulse management plan
 2. Titration of privilege level against Kent's cognitively and behaviorally demonstrated level of responsibility
- C. Provide planned periods of interaction with staff and peers that afford Kent opportunities to practice and acquire anger management and other social problem solving skills;
- D. Expand cultural enrichment and diversion opportunities as tolerated;
- E. Support educational, health educational and psycho-educational interventions.

IV. Group Therapy



Conscience Work in Kent's Treatment.

A conscience sensitive treatment component specifically designed for The Program addressed strengthening the domains of conscience in accordance with what we termed 'intrinsic or bedrock values of conscience.' Conscience work was conducted instead of the (perhaps) more familiar exercises in 'moral judgment' or 'moral reasoning' (i.e. Kohlbergian moral dilemma resolution) found elsewhere as a component in residential treatment programs. Conscience work was chosen to bridge the gap between, on the one hand, value-retrieval, value-seeking, and value-making essential to the adoption of goals governing goal directed behavior and, on the other hand, skill-building (essential to the practice of virtuous behavior). Through participation in conscience sensitive group therapy, Kent indicated the direction that should be taken with him in the individual and milieu therapy formats in order to promote his growth as a person of conscience. As mentioned in the Biopsychosocial Formulation, Kent had developmental delays and psychopathologic interferences in the domains of conscience. However he also had competencies and capacities that had been relatively spared and provided a substrate upon which to work:

A. *The conceptualization of conscience domain*

His moral imagination was to be engaged and strengthened by asking Kent:

1. To render an image of his conscience in drawing and words and to narrate his story as a person of conscience to group participants at a comfortable level of self-disclosure;
2. To consider and discuss how a person who wanted to think well of himself (or who wanted another person's approval) would think, weigh relative values, make choices and/or behave in imagined or real situations in which moral triggers were identified;
3. To produce a 'theory of mind' (more precisely: "a theory of moral mindedness"), meant to explain the motives and behaviors of fictional characters in films viewed with youth service staff or stories read in school. For example, Kent accepted the assignment to characterize Jean Valjean (as presented in the 1998 film adaptation by B. August of Victor Hugo's *Les Miserables*) as a person of conscience. Kent identified Valjean's moral emotional responses, including compassion, patience and cognitive control of fear and anger on behalf of respect for others. With assistance from other group members, Kent further identified, among Valjean's virtues, keeping promises to new attachment figures;
4. To consider how a person's maltreatment experiences may strengthen (as well as diminish) him as a person of conscience.

B. *The domain of moralized attachment*

Kent's earlier attachment relationships were seriously disrupted, as a result of which he was believed to have considerably diminished capacity for *moralized attachment*. He nonetheless demonstrated some surviving capacity for familial and extra-familial experiences of connectedness that he valued at the time or would value sufficiently to work towards preserving and strengthening, such that:

1. His awareness of the values these persons wished to transmit to him might be enhanced by participating in group exercises in which participants depicted and discussed their family trees (triple pass genograms).
2. Kent might be able to push back his moralized time line by guided retrieval of memories of approval from caring adults. This task was deemed best accomplished in individual therapy.

C. *The domain of moral emotional responsiveness*

Disabling affects, some of which interfered with moral emotional responsiveness (e.g. rage impeded progress in developing gratitude and forgiveness) others of which distorted moral emotions (e.g. expressions of excessive, grandiose or narcissistic guilt) merited surface level interpretation in the context of supportive individual psychotherapy and psycho-educational intervention in the context of group work. Generally, group work was expected to proceed with the exercise of describing emotional responses the agent would have to doing something good or right under conditions that varied as follows: when someone knew, when no one knew and when someone knew and didn't care (or actually disapproved). Then group work proceeded to describing emotional responses the agent had to doing something bad or wrong under identically varying conditions. Group practice in writing letters of gratitude and of apology to imaginary

persons (Kent had the option to write to someone real) were intended to expand Kent's repertory of reparative and healing strategies in the domain of moral emotional responsiveness.

D. The domain of moral valuation

Kent's had a surviving capacity for *valuation* that was susceptible of stronger moralization [e.g. via guided cognitive appreciation of value conflicts in the form of moral issues (i.e. right vs. wrong) and moral dilemmas (i.e. right vs. right)]. Generally, group exercises were conducted to identify reasons and motives for following or resisting urges and mandates (e.g. 'don't hit or kick') alike. Agents were challenged to exercise moral imagination to identify better reasons (e.g. a moral value such as 'don't cause harm') than their initial ones (e.g. 'don't do anything to get sent to juvie')

E. The domain of moral volition

Kent's threatened and misdirected *autonomy* had, by that time, taken the form of oppositional-defiance and risk-taking. It was nonetheless susceptible, via active promotion of moral agency and presentation of exemplars of moral advocacy, of being transformed by Kent in the service of moral growth and moral adventure. One exercise in group therapy is to engage each participant in predicting progress in internalizing moral mandates he or she recognizes as right or good but currently attributes to external authorities.

The Future of Conscience Sensitive Psychiatry

In **Teaching**: the authors have called attention to the great potential psychiatrists have for contributing value to ethics education and professionalism, and have made available essential course materials, relying upon interested readers to explore other offerings on this website. In **Clinical Encounters**, conscience sensitive psychiatry becomes apparent when a psychiatrist, mindful of being a professional of conscience, makes, accordingly, systematic, respectful and empathic inquiries into the experience of a patient who has been invited to become mindful of being a person of conscience. The accumulated **facts** about the presenting problem (be it suicidality, homicidality, substance abuse, eating disorder, or any other with which a psychiatrist is every day confronted) issue into symptomatology characterized in terms of onset, severity, frequency, duration and the like, but just as surely generate rich arrays of moral images, attendant moral emotions and motivations. Facts generate such arrays but are also embedded deeply in valuational matrices and volitional experiences. Facts, meanings, feelings, values and attributions--all are susceptible to a guided process of historical narrative, for which the authors have provided a case illustration. In **Research**: in the course of rendering a conscience sensitive case report the authors have introduced a proposed typology of conscience functioning disorder. The proposed typology is respectfully submitted for further discussion within the professional community. Refinements in sensitivity and specificity and new 'moralized' techniques in treatment are most certainly needed, but wait upon the diagnostic classification that will inform--and will, in turn, be informed by-- psychobiological research that investigates conscience gone awry.

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