PSYCHIATRIC DIAGNOSTIC (DSM 5) CONTEXTS OF PSYCHOPATHOLOGICAL INTERFERENCE IN CONSCIENCE FORMATION AND FUNCTIONING ACROSS THE YOUTH-SPAN: A GUIDELINE

MATTHEW R. GALVIN
[WRITING FOR THE INDIANA UNIVERSITY CONSCIENCE PROJECT]

ABSTRACT. Pastoral counselors as well as psychotherapists might readily engage with conscience sensitive psychiatrists at the moral psychological level in understanding psychopathological interferences in conscience formation and functioning. The timeline of conceptual efforts made thus far to chart the course of psychopathological interferences in conscience formation and functioning is demarcated. Conscience sensitive psychiatry requires durable, conceptual tools for organizing bio-psycho-social considerations refined according to current standard diagnostic conventions in order for research to continue but also for the sake of enabling meaningful conscience sensitive contributions to healing. The absence of a designated group of disorders centered upon conscience accentuates the need to provide an up-to-date supplemental typology that will promote conscience sensitivity in diagnostic considerations. A **GUIDELINE** is provided for considering types of psychopathological interference in conscience formation and functioning in the context of current psychiatric diagnostic conventions.
CONSCIENCE WORKS, *Theory, Research and Clinical Applications* 4(1): 1-41, 2014

KEY WORDS: CONSCIENCE (C): C DOMAINS, C FORMATION, C FUNCTIONING, C RELEVANT___, C SENSITIVE___, C STAGES; PSYCHIATRIC DIAGNOSIS, PSYCHIATRIC DISORDERS, PSYCHOPATHOLOGICAL INTERFERENCE, TYPES, TYPOLOGY, VALIDITY, YOUTH-SPACE, YOUTH-SPAN

TYPOGRAPHICAL INDICATORS: 'ALL CAPS' fonts indicate a CHAPTER HEAD in DSM 5; 'SMALL CAPS' fonts indicate PSYCHIATRIC DISORDERS, CONSCIENCE STAGES, CONSCIENCE DOMAINS, or specific CONSCIENCE SENSITIVE TASKS. *Italics* generally indicate *technical terms* or, as an alternative to **emboldened** fonts, emphasis. Text taken directly from any DSM is underlined and followed parenthetically by the appropriate page number of the particular DSM (III, III-R, IV or 5) under consideration. 'Underlined' text is also used to indicate instruments.

INTRODUCTION

At legal, theological and moral-philosophical levels of dialogue, one might still hear strains of argument that immorality and amorality in their very essence resist attribution to—or even strong association with— psychopathology. Indeed, at those levels of discourse, the perennial dichotomies '*Bad* vs *Sick*' and '*Evil* vs *Ill*' have, for persistence, pervasiveness, and intensity (as well as, just maybe, their degree of truth and falsity) rivaled the analogous dichotomy '*Nature* vs *Nurture*' in the history of biological science. Of more import in counseling or therapeutic encounters, however, are the intra-psychic and inter-personal semblances of these dichotomies: "Counselor, am I a bad person after all or am I suffering from some malady?" And in corollary, "If this is some malady, what does a good person do about it?" For many, an intertwining is inescapable. On the other hand, at the moral psychological level of description–a level at which pastoral counselors as well as psychotherapists[1] might readily engage—there is an open invitation to consider how conscience formation and functioning really are subject to psychopathological interference.

Psychopathological interference with conscience functioning as previously defined (Goenjian et al, 1999) denotes disturbances in the domains of conscience that may manifest as a diminished sense of personal goodness, disturbances in internal and external responses after acting morally, disturbances in methods of moral healing and self management after wrongdoing, and a sense of loss of efficacy/a sense of moral will power. Psychopathological interference with(in) conscience functioning has sometimes been distinguished from delay in moral development (conscience formation) in that delay implies that the individual is morally less mature but more or less on the same track as younger individuals within the same culture. However, for purposes of this essay, psychopathological interference in conscience will be viewed as inclusive of *delay*, *deficit* or *disability* as well as *disturbance* because, so long as they entail impairment these are all conditions subsumed by the conventional concept of mental disorders.

The question of just how genetic endowment modulated by enduring adverse circumstances and/or more acute psychosocial stressors might interfere with the formation, the functioning—or both the formation and the functioning— of conscience has

[1] Hereafter In this document "counselors" will signify pastoral counselors, marriage and family therapists, psychiatric social workers and other mental health clinicians.

occupied and often perplexed the participants of the **Indiana University Conscience Project** since the Project's inception. The timeline of our conceptual enterprise is demarcated by:

- The Stage Criteria for the Stilwell Conscience Interview (Stilwell, 1994: final version) devised and refined over the years for studies of conscience formed and functioning in relative advantage (Stilwell et al, 1985, 91, 94, 96, 97, 98). [Access brief descriptions of domains by stage at: http://shaw.medlib.iupui.edu/domaindes.html]
- "The Scoring Manual" (Stilwell, 1993) for the Stilwell Conscience Interview noting both sufficiency and deficiency in each domain of conscience (Stilwell and Galvin, 1993a, b), devised for studies of conscience formed and functioning in psychopathological conditions (Galvin et al, 1995). Stages of deficiency subsumed varieties of conscience to illustrate level of severity (and mounting cause for concern) but made no deliberate and consistent attempt to trace in any particular type of conscience a progression from less to more severe.
- "Conscience Sensitive Psychiatric Diagnosis of Maltreated Children and Adolescents" (Galvin et al, 1994, 2001) offered an approach to conscience formed and functioning in maltreatment conforming to the *multiaxial* [first established in the Diagnostic and Statistical Manual of Mental Disorders (DSM), third edition (III) and continued through DSM IV TR] and— on our interpretation— *trans*-axial diagnostic system.
- The Stilwell Structured Conscience Interview was initially devised for a study of conscience functioning in the aftermath of catastrophe (Goenjian et al, 1998) and enabled assignment of levels of psychopathological interference using 7 inquiries with sensitivity to 4 of the 5 conscience domains: CONCEPTUALIZATION, MORAL EMOTIONAL RESPONSIVENESS, MORAL VALUATION and MORAL VOLITION (but not MORAL ATTACHMENT). Items were scored 0 to 5, with 0 representing no psychopathological interference and 1 through 5 representing progressively more serious and persistent *de-moralization* (a term to be construed quite literally as a suspension or reversal of *moralizing* processes operating among inner states often described as cognitive or affective (Stilwell, 2002) [Access at: http://shaw.medlib.iupui.edu/overview.html]
  The final version of this instrument which included MORAL ATTACHMENT was completed in 1999 [Access at: http://shaw.medlib.iupui.edu/SSCI.pdf]
  .
- The Global Impression of Psychopathological Interference to Conscience Functioning (Stilwell, 1999), which resulted from efforts to devise a single instrument that could capture severity of psychopathological interference on five levels. [It can be accessed at http://shaw.medlib.iupui.edu/psychopatho.html and will be helpful to consult at this point]. The development of this instrument received its chief impetus from what we had learned in the Goenjian et al (1998) study of *conscience-in-catastrophe*. Accordingly the prevailing themes were ones of "traumatic disappointment, breaches of trust or destruction of trusted relationships" (Stilwell, 2002). Some reflections on our efforts a little over a decade later:

  1) Levels one through four explicitly identified feeling of estrangement whereas by level five, estrangement no longer needed to be mentioned because it was complete. There was an implication that the instrument would be most applicable for those who had attained a point in development characterized by more or less adequate conscience formation, that is to say there had been some relationship with which one could become disappointed, in which trust could be broken, or which could be lost or destroyed. The relationship was not expected to be conspicuously absent from the start (or very nearly the start) of the *youth-span* (the part of the lifespan occupying the period from the perinatal period to early adulthood). Accordingly, the first level of psychopathological interference implied that a normal stage of conscience well beyond the EXTERNAL STAGE had been attained before a natural or other catastrophe struck. A close reading of level one psychopathological interference to conscience functioning will reveal features resembling the non-pathological CONFUSED STAGE of conscience (ages 14-15 yrs) in relatively advantaged development. Indeed the fifth level of psychopathology seemed to capture a malevolent transformation more apt to occur in someone who had **not** had fairly normal antecedent development before catastrophe struck.

  2) If we remove the context of catastrophe but substitute for it the context of unfavorable conditions for moral development rooted in racism, a sense of ethnic purity or superiority, sexism or other forms of bias, a quite different (and actually quite hopeful) interpretation of levels one and two might occur to us. Consider now a person challenging one or more among principal moral attachment figures who have nurtured a sequestration and anomalous formation of conscience (on this more to follow). The person we are considering is in revolution against the further intergenerational transmission of prejudicial *dys*-values, The person we are considering is a person engaged in so-called 'generational

clean-up'. Would not such a person's *conscience-in-objection* have some of the characteristics represented in levels one and two and even, perhaps, three? But should this be considered psychopathological interference or a *healing dysphoria*.[2]

3) Divergences and combinations of psychopathology according to internalizing and externalizing patterns proved problematic in providing succinct descriptions to inform judgment of severity (as was also the case for The Current Global Assessment of Functioning Scale that was first adopted in DSM III-R)

CONDUCTING A REORDERING OF DISORDERS OF CONDUCT

When the **American Psychiatric Association** charged the DSM 5 Task Force to proceed in the development of plans for revision of the DSM, dialogue and debate ensued about whether CONDUCT DISORDER should be eliminated entirely from DSM 5 (Huffine vs Dunne, 2006). One facet of the debate turned upon the question of putative progressions from disruptive behavior disorder. To better understand what was at issue, imagine converging and diverging pathways through the youth-span as roots, trunk and branches of a tree. At root are the various predisposing and contributing factors exhibiting etiological heterogeneity: psychobiological vulnerabilities that might be intrinsic and/or extrinsic, known to be present but deep underground, hidden from view. The branches, beyond reach in the here and now, represent possible future trajectories which are sufficiently remote as to also be effectively hidden from view. The trunk is in the here and now. The trunk is the common pathway from roots to branches. But it is not even the trunk we are really able to encounter directly. We are constrained by circumstances (some accepted as a matter of course, others self imposed) to see and feel only the bark. In our metaphor, features of the bark surrounding the trunk correspond to psychosocial—by and large, externalized behavioral—manifestations. In psychiatric diagnostic nosology, the externalized behavioral descriptions deriving from clinical encounters with certain youth in aggregate eventuated in the more or less homogeneous diagnosis of CONDUCT DISORDER. CONDUCT DISORDER was not the only diagnostic consideration but was raised high upon the index of suspicion. Yet the suspected diagnosis was itself never altogether above suspicion: where there was palpable misconduct, was it owing to a disorder constituted in itself or to some other? So far as we know, patterns found in the bark of the trunk do not reliably predict which will be the major and which the minor branches that issue from the tree. From a vantage point above the canopy in all its ramifications (which would correspond to a retrospective view at the end of the youth-span), what was thought on the basis of examination of 'the bark' to reveal a trajectory towards adult sociopathy would be confirmed in some cases but not in others.[3] Different branches from the same trunk represent alternative trajectories into other (non-disruptive disorder) diagnoses or attenuate into no diagnosis whatsoever.

An adjacent facet of the debate was whether there was a deficit, which, it could be said, would require a core sample of the trunk to identify, and which might better predict trajectories.[4] There was precedent in the DSM which, In DSM III (1980), types of CONDUCT DISORDER were conceptualized according to a square-of-four combining features of *aggressive or not, socialized or not*. DSM III CONDUCT DISORDER Criterion B indicated the establishment in *socialized* types or failure to establish in *undersocialized* types: a normal degree of affection, empathy, or bond with others as evidenced by the following indications of social attachment: (1) has one or more peer –group friendships that have lasted over six months, (2) extends himself or herself for others even when no immediate advantage is likely (3) apparently feels guilt or remorse when such a reaction is appropriate (not just when caught

[2] The term is to be understood in analogy to what was once known in psychodynamic therapy as *working depression*.

[3] Consider unfulfilled predictions of adult antisocial personality disorder based upon the so-called 'MacDonald triad.' The triad was retrospectively distilled from aspects of childhood history, including maltreatment that, among the 100 adult inpatients studied, [could] signal those who would eventually make threats of violence. The triad consisted of cruelty to animals, fire setting and persistent enuresis (Macdonald, 1963). The first two nominated predictors have been appropriately contested, the third discredited.

[4] This idea had precedents certainly in psychodynamic theory, notably, the concept of *superego lacunae* which, however, it might be put in terms of our metaphor, was an attempt to biopsy the root instead of boring horizontally into the center of the trunk, and which concluded, after all, with a causal attribution of juvenile delinquency to parents living out their own antisocial tendencies vicariously (Johnson and Szurek, 1952, critiqued by Lewis, 1981).

or in difficulty), (4) avoids blaming or informing on companions, (5) shows concern for the welfare of friends or companions (pp.47-50).

The dichotomy *socialized or not* seemed to be a step in the right direction in locating the core deficit. It depended upon a level of description of apparent attachment and inner states susceptible of interpretation regarding capacities for empathy and expression of remorse. However, by the time of its third iteration DSM was already striving in the opposite direction to be generally a-theoretical with regard to etiology (p.7). In DSM III R (1987) the dichotomies *aggressive or not* and *socialized or not* were dropped as criteria because they seemed to lack clinical utility and to be at variance with research findings (p.411). Instead the typology of CONDUCT DISORDER became: group type, solitary aggressive type or undifferentiated type (p.56; p.411). Nonetheless, the impairments in social emotions were retained as *associated features*(i.e. falling short of being considered criteria): the child may have no concern for the feelings, wishes and well being of others, as shown by callous behavior, and may lack appropriate feelings of guilt or remorse. Such a child may readily inform on his or her companions and try to place blame for misdeeds on them (p.53). *Callous and Unemotional* (C-U) were to remain among associated features until the advent of DSM 5, when they would re-emerge in the form of an additional *specification*.

When it came about, the elimination of the dichotomy *socialized or not* seemed to some of us a step backward. However, it was thought, here was an opportunity to introduce a more specific aspect of socialization, namely *moralization,* the signatures of which could be detected in a cross sectional sampling, would have clinical utility, would enable better research and would once again be taking a step in the right direction in locating the core deficit. As in dendrochronology when a bored sample of a wooden beam from an ancient dwelling show rings that can be counted to determine the dwelling's age, so it was hoped the cross sectional sampling of conscience would show traces of conscience formation as well as display current conscience functioning. Moreover it was hoped that such a sampling would provide hints as to what might improve conscience functioning at least in the youth-span of the near-future (albeit without necessarily allowing us to venture predictions of conscience in the developmentally distant future of adulthood).

Accordingly, a proposal of criteria for CONSCIENCE FUNCTIONING DISORDER was advanced in hopes of contributing something to the conversation. [See our power point presentation: Stilwell and Galvin: **Reconceptualizing Disorders of Conduct.** Access at http://shaw.medlib.iupui.edu/reconceptualizingconductppt.htm]

THE PROPOSAL FOR CONSCIENCE FUNCTIONING DISORDER

A. A repetitive and persistent pattern of delay, deficiency, or deviancy in the moralization of attachment, emotional responsiveness, valuation, volition, and conceptualization of personal conscience manifested by one or more criteria in each of the following domains for at least the last six months:

MORALIZATION OF ATTACHMENT Relationships

1. Acknowledges or demonstrates desire for positive relationship with attachment figures, but repeatedly and persistently fails to internalize their rearing demands and prohibitions as personal moral imperatives
2. Acknowledges or demonstrates no desire for relationship with attachment figures as well as blatantly resisting their rearing demands and prohibitions
3. Acknowledges a paucity of childhood memories affirming basic goodness or having done good deeds

MORAL-EMOTIONAL RESPONSIVENESS

1. Acknowledges or demonstrates a variety of emotions, but fails to regulate them around the pursuit of goodness/rightfulness or the restraint of badness/wrongfulness
2. Acknowledges or demonstrates limited emotional or physiological arousal to demands and prohibitions
3. Acknowledges or demonstrates marked difficulty empathizing with the emotional responsiveness of others

MORAL VALUATION

1. Acknowledges or demonstrates repeated and persistent devaluation of moral imperatives of authority figures or institutions
   - a. With defensive justification
   - b. With callous disrespect
2. Acknowledges or demonstrates repeated and persistent devaluation of moral imperatives governing peer relationships or peer communities
   - a. With defensive justification
   - b. With callous disrespect
3. Acknowledges or demonstrates repeated and persistent devaluation of moral obligations to the self

- a. With defensive justification
- b. With callous disrespect

MORAL VOLITION

1. Acknowledges or demonstrates deceptive behavior destructive of
   - a. Relationship with family members (including pets and property)
   - b. Relationship with authority figures and institutions
   - c. Relationship with peers and the egalitarian community
   - d. Relationship with self
2. Acknowledges or demonstrates overtly aggressive behavior destructive of
   - a. Relationship with family members (including pets and property)
   - b. Relationship with authority figures and institutions
   - c. Relationship with peers and the egalitarian community
   - d. Relationship with self

PERSONAL CONCEPTUALIZATION OF CONSCIENCE

1. Demonstrates developmental delay in the organization of a personal conscience
2. Demonstrates value deficiency in the organization of a personal conscience
3. Demonstrates value deviancy in the organization of a personal conscience
4. Demonstrates disruption to previously organized personal conscience

B. The disturbance in the moralization of attachment, emotional responsiveness, valuation, volition, and conceptualization of conscience causes clinically significant impairment in individual well-being or interpersonal functioning within family, school, and community settings.

C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder (or criteria for an adult Disorder of Conscience yet to be defined).

Specify type based on age of onset:

- Childhood-Onset Type: onset of at least one criterion from each domain prior to age 10
  Adolescent-Onset Type: onset of at least one criterion from each domain prior to age 10

Specify severity (Mild)

- Delays in conscience development are prominent (i.e., could be considered normal in a younger child). Demonstrates mild resistance to self-examination or modification in one or more of the five domains of conscience (i.e., improving relationships with attachment figures; attaching emotional significance to issues of good and bad; right or wrong; developing and processing personal moral rules; controlling behavior; and defining a personal conscience).

Specify severity (Moderate)

- In addition to delayed conscience development, deficiencies in conscience functioning are prominent (e.g., inadequate development of personal moral rules). Demonstrates moderate resistance to self-examination or modification in one or more of the five domains of conscience.

Specify severity (Severe)

- In addition to delays and deficiencies, deviancies in conscience functioning are the prominent feature (e.g., intent to be devious, aggressively harmful, or both). Demonstrates severe resistance to self-examination or modification in any of the domains of conscience.

D. Relationship to Comorbidity

- A Disorder of Conscience Functioning may be an independent diagnosis or it may be secondary to psychopathological interference from other diagnoses (e.g. PTSD, mood disorders, ADHD, substance abuse, psychotic disorders). Treatment of comorbid psychopathology may free the individual for further conscience development and improved functioning.

E. The Disorder of Conscience Functioning is not better defined by another disorder.

DISORDER OF CONSCIENCE FUNCTIONING NOT OTHERWISE SPECIFIED

- This category is for a disorder of conscience functioning in which one or more of the five domains are unimpaired.

Seven subtypes of CONSCIENCE FUNCTIONING DISORDER were eventually proposed: OBSESSIONAL; DEVELOPMENTALLY DELAYED; DEFICIENT-ACUTE; DEFICIENT-ISOLATED; DISRUPTED; DEVIANT; and IMPOVERISHED-CHRONIC, SEVERE. CONSCIENCE FUNCTIONING DISORDER was conceptualized according to the then current *multi*—and, on our interpretation, *trans-axial* system. CONSCIENCE FUNCTIONING DISORDER would be encoded on Axis II according to the envisioned subtypes with the understanding of emergent influences of a reciprocal kind, horizontally with respect to other disorders and traits on Axis II and vertically with respect to Axis I Clinical Syndromes. Putative neurobiological correlates with possible *endophenotypical* significance would be encoded on Axis III (Stilwell et al, 2006).

However, the proposal did not eliminate the typological conundrum occurring when severity and difference-in-kind have not been (perhaps because, at a practical level they cannot be?) kept distinct from one another. Adopting the proposed typology of CONSCIENCE FUNCTIONING DISORDER we could conjecture a trajectory with DISRUPTED, DEVIANT and IMPOVERISHED, as milestones passed along the way on a continuum, based upon a genetic variant (a matter of difference-in-kind), sort of a time-bomb that would only begin ticking when adversities triggered it (cf. *the diathesis/stress model*). We might even rarely conjecture a trajectory with the same milestones, based upon a genetic variant both necessary and sufficient without any modulation by adverse life events, sort of a time-bomb that is set to go off no matter what. In the light of recent findings about inflammatory processes at work in various psychiatric conditions, we might conjecture, in the DISRUPTED type, stress activated pro-inflammatory pathways that intermittently impair conscience functioning in susceptible domains. However, we could also conjecture the longer, grimmer trajectory towards habitual harm based upon the seriousness and persistence of exposure to adversities. According to that conjecture, cumulative neurobiological sequelae, according to age at onset, intensity, frequency and duration, *inter alia*, produce a difference-in-kind by transducing stress into a greater, cumulative diathesis (a model in which *allostatic burden* creates the *phenocopy* of a much rarer genetic variant). In this case we have sort of a time-bomb that is assembled over time from diverse parts [or as it might also be conceived, what was extrinsic and perhaps susceptible of prevention becomes intrinsic at the level of transcriptions affecting neuronal architecture, neuronal connectivity, and neurotransmission].

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS FIFTH EDITION

In 2013, DSM 5 became a *fait accompli*. There are welcome innovations and laudable progressions in DSM 5. In DSM 5 there is more emphasis upon development as relevant across the lifespan. There is more emphasis upon balancing categorical approaches with dimensional approaches to diagnosis. According to the Introduction, the Diagnostic Spectra Study Group recommended to the Diagnostic Work Groups that the disorders with which they were concerned be re-grouped on the basis of eleven scientific *validators* or indicators: shared neural substrates, family traits, genetic risk factors, specific environmental risk factors, biomarkers, temperamental antecedents, abnormalities of emotional or cognitive processing, symptom similarity, course of illness, high comorbidity, and shared treatment response (p.12). These validators can be sorted according to whether they are *antecedent, concurrent* or *predictive* (Regier, 2013) corresponding to roots, trunk and branches of our youth-span tree. Of special note, one of the organizing principles in establishing adjacencies in chapters was how disorders clustered according to *internalizing* and *externalizing* factors. In DSM 5 the multi-axial system has been eliminated, making theoretical trans-axial explanations moot. For better or worse, CONDUCT DISORDER remains in the *nosology*.

We know CONSCIENCE FORMATION and FUNCTIONING can go awry in many ways. We also know the psychopathological interference in CONSCIENCE FORMATION and FUNCTIONING is only rarely made explicit in formal psychiatric diagnostic criteria. Pre-eminent exceptions that can be found among the externalizing and internalizing disorders (which were formerly encoded on DSM IV Axis I) are CONDUCT DISORDER and MAJOR DEPRESSIVE DISORDER, respectively.

In DSM 5 the essential feature of CONDUCT DISORDER remains a repetitive and persistent pattern of behavior in which [there is] the violation of the basic rights of others or major age-appropriate societal norms or rules (p.472).This places — at the core of the disorder—particular deficits we recognize in the CONSCIENCE DOMAIN: MORAL VALUATION. The additional specification, with limited prosocial emotions (p.470), might be considered a new rendering of the dichotomy *socialized or not* (at least in the affective domain). It was adopted instead of C-U after unsuccessful vetting of C-U (and alternative terms). The additional specification refers to what we recognize as deficits in the CONSCIENCE DOMAIN: MORAL EMOTIONAL RESPONSIVENESS.

An important part of Criterion A for MAJOR DEPRESSIVE DISORDER remains feelings of worthlessness or excessive or inappropriate guilt (p.161). In this inclusion we again recognize difficulties peculiar to CONSCIENCE DOMAINS: in this case, MORAL VALUATION and MORAL EMOTIONAL RESPONSIVENESS.

Another example, among the personality disorders formerly encoded on DSM IV Axis II, one finds in DSM 5 the criterion for OBSESSIVE-COMPULSIVE PERSONALITY DISORDER: [i]s overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification) (p.678).

As in DSM IV, in DSM 5 mention of associated features readily interpretable as conscience dysfunctions in various conditions are made with somewhat more frequency. When conscience dysfunction is neither included in formal diagnostic criteria nor mentioned as an associated feature, its presence and mediating significance may require *inferential work* (more or less, depending on the condition) on the part of the counselor in order to bring it to the foreground. In INTERMITTENT EXPLOSIVE DISORDER, for example, while reference is no longer made to the experience of remorse after episodes of dyscontrol, aggressive outbursts are still associated with significant distress (p.467). It is incumbent upon the counselor/clinician to ascertain whether the distress is moral-emotional in manifestation. And yet it remains to be emphasized that virtually all psychiatric disorders, by virtue of being disorders, do not spare human conscience in at least one crucial respect: that is, in exercising their potential for producing *de-moralization* . Indeed we wonder whether de-moralization should be considered as chief among the *cross-cutting consequences* (to use the current terminology) of psychopathological interference in general.

TOWARDS A TYPOLOGY

CONSCIENCE SENSITIVE PSYCHIATRY requires durable, conceptual tools for organizing diagnostic considerations refined according to current standard diagnostic conventions in order for research to continue but also for the sake of enabling meaningful conscience sensitive contributions to healing. The absence of a designated group of disorders centered upon conscience (or moral developmental psychopathology) accentuates the need (at a minimum) to provide an up-to-date supplemental typology that will promote conscience sensitivity in diagnostic considerations. That is the impetus for this **GUIDELINE.**

The following suppositions are made:

1) Severity within types *vs.* severity defining types: we are not necessarily wedded to a typology which differentiates some types according to the degree of progression of severity corresponding to an imagined *continuum of casualty* while it turns around and differentiates other types based upon some core features irrespective of severity. A typology might manage differentiation mostly according to some core features irrespective of severity. It will still have need of a severity scale with specifications applicable within each type [e.g. none=0—minimal=1—mild=2—moderate=3—severe=4 (if the evaluator is not apt to encounter anyone at the extreme); or alternatively, none/minimal=1—mild=2—moderate=3—severe=4—extreme=5 (if the evaluator is not apt to encounter anyone free of any psychopathology whatsoever)].

> From an intuitive and naturalistic standpoint, 'severity' in real life itself is rarely based only on intensity, frequency and/or persistence. Severity is also based on location, timing in life and the presence of ameliorating and aggravating factors, not to mention attributions of cause and what meaning the symptom conveys to the person suffering. In **Introduction to Clinical Medicine** courses taught from the humanistic medical model, first year students learn to characterize pain as well as other symptoms accordingly. To keep from being unwieldy, research and clinical instruments devised to measure severity frequently narrow the field of variables familiar to first year medical students. The Cross Cutting Symptom Measure in DSM 5, for example, takes into account determinants of intensity (how much) and frequency (how often) in identifying the severity of symptomatology.[5]

[5] Keeping in mind the DISRUPTIVE, IMPULSE CONTROL AND CONDUCT DISORDERS (which, oddly enough, do not have a dedicated domain represented by a domain on the Cross Cutting Symptom Measure in DSM 5), there is yet another caveat in evaluating severity that really comes down to a question of perspective: is it more severe when it occurs at an earlier age, indicative of more damage having been done to the person and prognosticating a worse outcome for that individual in more

2) Such a typology as we are considering will need to allow for *conversion* from one type to another [perhaps predictable from combinations of features of the experience of adversity: age at onset (occurrence during developmentally critical or sensitive periods), as well as severity when it is understood as intensity/frequency plus, perhaps, duration].

> Without agreement upon and/or the means to ascertain biomarkers, conversion between types attributable at the psychosocial level to enduring circumstances of adversity and, at a biological level, to a phenocopy of a genetic variant rendered by allostatic burden cannot be readily distinguished from changes due to diagnostic instability.

3) Types of conscience delay or dysfunction can be discerned in the absence of any diagnosis per DSM 5.

> To psychologists who conduct personality and projective testing, this state of affairs is familiar. Consider an elaboration in the vein of an externalizing tendency to harm others. The presence of sociopathic tendencies (alternatively termed psychopathic deviancy or antisocial traits) might well be discovered in the Minnesota Multiphasic Personality Inventory or by Rorschach or any number of dimensional rating scales completed by the youth and those who know the youth. And yet the person of interest hitherto has succeeded—and might continue henceforth to succeed— in avoiding detection on anyone's radar for having violated the rights of others or major age appropriate norms and rules. This might not even be because of masterful deception, it could simply be because of the presence of a real or figurative 'cop on the corner', limited opportunity, the consistent experience of immediate gratification enabled by overly permissive authority figures, or savvy about avoiding loss of freedom in the service of personal empowerment (cf. Cleckley,1964). An elaboration could likewise be made in the vein of an internalizing tendency to harm oneself. So the typology should be conceived in such a way as to be serviceable to bio-psycho-social formulation without reference to more narrowly agreed upon diagnosable psychiatric conditions.

4) A psychiatric disorder might be diagnosed per DSM 5 without any discernible conscience delay or dysfunction.

> This state of affairs is also familiar, for example in mild DEPRESSION or ANXIETY DISORDERS. However, this state of affairs is not easily imagined in the case of someone who meets criteria for CONDUCT DISORDER, even if it is someone without the C-U trait.

The following typology of psychopathological interference in conscience formation and functioning is adapted from our previous work, refined in the light of experiences with routinely conducted CONSCIENCE SENSITIVE PSYCHIATRIC EVALUATIONS in outpatient clinics (1998-present), acute inpatient psychiatric units (2001-2006), therapeutic residential programs for youth in adversity (1998- present), and a therapeutic residential program for youth with developmental disabilities (2007-2012)[6], weighed with recent reflection upon our past work on diagnostic considerations, last formally addressed in 2006 and, of course, a recent close reading of DSM 5. In this typology an effort has been made to preserve the distinction between kind and severity. Kinds will sometimes be seen to conform to or expand upon the subtypes proposed in CONSCIENCE FUNCTIONING DISORDER but descriptors of severity *qua* criteria have either been de-emphasized or removed. Nonetheless, within some types manifestations on a continuum are suggested by the descriptive triad in the title. Formally, severity is simply determined by providing a scale scored 0 corresponding to 'none/minimal' to 5 corresponding to 'extreme.' For many counselors the descriptive terms: 'mild' 'moderate' and 'severe' will be sufficient and will best comport with DSM 5 designations of severity. This Scale of Severity of PSYCHOPATHOLOGY (PI) –IN-CONSCIENCE is not intended to replace the Global Assessment of Psychopathological Interference to

---

than one sphere of life; or is it more severe occurring at a later age, but when the individual is more lethally equipped to do considerably more damage with far worse outcomes for others?

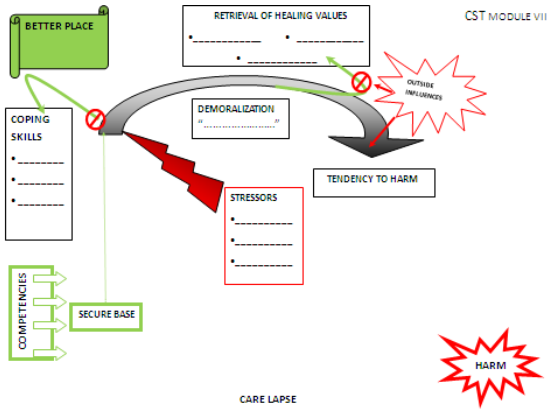
[6] It should be duly noted that our CONSCIENCE SENSITIVE PSYCHIATRIC EVALUATIONS have not generally been conducted within correctional facilities or as forensic psychiatric evaluations.

Conscience Functioning which we still recommend for studies of trauma, especially catastrophic trauma, and stressor-related disorders. In adopting a simple scale of severity applicable only within types, no attempt need be made, as was made in the Global Assessment, to capture progressions that tend to diverge in their forms: as internalizing (tending to cluster in the duo domains of MORALIZED ATTACHMENT and MORAL EMOTIONAL RESPONSIVENESS) and as externalizing (tending to cluster in the duo domains of MORAL VALUATION and MORAL VOLITION). Instead, The Scale of Severity of PI –IN-CONSCIENCE takes 'as grist for the mill' the responses of the interviewee to CONSCIENCE SENSITIVE INQUIRIES and/or CONSCIENCE SENSITIVE TASKS (see **APPENDIX)** PLUS the categorical diagnostic context PLUS the internalizing and/or externalizing signs and symptoms culled from dimensional approaches, PLUS observations made in the *youth- space*[7] recorded by caregivers, the counselor or others, all of which are weighed for *preponderance* of evidence to support the evaluator's designation of severity. However, because the external scaffolding of a safe, structured environment with consistent limit setting may reduce or eliminate opportunities for externalizing behaviors, in such youth-spaces, tendencies (attitudes, dispositions) towards harmful-behavior and towards demoralization and harm prevention should be given additional weight. As noted, in the absence of a multi axial system, the formalized trans-axial approach as a way to represent endophenotypes developmentally and dimensionally that might issue into *Clinical Disorders* is no longer a meaningful interpretation of nosological conventions. Otherwise we hope to have conserved the conceptual features of previous work that brought developmental, dimensional and relational considerations to categorization while assuming an interactional model of brain development and experience.

This typology may be used in a variety of counseling/therapeutic settings, especially residential ones, for '*wayward youth*' in which the ultimate goal of CONSCIENCE SENSITIVE EVALUATION will be to inform CONSCIENCE-SENSITIVE TREATMENT, particularly in developing PERSONALIZED DEMORALIZATION AND HARM PREVENTION PLANS in which psychopathological interference in conscience functioning will be made explicit (see the figure below).

FIGURE

THE 'TURN-AROUNDS' WHICH CAN BE MADE BY CHOOSING TO USE COPING SKILLS AND CHOOSING TO RETRIEVE LIFE AFFIRMING VALUES MAY BE LIMITED BY DEVELOPMENTAL DELAYS AND/OR BLOCKED BY PSYCHOPATHOLOGICAL INTERFERENCES



[7] *Youth-span* was the term we chose as short-hand for that part of the lifespan from 'zero to three' onwards into adulthood. The term *youth-space* suggested itself as a companion to *youth-span* and will be used primarily in the context of encounters that caregivers and youth workers have with youth in the milieu of therapeutic residential and foster settings, and in transitioning from one level of care to another. The term might also be employed to describe home-visits, neighborhood and on grounds schooling or in school psycho-educational activities. Older counselors and therapists may recall Child Psychologist Fritz Redl (1902-88) who made the great contribution of describing *life-space interviews* conducted in the *milieux* of residential programs (Redl, 1966). While certainly compatible with life space interviews, encounters in a *youth-space* are simply the opportunities that occur for interaction and observation of youth in a variety of settings other than conscience sensitive psychiatric interviews.

It is further hoped those who are called to stewardship of moral nature in the youth-span, be they pastoral counselors or psychotherapists with backgrounds in marriage/family therapy, social work and clinical mental health will find the typology serviceable as they assume their respective roles in reducing and managing psychopathological interferences in CONSCIENCE FORMATION and FUNCTIONING.

A TYPOLOGY OF PSYCHOPATHOLOGICAL INTERFERENCE IN CONSCIENCE FORMATION AND FUNCTIONING ACROSS THE YOUTH-SPAN ORGANIZED ACCORDING TO DSM 5[8]

PSYCHOPATHOLOGICAL INTERFERENCE IN CONSCIENCE FORMATION AND FUNCTIONING (PI-IN-CONSCIENCE) ATTRIBUTABLE TO INTRINSIC VULNERABILITY

PI- IN-CONSCIENCE ASSOCIATED WITH DEVELOPMENTAL DELAY

A. Context:

At least one underlying brain/mind system 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. This type of conscience dysfunction may be associated with NEURODEVELOPMENTAL DISORDERS (p.31ff)[9] such as INTELLECTUAL DISABILITIES and AUTISM SPECTRUM DISORDERS. In the case of INTELLECTUAL DISABILITIES the diagnostic context is to be found chiefly in the tabulated *social domain* from which inferences must be drawn regarding conscience formation and functioning. Hence in milder forms, within the social domain of INTELLECTUAL DISABILITIES, difficulties may arise in regulating emotion and behavior in age appropriate fashion. There may also be immature social judgment and risk of being manipulated (gullibility) (p.34). In the case of AUTISM SPECTRUM DISORDERS, over and above vulnerabilities incurred from coexisting INTELLECTUAL DISABILITIES, there may be deficits in social-emotional reciprocity (Criterion A1), impaired joint attention (p.54) and limited ability to form *theory of mind*, another essential developmental building block for empathic responsiveness. [D]isruptive/challenging behaviors are more common in children and adolescents with autism spectrum disorder than other disorders, including intellectual disability (p.55), and there may be excessive adherence to routines and insistence on adherence to rules (p. 54). Self injury within the context of NEURODEVELOPMENTAL DISORDERS may, in some cases, be construed as behavioral equivalents to self-devaluation but in other cases may be self stimulating behavior carried to an extreme. In DSM 5 NEUROBEHAVIORAL DISORDER ASSOCIATED WITH PRENATAL ALCOHOL EXPOSURE is a CONDITION FOR FURTHER STUDY (p.798). Overlaps are likely among PI- IN-CONSCIENCE ASSOCIATED WITH DEVELOPMENTAL DELAY, PI-IN-CONSCIENCE FROM NEURODEVELOPMENTAL CHALLENGES (see below) and TYPES OF PI THAT WEAKEN,

---

[8] Whenever we have accumulated and analyzed sufficient clinical experiences to be confident in doing so, we have followed the format introduced by Barb Stilwell in her documentation of the subtypes of CONSCIENCE FUNCTIONING DISORDER in which **context** for the proposed type of PI is provided first and **characteristics** of the proposed type of PI second. The **characteristics** are given in the following order of CONSCIENCE DOMAINS: CONCEPTUALIZATION OF CONSCIENCE OR MORAL IMAGINATION, MORALIZED ATTACHMENT, MORAL EMOTIONAL RESPONSIVENESS, MORAL VALUATION AND MORAL VOLITION. "Upon conscience sensitive inquiry…" or "In response to conscience sensitive tasks…" indicates a specific stimulus listed in the **APPENDIX** to this document. Otherwise the **characteristic** is more likely to have been inferred from CONSCIENCE RELEVANT observations. There are psychiatric diagnostic contexts in the youth-span for which our collective experience with the Stilwell Conscience Interview and the Stilwell Structured Conscience Interview (used mostly in research) and the CONSCIENCE SENSITIVE INQUIRIES and CONSCIENCE SENSITIVE TASKS used in clinical settings have thus far been insufficient for the purpose of identifying characteristics beyond what may be found by standard psychiatric, psychological or clinical assessments. Sometimes this has been because the degree of variability in pre-morbid functioning and clinical presentation or such a high degree of co-morbidity (diagnostic density) of the conditions that they were not readily susceptible of typing in terms of PI-IN-CONSCIENCE. Sometimes this has been because at the point of evaluation children were too immature in chronological or developmental age for us to include direct CONSCIENCE SENSITIVE INQUIRY (of the child). Sometimes we have deferred descriptions pending further study. Accordingly we have not always had warrant for organization with **context** and **characteristics.** Instead **vignettes** are offered and sometimes simply **comments.**

[9] NEURODEVELOPMENTAL DISORDERS to which this **GUIDELINE** may be less applicable are: COMMUNICATION DISORDERS, MOTOR DISORDERS other than TOURETTE'S DISORDER and other specified and unspecified disorders

CONSTRICT AND THWART CONSCIENCE FUNCTIONING AND IMPEDE FURTHER CONSCIENCE FORMATION (see below).

B. Conscience Dysfunction characterized by preponderance of the following:

- To the extent that conscience sensitive tasks such as drawing or moralized storytelling can be accomplished, immaturity in moral awareness is evident.
- In the interview and in the youth-space, desire to please others is intact or exaggerated, but concretely demonstrated.
- Conscience sensitive inquiries reveal an impoverished vocabulary for inner states including moral emotions; the impression conveyed in the interview may be offset in the youth-space by spontaneous, if awkward, affiliative affective behavioral expressions in response to encouragements.
- In the interview and in the youth-space, when it occurs resistance, to authority is sporadic, not consolidated.
- In the youth-space, there is evidence of distress when rules are not or cannot be followed literally.
- In the youth-space, there is 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 minimal if borderline, less than one full stage behind age expectation, mild if one stage behind age expectation; moderate if two stages behind, or severe if three stages behind age expectation, profound intellectual disability = extreme delay in conscience formation [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).

PI-IN-CONSCIENCE FROM NEURODEVELOPMENTAL CHALLENGES

A. Context:

One or another intrinsic feature of the brain/mind system (e.g. endophenotypical variations upon genetic endowment; *dimensions of temperament*) may constitute an intrinsic vulnerability in the formation and functionality of conscience given certain socio-cultural contexts that are outliers from normative ones (e.g. temperamental parent-child misfit, inappropriate parental expectation to reality ratio, classroom or work setting without minimally flexible accommodations) and which are disadvantageous for unique personal flourishing. The intrinsic vulnerability may predispose to internalizing symptoms or externalizing signs or a combination of the two. This type of PI-IN-CONSCIENCE functioning may be associated with NEURODEVELOPMENTAL DISORDERS such as ATTENTION-DEFICIT HYPERACTIVE DISORDERS, LEARNING DISABILITIES and TOURETTE'S DISORDER.

Although its current nosological home is with the NEURODEVELOPMENTAL DISORDERS, ATTENTION-DEFICIT HYPERACTIVITY DISORDER is frequently comorbid with diagnoses in the DISRUPTIVE, IMPULSE-CONTROL AND CONDUCT DISORDERS group (p. 461ff) and later in the youth-span, with the SUBSTANCE- RELATED AND ADDICTIVE DISORDERS group (p. 481 ff). DSM 5 notes that comorbidity occurs somewhat less often with internalizing disorders such as depression and anxiety. Of particular note, in CONDUCT DISORDER the PI-IN-CONSCIENCE formation and, to an even greater extent, PI-IN-CONSCIENCE functioning occurs chiefly in the domain of MORAL VALUATION. Accordingly, when CONDUCT DISORDER is a comorbid disorder, the PI peculiar to it often eclipses the PI more peculiar to the pre-existent condition of ATTENTION-DEFICIT HYPERACTIVE DISORDER operating chiefly in the domain of MORAL AUTONOMY. It requires some inferential effort and translation into conscience language from the neuropsychological language of executive functions and from temperamental constructs such as behavioral inhibition, effortful control, negative emotionality and elevated novelty seeking; but the appropriate translations having been made, it can be readily appreciated that an individual with ATTENTION DEFICIT HYPERACTIVE DISORDER struggling with limited success to develop agentically in the domain of MORAL AUTONOMY may have his or her trajectory towards both externalized and internalized harm mediated by de-moralization experiences recurring across the youth-span.

B. Conscience Dysfunction characterized by preponderance of the following:

- Upon conscience sensitive inquiry or assignment of conscience sensitive tasks such as drawing the conscience, moral awareness may be discerned as having attained a stage somewhat less than age-expectable.
- Upon conscience sensitive inquiry or assignment of conscience sensitive tasks such as the moralized genogram, moral attachment figures are readily identified and attestation is made to feeling like a good person most of the time. However, in youth-space encounters, intrusiveness and reduced behavioral inhibition may dispose to caregiver exhaustion and affect the quality of the security-oughtness-empathy bond.
- Upon conscience sensitive inquiry, moral emotional responsiveness is represented as congruous with self ascribed right and wrong doing. However, in youth-space encounters, when directed by authority figures to wholly or partially unintended harmful consequences of behaviors, painful affects are apt to be avoided or disowned and attributions of responsibility externalized. Caregivers are nonetheless able to discern moral emotional responses irrespective of self disclosure. There is apt to be a limited or rudimentary repertory of reparative and amendatory strategies. Skill-acquisition in expressions of gratitude often surpasses skill-acquisition in expressions of apology or seeking forgiveness.
- Transient compliance with authority figures is evident but frequent redirection may be required.
- Upon conscience sensitive inquiry, attestations are made to being overmastered by impulses in spite of efforts at control; some success experiences in self control are nonetheless presented with a sense of pride in accomplishment.

PI-IN-CONSCIENCE DUE TO MAJOR COGNITIVE-AFFECTIVE CONDITIONS

COMMENTS

Many of the diagnoses that used to be encoded on DSM IV Axis I as Clinical Disorders are now situated in DSM 5 after the Neurodevelopmental Disorders and before the Trauma- and Stressor- Related Disorders (p.265ff) Adjacency of chapters, it is to be kept in mind, is deliberately planned according to the relatedness of disorders.

Schizophrenia Spectrum Disorders and Other Psychotic Disorders (p.87ff) come first, most proximal to the Neurodevelopmental Disorders. These include SCHIZOTYPAL (PERSONALITY) DISORDER, DELUSIONAL DISORDER*, BRIEF PSYCHOTIC DISORDER, SCHIZOPHRENIFORM DISORDER, SCHIZOPHRENIA*, SCHIZOAFFECTIVE DISORDER*, SUBSTANCE/MEDICATION INDUCED PSYCHOTIC DISORDER, PSYCHOTIC DISORDER DUE TO ANOTHER MEDICAL CONDITION, CATATONIA ASSOCIATED WITH ANOTHER MENTAL DISORDER, CATATONIA ASSOCIATED WITH ANOTHER MEDICAL CONDITION, UNSPECIFIED CATATONIA, OTHER SPECIFIED SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDER and UNSPECIFIED SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS.[10] SCHIZOTYPAL traits and precursors of SCHIZOPHRENIA emergent in childhood notwithstanding, early onset and very early onset SCHIZOPHRENIA are rare. Although DELUSIONAL DISORDER with a lifetime prevalence of 0.2% can occur in younger age groups, the condition may be more prevalent in older individuals (p.92).

For children in the imaginative 4-6 years old range, who have come to attention for endorsement of hearing voices, the counselor should include among the differential diagnostic considerations the possibility of conscience becoming more internalized with vivid, precocious (albeit developmentally transient) experiences of conscience as PERSONALIZED. Among the relatively advantaged, this is not reliably found as a stage in CONSCIENCE CONCEPTUALIZATION until the modal age 12-13 years by which time it poses no difficulties in terms of reality testing, as might be the case for someone much younger. While not always an agreeable experience, unless there has been trauma, the voices described are aligned with endeavors to be good or to avoid wrong doing. They often (but not invariably) have a religious context. Usually clinical concerns can be allayed by pursuing an age appropriate CONSCIENCE SENSITIVE LINE OF INQUIRY beginning with "Is there a part of you that helps you figure out good and bad,

[10] The **GUIDELINE** is concerned with those youth who are most likely to be seen by the counselor collaborating with a physician in the general practice of child and adolescent psychiatry. Accordingly, only the disorders marked with an asterisk will be given attention.

right and wrong?" carefully ensuring that this line of inquiry is kept independent from the customary line of inquiry about the experience of voices (e.g. "Tell me more about how you mind sometimes plays tricks on you"). Once both lines of inquiry have been completed the child might be asked to compare and contrast what has been described in each independent line of inquiry: "Now you've told me about hearing voices. You've also told me about the part of you that helps you figure good and bad, right from wrong. Are these the same or are they somehow different?"

The psychotic features of schizophrenia typically emerge between the late teens and the mid-30's…. The peak age at onset for the first psychotic episode is in the early- to mid-20's for males and in the late 20's for females. The lifetime prevalence is 0.3%-0.7% (p.102). SCHIZOAFFECTIVE DISORDER typically declares itself in early adulthood, although onset can occur anywhere from adolescence to late in life (pp.107-108). Command auditory hallucinations to harm self and/or others will often have MORAL VALUATIONAL and MORAL VOLITIONAL dimensions. In the most perilous state of affairs, conscience, more or less still distinguished by the person from the hallucinations, will be represented as allied with them in disposing the person to harm. In many cases, however, conscience (moral consciousness/moral awareness) may join (and be supported by the counselor) in the struggle to oppose the commands to harm. How and when to engage the person in HARM AND DEMORALIZATION PREVENTION PLANNING that includes RETRIEVAL OF LIFE-AFFIRMING VALUES will depend not only upon how soon psychotropic medication attenuates the intensity and frequency of the hallucinatory experiences but also upon the person's level of recovery from cognitive disorganization. In early stages of recovery (but also in early stages of relapse), the person's efforts to recover MORAL AWARENESS and expand MORAL IMAGINATION should be appreciated by the counselor but treated cautiously and judiciously because these efforts may be indicative of resurgent hallucinations and/or grandiose delusions, may compromise reality testing or at the very least distract from the tasks of basic recovery. Moralistic ruminations may propel the person living with schizophrenia across the threshold from a matter of fact recognition of past failures to take responsibility for behaviors (attributable to illness) to a condition of self-loathing, counterproductive to adaptive MORAL ENGAGEMENT. It should be noted that *the negative symptoms* of schizophrenia will remain ongoing concerns to the conscience sensitive psychiatrist and clinician/counselor. Among the negative symptoms of particular ongoing concern, because of its clear-cut psychopathological interference with conscience functions, will be diminished emotional expression affecting the conscience domain of MORAL EMOTIONAL RESPONSIVENESS, often requiring rehabilitative moral emotional skill building. Another will be general avolition which, it hardly need be said, in its pervasive pernicious effects at even the most basic level of self care such as grooming and hygiene and even the most basic activities of daily living, will certainly not spare the CONSCIENCE DOMAIN: MORAL VOLITION. Encouragement and support while shaping moral as well as other tasks of everyday life so that they are not too daunting will be needed. Psychiatrists, counselors and caregivers alike will need to be especially mindful of *the righting reflex* and *expressed emotionality*.

BIPOLAR AND RELATED DISORDERS (p.123ff) are next in DSM 5. Under this head we find BIPOLAR I DISORDER*, BIPOLAR II DISORDER*, CYCLOTHYMIC DISORDER*, SUBSTANCE/MEDICATION–INDUCED BIPOLAR AND RELATED DISORDER, BIPOLAR AND RELATED DISORDER DUE TO ANOTHER MEDICAL CONDITION, OTHER SPECIFIED BIPOLAR AND RELATED DISORDER and UNSPECIFIED BIPOLAR AND RELATED DISORDER. Only the disorders marked with an asterisk will be given attention in this **GUIDELINE**, and those briefly. DSM IV bipolar I, bipolar II and bipolar disorder not otherwise specified yield a combined prevalence rate of 1.8% in U.S. and non-U.S. community samples, with higher rates (2.7% inclusive) in youths age 12 years or younger (p.136) CYCLOTHYMIC DISORDER usually begins in adolescence or early adulthood and is sometimes considered to reflect a temperamental predisposition to other disorders in this chapter (p.140). When it doesn't progress to another disorder in the chapter, as it does in 15%-50% (p.140), it may persist as a *forme fruste.* Among children with cyclothymic disorder, the mean age of onset is 6.5 years of age (p.141).

Singer Dolores Keane covers a song called "Caledonia" (written by Dougie McClean) which contains the following lyric:

> I have moved and I've kept on moving/ Proved the points that I needed proving/ Lost the friends I needed losing/ Found others on the way/ I have kissed the fellas and left them sighing/ Stolen dreams, yes there's no denying/ I've travelled hard sometimes/ With conscience flying/ Somewhere with the wind….

The lyric's relevance may be cross cutting across the broad range of normality as well as disorders other than bipolar ones, but "conscience flying somewhere with the wind" is especially *a propos* hypomanic and manic episodes. For hypomanic and manic episodes, criteria are essentially the same save that severity (understood in terms of intensity and duration but not in terms of

lifetime functional impairment) is incorporated in the criteria and makes the difference in type of episode (cf. the previous remarks made about the role of severity in typology). Both manic and hypomanic episodes occur in bipolar I disorder but only hypomanic episodes in bipolar II disorder. Some inferential work is required but Criterion A: a distinct period of abnormally and persistently elevated, expansive or irritable mood (p.132) can be seen to constrict the range, suspend and produce incongruity of the MORAL EMOTIONS whilst in Criterion B, inflated self esteem or grandiosity, increase in goal directed activity and excessive involvement in activities that have a high potential for painful consequences (pp.132-133) can readily be mapped as PI onto the conscience domains of MORAL VALUATION and MORAL VOLITION. Conscience may come down to earth after "flying somewhere in the wind" and begin troubling the person during euthymic intervals when reflection upon the harmful consequences of behaviors becomes possible, but may relentlessly torment the person during depressive episodes. The PI of depression in conscience functioning will be described further on, in the context of DEPRESSIVE DISORDERS.

PI-IN-CONSCIENCE IN DEPRESSIVE DISORDERS

A. Context.

In DSM 5, the DEPRESSIVE DISORDERS (p.155ff) include DISRUPTIVE MOOD DYSREGULATION DISORDER, MAJOR DEPRESSIVE DISORDER, PERSISTENT DEPRESSIVE DISORDER (DYSTHYMIA), and PREMENSTRUAL DYSPHORIC DISORDER, *inter alia*[11]

Many clinicians welcome the new DISRUPTIVE MOOD DYSREGULATION DISORDER as it seems to comport with clinical findings in those many cases in which juvenile mood instability is seen against a background of persistently irritable mood (p.156). In the previous nosology, clinical findings that included severe recurrent temper outbursts (p.156), did not quite allow bipolar disorders to enter into the differential diagnosis, even when developmental considerations were brought to bear in modifying how manic and hypomanic episodes were to be construed. This psychiatrist often resorted to the diagnosis of MOOD DISORDER NOS with informal specifications of emotional lability, affective dysregulation or anger dyscontrol and frequently indicated co-morbidity with ATTENTION DEFICIT HYPERACTIVE DISORDER. If the new nomenclature is itself any indication we will eventually find PI more likely in MORAL EMOTIONAL RESPONSIVENESS and MORAL VOLITION with perhaps less salience in MORALIZED ATTACHMENT (although attachment relationships might be badly strained) and MORAL VALUATION.

It has already been pointed out that PI- IN-CONSCIENCE in MAJOR DEPRESSIVE DISORDER is recognized explicitly at the level of criteria: feelings of worthlessness or excessive or inappropriate guilt (p.161). The use of affective language in Criterion A7 'feelings' may disguise the fact that 'worthlessness' is essentially a MORAL VALUATIONAL term, here applied to self. Worthlessness may be adduced as a theme in support of the suicidal ideation and as a motive for the suicide attempts referred to in Criterion A9. On the other hand, 'excessive or inappropriate guilt' is clear in referring to MORAL EMOTIONAL RESPONSIVENESS. Only minor inferential work is required to appreciate that when Criterion A2 applies, marked diminished interest…in all or almost all activities (p.160) is not likely to exempt those activities requiring MORAL IMAGINATION and when Criterion A6 applies, loss of energy (p.161) is not likely to spare the energy requiring process of MORAL ENGAGEMENT. Indecisiveness embedded in Criterion A8 will be readily seen as a vitiating factor in MORAL VOLITION. PERSISTENT DEPRESSIVE DISORDER does not implicate 'feelings of worthlessness' but does include in Criterion B, low self esteem low energy and difficulty making decisions (p. 168). PREMENSTRUAL DYSPHORIC DISORDER also does not implicate feelings of worthlessness *per se* but does include in Criterion B self deprecating thoughts and in Criterion C, decreased interest, lack of energy, and a sense of being overwhelmed out of control (p. 172) each with potential for transient PI in domains of conscience.

[11] Until this point we have included each of the disorders subsumed by a chapter head in DSM 5 to convey something of the detailed presentation that is to be found in DSM 5. Henceforth we will identify only those disorders we are apt to encounter in the youth-span and about which we have something to say about conscience, indicating that there are still others we will not discuss with the term *inter alia*.

B. Conscience Dysfunction characterized by preponderance of the following:

- Upon conscience sensitive inquiry, there is evidence of diminished moral engagement; projects previously imbued with moral significance are treated as less consequential. Moral imagination is often stymied by ruminations and self-focused preoccupations.
- In retrieval of MORAL MEMORIES or while more formally working on the conscience sensitive task of a personal MORAL TIMELINE, experiences of disapprobation far outnumber experiences of approbation, for which more effort is required in recollection. Personal goodness is in doubt. PRINCIPAL MORAL ATTACHMENT figures may be seen as "better off without me," which might refer to sentiments ranging from isolativeness to suicidality. However a preserved desire to do no harm (non-maleficence) to loved ones may be an important life affirming value that can be made explicit and incorporated into a PERSONALIZED DEMORALIZATION AND HARM PREVENTION PLAN.
- In response to conscience sensitive inquiry, there will often be acknowledgement that MORAL EMOTIONAL RESPONSES to right doing have become more rare, more blunted and less sustained during the depressive episode, whilst there have been intensifications of MORAL EMOTIONAL RESPONSES to wrong doing. There will often be demonstrable excesses of negative moral emotions such as guilt and shame. Fear of punishment (especially eternal retribution) or 'fear of botching the job' may be the only discoverable emotions motivating resistance to suicidality. There may also be experienced an excess of disgust (self loathing). Inadequate skill or investment in managing excesses of negative moral emotions is likely to be a feature. Healing measures such as seeking forgiveness and expressing gratitude may be experienced by the person as ineffective (e.g. being persuaded that forgiveness is impossible considering the transgression), or intolerable (the incurrence of a debt of gratitude is experienced as burdensome, something to be avoided), treated as perfunctory or subjected to hypercritical nullifying self-appraisal, e.g. seen as lacking in some essential feature like being genuine.
- In addition to self-devaluations revealed in the conscience sensitive encounter, there are acknowledgments of low energy for employing existing coping skills or acquiring new ones. There may be demonstrations of impaired ability to recognize or *retrieve life affirming values* and of poor judgement in determining upon whom to rely in *the survival strategy* of the PERSONALIZED DEMORALIZATION AND HARM PREVENTION PLAN.

In DSM 5 separate chapters are devoted to THE ANXIETY DISORDERS**,** OBSESSIVE-COMPULSIVE AND RELATED DISORDERS and TRAUMA- AND STRESSOR- RELATED DISORDERS**.**

PI-IN-CONSCIENCE IN ANXIETY DISORDERS

A. Context.

In DSM 5, THE ANXIETY DISORDERS are: SEPARATION ANXIETY DISORDER, SELECTIVE MUTISM, SPECIFIC PHOBIA, SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA), PANIC DISORDER, AGORAPHOBIA, AND GENERALIZED ANXIETY DISORDER.

'Everyone worries about something at least sometimes, what would you say are your top three worries?' thus might counselors approach the subject of anxiety, reckoning with its universality, developmental continuities and discontinuities, temperamental varieties and the need to characterize it in any disorder by demonstrating excess and impairment. We learned from our studies of relatively advantaged children and adolescents that from the standpoint of factor analysis, adaptive MORAL EMOTIONAL RESPONSIVENESS (MER) had two meaningful parts: MER I: INTERNALIZED ANXIETY, EXTERNALIZED ANXIETY AND MOOD and MER II: PSYCHOPHYSIOLOGICAL RESPONSE, REPARATION AND HEALING. We learned a moral person is apt to worry from time to time about being at least 'good enough' if not the best he or she can be; about harms done by omission and commission; about contributing to harm as a consumer, by being part of an organization or by taking part in a system; even about those harms done only in imagination. In a moral person, worries about harm are not likely to be purely altruistic but neither will they be altogether base. Intermingled with *an empathic response to the person harmed* (one definition of adaptive guilt) will be fear of punishment (including eternal retribution) and other consequences such as loss of reputation, loss of power (diminution in group standing) or loss of a sense of integrity.

B. Conscience need not be affected by PI from the Anxiety Disorders, but when it is we would expect there to be:

- MORAL IMAGINATION in overdrive. What might be for someone else a mere matter of taste or preference will be imbued with major moral significance.
- Sometimes any pride in self-ascribed right-doing will be attenuated or even overturned by worry over the possibility of disapprobation from a principal MORAL ATTACHMENT figure.
- Signs of excess in both MER I AND II. Sometimes eagerness to engage in right doing or undo wrong-doing will attain desperate proportions.
- Sometimes fear of wrong doing will be reflected in a litany of *Afraid-I-Might's* that
- Will paralyze MORAL VOLITION in ever more constricting bonds. There may be (a potentially therapeutic) conflict resulting from an awareness that accepting the bondage of anxiety stymies participation in moral (as well as other) adventures and interferes with a desire to make meaningful contributions.

The OBSESSIVE-COMPULSIVE AND RELATED DISORDERS chapter includes the eponymous disorder as well as BODY DYSMORPHIC DISORDER, HOARDING DISORDER, TRICHOTILLOMANIA and EXCORIATION DISORDER.

OBSESSIONAL PI-IN-CONSCIENCE

A. CONTEXT

DSM 5 emphasizes that **OBSESSIVE-COMPULSIVE DISORDER** (OCD) is not the same **AS OBSESSIVE-COMPULSIVE PERSONALITY DISORDER:**

Although [they] have similar names, the clinical manifestations of these disorders are quite different. Obsessive-compulsive personality disorder is not characterized by intrusive thoughts, images, or urges or by repetitive behavior that are performed in response to these intrusions; instead, it involves an enduring and pervasive maladaptive pattern of excessive perfectionism and rigid control. If an individual manifests both OCD and obsessive-compulsive personality disorder, both diagnoses are given (p.242). We find in DSM 5 the criterion for OBSESSIVE-COMPULSIVE PERSONALITY DISORDER: Is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification) (p.678). Earlier conceptual work on PI-IN-CONSCIENCE in this area was concerned more with obsessive-compulsive personality traits emergent in childhood than with OCD per se. In her documentation to support CONSCIENCE FUNCTIONING DISORDER OBSESSIONAL TYPE, Barb Stilwell (2006, unpublished) noted it was likely to be co-morbid with OCD or OBSESSIVE-COMPULSIVE PERSONALITY DISORDER. CONSCIENCE FUNCTIONING DISORDER, OBSESSIONAL TYPE required all five of the following:

(1) Hypercritical concern about personal moral value
(2) Obsessional worry about minor infractions of societal rules
(3) Lack of satisfaction with reparative actions after minor wrongdoing
(4) Lack of ability to forgive self after minor wrongdoing
(5) Indecisive when moral action is required

The comorbidity of OCD with lifetime diagnoses of anxiety disorder –76% according to DSM 5 (p. 242)— makes clinical encounter with pure forms of OCD rare and, accordingly, it is impossible for those in general psychiatric practice in the youth-span to sort out PI–IN-CONSCIENCE owing strictly to OCD from PI-IN CONSCIENCE owing to other anxiety disorders and personality traits. That observation should not be taken as a comment on the futility of conducting a CONSCIENCE SENSITIVE INTERVIEW with a person with OCD. We believe quite the contrary that the CONSCIENCE SENSITIVE INTERVIEW and CONSCIENCE SENSITIVE TASKS are generously informative and foundational for those with capacity for mindfulness and/or insight that might be recruited by *motivational approaches*.[12]

[12] *Motivational approaches* are probably more often associated with substance abuse disorders. They are often thought of as brief treatment approaches designed to produce rapid internally motivated change in addictive behavior and other problem behaviors. The core principles of motivational interviewing are (1) express empathy; (2) develop discrepancy; (3) avoid argumentation; (4) roll with resistance; (5) support self-efficacy. For a brief annotated summary see The Annenberg Foundation Trust at Sunnylands' Adolescent Mental Health Initiative Commission on Adolescent Substance and Alcohol Abuse, C O'Brien,

B. Conscience dysfunction characterized by preponderance of 1- 5 above and the following:

- In response to the task of drawing conscience, the salient domain represented in the image is often MORAL VALUATION with MORAL EMOTIONS being less conspicuous.
- In response to conscience sensitive inquires about principal moral attachment figures, a sense may be conveyed that power is perceived to be distributed within a rigid, stratified authoritative hierarchy. However due to the excessive degree of internalization, when compared to age mates, motivation for right doing may require less approbation from authorities or peers. In addition, avoidance of wrong doing may require less disapprobation from others.
- Among moral emotional responses to right doing, the capacity for joy is especially limited. Hyper-sensitivity to criticism may be paired with hyper-criticality of others.
- There is often a proliferation of do's and don'ts with little distinction made among them in terms of moral content; a case of being a 'ruly child' as opposed to an 'unruly' one.
- Often seen as strong willed when compulsions are confronted or interrupted; may engage in ponderous deliberations before arriving at any decision, any laxity in observing prohibitions requires extensive rationalization.

Pending further study, we have deferred any descriptions of PI -IN- CONSCIENCE in BODY DYSMORPHIC DISORDER (formerly subsumed by the specific phobias as *dysmorphophobia*), newly designated in DSM 5 and seen as related more to Obsessive-Compulsive Disorder rather than to being one of the Somatoform Disorders (DSM IV p.466), it has as mean age at disorder 16-17 years, the median age at onset is 15 years and the most common age at onset at 12-13 years (p. 244). Its current prevalence is 9%- 15% among dermatology patients, and 7%-8% among U.S. cosmetic surgery patients (p.244). Specification is recommended regarding degree of insight ranging from absent insight/ delusional beliefs to good (p.245). It is certainly worthy of study from the standpoint of conscience, with findings of PI to be anticipated particularly in domains of CONCEPTUALIZATION/ MORAL IMAGINATION, MORAL SELF VALUATION and MORAL VOLITION as well as the likely presence of *demoralization*. For those with the capacity for good or fair insight, we might envision exercises that stretch the MORAL IMAGINATION and use of VALUE MATRIX to better inform *motivational interviewing*.

While some children may have precursors of HOARDING DISORDER [DSM 5 indicates symptoms may first emerge around ages 11-15 years (p.247)], we find many more children have predilections for collecting things. Admittedly some of the things collected have dubious value when seen from an adult or even a peer's perspective. DSM 5 notes: Because children and adolescents typically do not control their environment and discarding behaviors , the possible intervention of third parties(e.g., parents keeping the spaces useable and thus reducing interference) should be considered when making the diagnosis (p. 249). According to DSM 5 There is considerable comorbidity (75%) with anxiety and mood disorders (p.251). In those cases when hoarding has emerged as a problem in the youth-span, a conscience sensitive approach to psychiatric evaluation might contribute a great deal because of the comorbidity but also because it will lay the groundwork for use of the VALUE MATRIX to better inform motivational approaches.

Commission Chair (2005): Treatment of substance use disorders, in **Treating and Preventing Adolescent Mental Health Disorders** (D. Evans et al. Eds) Oxford University Press, pp 397-398. The use of the VALUE MATRIX in particular affords opportunity to re-evaluate the values behind rules and increases awareness of VALUE GAPS: that is the discrepancy and unease that develops in judging the goodness or worthiness of a personal value and then assessing the relative motivational strength of the same value.

PSYCHOPATHOLOGICAL INTERFERENCE (PI)
IN CONSCIENCE FORMATION AND FUNCTIONING
ATTRIBUTABLE TO VULNERABILITY WITH EXTRINSIC ORIGINS

Under this head, we consider etiologies in which the developmental theme of temperament recedes into the background and the developmental theme of attachment becomes dominant in its manifold harmonies and discords. Over the years, we have made much of the central importance of attachment experiences, intact and disrupted, with respect to how conscience is formed. We've made so much of it in fact that in CONSCIENCE THEORY, while we regard CONCEPTUALIZATION OF CONSCIENCE as the domain that draws together and anchors the ever changing processes of conscience formation and functioning in personal meaning, we regard MORALIZED ATTACHMENT to be most foundational. While we readily acknowledge that the work of empathy is conducted in the domain of MORAL EMOTIONAL RESPONSIVENESS; we believe its home is in MORALIZED ATTACHMENT. While we find that *ought's* and *ought not's* are collected, shuffled and reshuffled in the domain of MORAL VALUATION, we discern the ability to 'attach value' to any rule to derive from MORALIZED ATTACHMENT. All of this is summed up with a core idea: the *security-empathy-oughtness* link.

What if the link absolutely fails to be established? How prevalent can such a condition be? Is the capacity for attachment in the category: *use it or lose it?* Or can it be called out of dormancy and expanded?

TYPES OF PI THAT
RESULT IN DETACHED AND ATTENUATED CONSCIENCE FUNCTIONING

A. CONTEXT:

DSM 5 begins the section TRAUMA AND STRESSOR RELATED DISORDERS with REACTIVE ATTACHMENT DISORDER (RAD) and DISINHIBITED SOCIAL ENGAGEMENT DISORDER. These disorders occur at the very beginning of the youth-span. The two subtypes of RAD in DSM IV have been reconfigured in DSM 5 as separate disorders. Exposures to extremes of insufficient care (p.265, p.268) are built into Criterion C of both, and in both disorders, Criterion D amounts to the presumption that Criterion C is responsible for the disturbed behavior in Criterion A. The chief differences between the two disorders are to be found in Criterion A and Criterion B of each. In REACTIVE ATTACHMENT DISORDER Criterion A refers to a consistent pattern of inhibition and emotionally withdrawn behavior towards adult caregivers, manifested by both of the following: 1. the child rarely or minimally seeks comfort when distressed and 2. The child rarely or minimally responds to comfort when distressed. Criterion B refers to a persistent social and emotional disturbance characterized by at least two of the following: 1. Minimal social and emotional responsiveness to others, 2. limited positive affect, and 3. Episodes of unexplained irritability, sadness , or fearfulness that are evident even during nonthreatening interactions with adult caregivers(p.265). Very little inferential work needs be done in order for the counselor/therapist to appreciate that moralization, insofar as it is one kind of socialization, is bound to suffer. The child has not been given the pieces to put together a moral emotional barometer preset in the 'feel-good— am-good' range upon which children raised in more favorable conditions can rely. Nor has the child acquired skills to manage moral emotions that do arise. In DISINHIBITED SOCIAL ENGAGEMENT DISORDER, Criterion A refers to a pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits two of four behaviors (p.268). Three of the possibilities pertain to personal safety and, by implication, involve heedlessness in causing concern among those caregivers who eventually emerge in the child's life and who really do care. In conscience language, the child lacks rudimentary self-regarding/self-derived as well as authority-regarding/authority-derived MORAL VALUATION. In a description that almost invokes explicit conscience language, one of the possibilities is overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age appropriate social boundaries) (p.268). [13]

Most of us (this psychiatrist included) practice in settings where this disorder is rare. However we will nonetheless be asked to consider it as a diagnosis fairly often, by foster parents and adoptive parents whose child's early history may be sketchy but

[13] An interesting difference between the criteria for the two disorders is the stipulation of onset before 5 years in RAD, but not in DISINHIBITED SOCIAL ENGAGEMENT DISORDER.

whose behavior leads to conjectures that there have been abject failures (as opposed to more common disruptions and distortions of attachment) in the form of extremes of insufficient care. A history of early institutionalization (e.g. in orphanages known to have had deplorable conditions) among international adoptees is a case in point. Because of the rarity of these conditions, and because those for whom it is considered among differential diagnoses are often too immature in chronological and/or developmental age at the point of evaluation for us to include direct conscience sensitive inquiry of the child, we are not yet able to provide typical responses to conscience sensitive inquiries or conscience sensitive tasks. Most of what can be said of PI-IN-CONSCIENCE derives from observations made by caregivers in the youth-space.

B. Vignettes[14]

A 5 year old international adoptee was probably born prematurely and had mild cerebral palsy with delays in speech, fine motor adaptation and gross motor skills. Her adoptive parents were unaware of any maltreatment but had harbored concern about RAD. Neuroimaging had shown a morbid softening of white matter around the ventricles of the brain. She had a brainwave study that showed low amplitude in the electrical patterns generated by the brain but no clear cut abnormalities. She had behavioral problems with rages mostly occurring in afternoons and evenings, inattention, perseverations and tics. She was diagnosed, according to DSM IV with Pervasive Developmental Disorder *Not Otherwise Specified* (NOS) with note made of the clinical salience of inattention and Tic Disorder. Her IQ was eventually measured in the average range. She had difficulty making eye contact, engaged in self stimulatory behaviors and used primarily nonsense verbiage in response to general questions about herself that effectively contraindicated engagement in a conscience interview.

A 5 year old international adoptee had been in an orphanage in which she was sexually abused. She eventually became sexually reactive towards her sister. When separated from her adoptive mother in the waiting area she became anxious and cried, she startled easily. She referred to "bad secrets" about which she had preoccupations. She acknowledged behavioral dyscontrol, remarking with flat affect: "sometimes I hit people's tummies so hard." She had had suicidal ideation and exhibited a sense of hopelessness. Her Full Scale IQ= 73 (by WISC IV). Neuropsychological evaluation included items from A Developmental Neuropsychological Assessment (NEPSY) which were interpreted as showing "significant weakness in frontal-executive functioning, affecting attention, concentration as well as memory processing." Conscience relevant psychological remarks conveyed the impression of profound damage to her sense of self, a 'fear-based pattern' in perceptions of reality, an overall inability to integrate emotions. Also included in the neuropsychological evaluation was the Behavioral Rating Inventory of Executive Functions (BRIEF) which indicated difficulties with initiating plans, organizing, self monitoring and sustained working memory. She was considered to be too immature and her emotional stability too tenuous for a formal conscience interview.

A 5 year old adoptee was born to a mother who had acknowledged substance abuse early in her pregnancy. He was adopted on the day of his birth. There was no history of maltreatment. He was bossy, demanding and would hit both children and teachers at his school. After psychiatric evaluation, he was diagnosed with Attention Deficit Hyperactive Disorder and Possible Mood Disorder NOS (Affective Dysregulation). However adoptive parents were also concerned to exclude RAD. The psychiatric evaluation was conscience sensitive.

- In response to conscience sensitive inquiry, he described his conscience in a manner consistent with the EXTERNAL STAGE.
- Adoptive parents declaimed "Almost everything we offer him that's good turns into something bad," citing for example lessons they provided him for enrichment in musical arts.

[14] In accordance with HIPAA regulations adopted as part of our governance, all identifying information including birth date, race, ethnicity, the location of the subject of this report and any dates of admission to and names of any treatment facilities have been expunged. Physical features and specific details of maladaptive behavior that might allow identification have likewise been deleted. Direct quotes have been preserved to illustrate responses to CONSCIENCE SENSITIVE INQUIRIES. In the vignettes, end-products from CONSCIENCE SENSITIVE TASKS are described but not reproduced for this document.

- In response to conscience sensitive inquiry, his MORAL EMOTIONAL RESPONSIVENESS to self-ascribed right-doing was colorfully described as "Flags waving inside!" whereas his response to self-ascribed wrong-doing was " like [someone] throwing rocks."
- MORAL VOLITION had need of supportive scaffolding. He required close parental supervision and frequent redirection for much of his youth-span, but disruptive behaviors were never serious violations of rights of others or major age appropriate norms and rules. At age 10 years old, because of the emergence of frequent lying, we supplemented his psychotherapy by engaging in focused work using the VALUE MATRIX, a conscience sensitive task.

A 6 year old international adoptee was born prematurely. Referral information included accounts of prenatal exposure to alcohol. She had been in a series of orphanages in which she had been subjected to neglect with eventual findings of malnutrition. She engaged in pica and skin-picking. At the point of evaluation she was having hallucinatory-like experiences during which "my mind blinks on and off" Sometimes these were perceived as vague sounds, other times as voices using "bad words like 'stupid' and 'dumb'" Sometimes they generated considerable concern for her safety when she would attribute to them urgings to dangerous behaviors. Her working diagnoses were Victim of Maltreatment, Post Traumatic Stress Disorder (with Dissociative Episodes), Mood Disorder NOS (Affective Dysregulation) and History of Treatment for Attention Deficit Hyperactive Disorder. Ongoing neurological evaluation eventually included a brainwave study interpreted as consistent with static encephalopathy (that is to say, a non-progressive diffuse brain impairment underlying a cognitive disorder not otherwise specified). Neuropsychological testing in her case revealed a Full Scale IQ= 70 (by WISC IV).

- Upon conscience sensitive inquiry, she said there was a part of herself that was not the same as the voices and which helped her figure out what was right from what was wrong, what would be good and what would be bad.
- She could not identify any changes inside her when she had done either something she thought was good/ right or something that in her eyes was bad/wrong. Based upon youth-space experiences, adoptive mother shared impressions undoubtedly formed in both frustration and fear, that her daughter's rage outbursts were without demonstrations of remorse afterwards: "[She's] like a sociopath!"
- However, when asked about what kinds of things she considered to be wrong, she offered without any hesitation "Bad words!" In the course of the interview she had acknowledged such things as not paying attention in class and having been obliged to take time-outs. She also acknowledged anger dyscontrol at home. None of these manifestations of her disorder seemed particularly imbued with moral significance for her.

A 61/2 year old international adoptee was also born prematurely. She had suffered a stormy perinatal course. There was no known history of maltreatment but history gathered in successive clinical encounters with several professionals (including a therapist who specialized in work with children with RAD) and neuropsychological evaluation were indicative of signs and symptoms frequently seen in trauma disorders. Her working diagnoses were Post Traumatic Stress Disorder (unknown stressor), Mood Disorder NOS (Affective Dysregulation) and Attention Deficit Hyperactive Disorder. Her Full Scale IQ=84 by Wechsler Intelligence Scale for Children IV (WISC IV). The neuropsychological evaluation was interpreted as consistent with static encephalopathy and included the remarks: "There is no question that she has had developmental failure in areas of bonding, attachment, safety, security in addition to institutional neglect in which she has fought to survive."

- Upon clinical encounter, she described her rage outbursts as "white fire" [after which] "my brain goes quiet." Pursuant age-appropriate inquiries into the experience of conscience yielded little else
- During her rage outbursts when she would search for knives while threatening to kill them, she had required parental safety and security interventions
- While expressions of remorse were not reported, she seemed to recover a remarkable degree of superficial affability between episodes of dyscontrol
- The neuropsychological evaluation included items from A Developmental Neuropsychological Assessment (NEPSY) which were interpreted as "A pattern of a generalized, diffuse organic brain dysfunction…with significant weakness in frontal-executive function" (findings relevant to moral judgement that we would include in our conception of MORAL VALUATION/MORAL VOLITION). Another conscience relevant psychological description included "Unable to self regulate control at any level."

A 9 year old international adoptee had been in orphanage fifteen months after being subjected to maltreatment in the form of sexual and physical abuse as well as neglect. She engaged in disruptive behaviors but her fear of abandonment was most salient in the clinical picture. She was diagnosed with Post Traumatic Stress Disorder, Depression and Anxiety NOS.

- She conveyed that her conscience was a part of her residing in her head. It made her feel badly: "[It] kinda makes me do it [when] I don't want to," referring to what she perceived as the right thing to do.
- MORAL EMOTIONS were present and congruous with self-ascribed right and wrong doing however she lacked reparative and amendatory strategies.
- She conveyed that she experienced a balance between approbative and disapprobative responses from her adoptive parents both of whom were identified as principal moral attachment figures.
- She denied self devaluations.

Seen for psychiatric evaluation when he turned six, he was adopted before he was 3 years old. He had been conceived after the rape of his mother, not quite attaining her teens at the time. The biological father had a history of incarceration for sexual offenses against minors. It was not known whether his history of incarcerations began antecedently or only subsequently to the rape. Neglect was confirmed; sexual abuse suspected; and steps were taken to have him adopted. His adoptive parents decided not to share any of their knowledge about his origins. Early in his new life in the adoptive home he engaged in roaming at night, causing concern for his adoptive parents. He engaged in sensation seeking and was subject to impulsiveness. When he entered school he began stealing from his teacher. Adoptive parents declared: "If he sees something he likes he has to have it." Affectively, he was described as "happy go lucky." He had symptoms of ADHD and Disruptive Behavior Disorder NOS. He was considered to possibly have RAD, disinhibited type.

Upon conscience sensitive inquiry, he was able to acknowledge stealing and simply identified consequences of stealing as "getting into trouble." His adoptive parents did not discern any particular moral emotional responses to either right or wrong doing. In spite of his impoverished moral emotional responses, he could indentify at least one successful experience in resisting an impulse to steal but it was not clear what motivated him to counteract his impulse, that is to say he did not identify any specific *becauses* for not stealing.

A few years later, at 8 years old, he was acutely hospitalized after he had stolen a firearm from the safe in his adoptive parents' home, loaded it and concealed it outside. He exhibited no distress about being in hospital and cheerily greeted this psychiatrist recognizing him from previous outpatient encounters. He denied any intent to use the weapon against anyone. The opportunity arose in the conscience sensitive evaluation to inquire about **do's** and **don'ts** he had with respect to firearms. He said "Don't shoot at people—that can hurt you or someone else." He wasn't able to adduce his *becauses* for stealing the weapon, but indicated that stealing the weapon or anything else was wrong. In response to formal conscience sensitive inquiries, he indicated he was not aware of a part of himself that helped him figure our right and wrong or good and bad. Instead, he relied on others: "People always tell me what is right and wrong." Asked what he would do when people didn't let him know, he said if he believed he needed to know the difference he would ask someone. Asked for examples of when he thought he might need to know the difference, he said he thought he probably should ask before taking food and any objects he desired. At this point in his life, he said when he engaged in right doing (in spite of his difficulty assigning valences to his behaviors) he was apt to feel happy. If his good deed was not recognized by others, he was apt to bring it to their attention. Undetected wrong doing, he said made him angry. He professed to feel sad when he was <u>not</u> caught stealing. His limited sense of proportion in judging right from wrong became apparent in his selection of wrongdoings about which he was invited to tell: "Looking back on your life now, what do you think was one of the worst things you'd ever done?" He gave an account of painting the wrong wall contrary to his adoptive father's instructions: "I didn't follow directions. Dad said that it was okay" his adoptive father added "—I make mistakes too." He readily identified those who cared most about his goodness as his adoptive parents and sometimes his sisters.

By this time his adoptive parents perceived that he entirely "lack[ed] a conscience" Conscience sensitive items on a dimensional rating scale indicated cruelty to animals, firesetting and diminished moral emotions such as guilt. In the course of the acute psychiatric hospitalization, in addition to standard therapeutic interventions, conscience sensitive tasks were employed. These included a VALUE MATRIX used with him in individual clinical encounters first, then in family work. He was assisted in generating as many *becauses* as he could come up with for not handling firearms at least until he was eighteen. His adoptive father to whom firearms were a very important part of growing up insisted that the proposal be amended to don't handle firearms

until eighteen years old or under parental supervision. Another conscience sensitive task was a LETTER OF APOLOGY to his parents. In preparation for this task, he was asked to think of apologies that had been made to him and to identify what made them strong or weak in his eyes. He reflected upon an apology a peer had made to him. He said he had appreciated the apology offered him because "It wouldn't be showing good character [not to make an apology under the circumstances] and I would be sad."

In spite of medications and continued outpatient work in the rural community in which he lived, his behaviors could not be sufficiently controlled and, accordingly, his adoptive parents sought placement for him in a residential program. They were unable to obtain funding from his school or from county welfare: the local educational authority indicated that they could manage his education without seeking and funding a placement out of the home and the county said he had not yet met their definition of *serious and persistent* criteria necessary for a psychiatric residential treatment facility (which it had only recently been determined by class action lawsuit should be funded by Medicaid). Exhausting these avenues, the adoptive parents eventually elected to paid out of pocket for a residential placement but could afford do so for a period of only six months.

Upon returning to his adoptive family he resumed outpatient work and continued to see this psychiatrist for medication. At age thirteen, during one medication check, in response to conscience sensitive inquiry about rules he was aware of having acquired as his own. He said he had new rules of his own: "Don't mess with guns." "Don't play with knives." and "Do not hurt animals." He acknowledged he had difficulties following his own rules. Firearms had been removed so the opportunity did not present itself. He had taken a knife without permission and used it to cut hot dogs to size for fishing with his sister. "With the dog [which was tethered and running back and forth during his provocations]—I had her so worked up— she was breathing hard, choking and trying to bite. When his adoptive mother insisted he stop he became angry ("unlike himself" she said).

Negotiated accommodations with the school and vigilance from adoptive parents seemed sufficient to maintain him at home and in the community until adoptive mother's health began to suffer and he advanced in puberty.

At fifteen there was a recrudescence of stealing. However it now took the form of stealing under garments and feminine hygiene products from his adoptive mother and sister. At school he threatened a female peer with rape and police were called in but no arrest was made. His psychotherapist recommended psychiatric reevaluation. Suicidality had also become salient in the clinical picture and we began work on a DEMORALIZATION AND HARM PREVENTION PLAN which he continued to work on with his psychotherapist.

His sexual reactivity had issued in inappropriate and unwanted sexual behaviors that thus far had been successfully resisted by his victims and authority figures. However, ensuring the safety of their daughters became overwhelming to the adoptive parents. Cruelty to animals had also resurfaced. With parental consent, child protective services were contacted. A specialized psychosexual evaluation recommended. When he was seen again by this psychiatrist, he indicated he judged his sexual harassments and behaviors to be wrong but he said that he was at times overmastered by his urges. After discussion, he acknowledged he would benefit from specialized work in a residential setting to prevent sexual offenses.

TYPES OF PI THAT
DISRUPT, COMPROMISE AND SUSPEND CONSCIENCE FUNCTIONING

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 have been morally supportive, but it is insufficient in structural strength to allow assimilation of the trauma and its aftermath. This type of PI- IN-CONSCIENCE is likely to be associated with TRAUMA- AND STRESSOR- RELATED DISORDERS such as POST TRAUMATIC STRESS DISORDER.
OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION and may be encoded in the given case include: HOMELESSNESS, LACK OF ADEQUATE FOOD OR SAFE DRINKING WATER, VICTIM OF TERRORISM OR TORTURE, EXPOSURE TO DISASTER, WAR, OR OTHER HOSTILITIES.

Informed by our studies (Goenjian, et al, 1999) of *conscience-in-catastrophe*, Barb Stilwell (Stilwell et al, 2006; Stilwell, unpublished) proposed criteria for CONSCIENCE FUNCTIONING DISORDER, DISRUPTED TYPE requiring three of the following:

(1) 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.

In adding to and refining the original criteria, we are indebted to **Conscience Project** Participant John Sullivan for his insights derived from long years of CONSCIENCE-SENSITIVE GROUP PSYCHOTHERAPY with returning warriors.

B. Conscience Dysfunction is characterized by preponderance of the following:

- Confusion about the moral foundation of life. Suspension of moral awareness except of moral wounds incurred in war (also termed *concupiscence in the returning warrior*). Paralysis of moral engagement and imagination
- Alienation from previously established moral attachment figures
- A sense of futility about ever *feeling* like a good person again (may progress to a conviction of not *being* a good person)
- Numbing of empathy and moral emotions vie with upsurges of survivor guilt
- Sporadic expressions of contempt or disrespect for others or participation in antisocial behavior for which the individual has no rational explanation
- Sporadic expressions of disrespect or participation in antisocial behavior that the individual does not remember

Age at onset, duration of trauma, and time since exposure to the trauma are all important considerations.

TYPES OF PI THAT WEAKEN, CONSTRICT AND THWART CONSCIENCE FUNCTIONING AND IMPEDE FURTHER CONSCIENCE FORMATION

A. Context:

The individual has been chronically traumatized, usually from early childhood, by lack of moral support in an environment of threat (e.g. exposure to domestic and out-of-home violence, abuse, neglect, abandonment, food insecurity, homelessness and other forms of poverty).

Among DSM 5 diagnoses carried by these individuals, CONDUCT DISORDER is common. There may also be current diagnosis or at least historical note made of TRAUMA- AND STRESSOR- RELATED DISORDERS. However, the trauma and stress often have the character of *enduring circumstances* earlier in the youth-span and by the time we encounter them in residential settings, POST TRAUMATIC STRESS DISORDER (as we might associate with more acute forms) is not so salient. The need for developmental psychopathological and /or psychodynamic interpretation is posed by the qualifying phrase "associated with the traumatic event(s)" appended to many of the criteria. There is, unfortunately, no difficulty in meeting A Criterion: Exposure to actual or threatened death, serious injury, or sexual violence. B Criterion: Presence of one (or more) of the… intrusion symptoms may have been present in the past, but in interviews, youth often insist the distressing memories are no longer recurrent or involuntary. Traumatic memories may actually be retrieved with volitional effort. Disrupted sleep patterns may no longer be associated with recurrent distressing dreams but sleep difficulties persist (thereby meeting E.6 Criterion instead). Though traumatic recollections and dreams have faded into the background they can be reactivated fairly readily. In the past cogent arguments have been made that episodes of anger dyscontrol were—or occurred during— dissociative experiences. C Criterion: Avoidance will often be more difficult to establish, unless they are liberally (and psychodynamically) interpreted. D Criterion: Negative alterations in cognitions and mood seem almost *de rigueur* in the persons under consideration but may not be so clearly associated with the traumatic event, beginning or worsening after the traumatic event occurred. Criterion D 2: Persistent and exaggerated negative beliefs or expectations about oneself, others or the world is exemplified parenthetically in DSM 5 with "I am bad." "No one can be trusted." Both are commonplace responses, often given verbatim, to conscience sensitive inquiries.[15] Minimally provoked

[15] From the repertory of CONSCIENCE SENSITIVE INQUIRIES it is possible to select "Do you think you were born a good person?" Responses we hear might convey the conviction "I was born good and stayed good," or "I was born good but went bad." Sometimes before any inquiry is even made, information has already been conveyed by visible markings, prominent tattoos often

angry outbursts, reckless or self destructive behavior are likewise commonplace and sufficient to meet Criterion E: Alterations in arousal and reactivity, again on condition that the link is made with the trauma (PP. 271-280). PERSISTENT DEPRESSION DISORDER are often present along with co-morbid SUBSTANCE USE DISORDERS Whether or not these individuals with these types of PI-in-conscience meet criteria for current POST TRAUMATIC STRESS DISORDER, they are considered here because of the accumulating evidence that trauma and stress related psychobiological changes have occurred that are likely to have etiological significance. OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION (p.715ff) and may be encoded in the given case include: CHILD MALTREATMENT AND NEGLECT PROBLEMS: CONFIRMED, SUSPECTED or given by PERSONAL HISTORY (pp. 717-719); and PROBLEMS RELATED TO LIVING IN A RESIDENTIAL INSTITUTION.

B. Conscience dysfunction is characterized by preponderance of the following:

- Conceptualization of conscience lacks evidence of personal moral meaning.
- Trust and empathy between the person and attachment figures have been weakened. What semblance of trust does persist is limited to a very few individuals (e.g. one's own gang).
- 'Low voltage' emotional responses (sadness, guilt, shame) to what society deems immoral behavior.
- Paranoid sensitivity with misinterpretation of ambiguous social stimuli as threats, reactive affective defensive aggressive reactions.
- Dominance of survival values and strategies; hostile and suspicious stance towards authority.

In the matter of conscience, consideration needs be given to:

- The degree of difficulty in *desistence*—not proceeding along harm's way and/or attempting to make a turnaround out of harm's way (what can be termed *counter-vicious effort*).
- The degree of difficulty in resetting a course towards flourishing (what can be termed *virtuous effort*).

These are considerations that are likely to arise in types of PI that have weakened, constricted or thwarted conscience functioning and impeded further formation.

In DSM 5 TRAUMA- AND STRESSOR-RELATED DISORDERS is followed by several disorders which occur in the youth-span and which may or may not produce PI-IN-CONSCIENCE but for which we have not collected a sufficient number of CONSCIENCE SENSITIVE INTERVIEWS or conducted a sufficient number of CONSCIENCE SENSITIVE TASKS to provide meaningful typological descriptions. These are SOMATIC SYMPTOM AND RELATED DISORDERS, FEEDING AND EATING DISORDERS, and ELIMINATION DISORDERS. These await further study. Disrupted patterns of sleep are frequently encountered but usually not in the pure form (without co-morbidity) of SLEEP-WAKE DISORDERS. We do know that in normal conscience functioning, sleep is often reported to suffer or may be a touchstone of moral behavior: "If I do *x* (or don't do *y*) at least I will be able to sleep at night." It would therefore be of interest to collect systematic data from the formal Stilwell Conscience Interview or CONSCIENCE SENSITIVE PSYCHIATRIC EVALUATIONS conducted in a referral population to Sleep Disorder Clinics.

GENDER DYSPHORIA has been given its own chapter in DSM 5. Virtually all of this psychiatrist's experiences have been in cases in which youth were referred for anxiety, disruptive behavior, depression or autism spectrum disorder rather than *gender dysphoria*. Even allowing for the comorbidity which actually occasioned their visits, the number of CONSCIENCE SENSITIVE EVALUATIONS that have been conducted with youth who identified any clinically significant distress (when distress has been

---

festooned with gang regalia, a kind of post-modern illuminated manuscript, expressing the conviction their bearer has been "Born Bad" or has been spawned from "Bad Seed." We need not—ought not—accept these declarations of personal intuitions as true correlates of inborn errors (as kinds of phenotypic expressions, corresponding to a genetic variant disposing to sociopathy). It is important in our work to remember that while the declarations may have been made in indelible ink, tattoos nonetheless can be removed— albeit at some expense and discomfort—or perhaps at least transformed with figurative emendations: "Born Bad—Went Good" or at the very least "Born Bad–Getting Better."

present, the adults—not necessarily parents—in the youth-space have been more apt to identify it than the youth) over the incongruence between experienced/expressed and assigned gender (p. 452) is insufficient for commentary beyond what we find in DSM 5. On the other hand persons who have traversed a youth-span during which they expressed *nonconformity to gender roles* (p.458) in a hostile environment have, upon CONSCIENCE SENSITIVE INQUIRY, often provided poignant accounts which touch upon the moral dimensions of their struggle with the hegemony of hetero-normative and exclusionary values. In these cases there may also be encoded OTHER PROBLEMS RELATED TO THE SOCIAL ENVIRONMENT: SOCIAL EXCLUSION OR REJECTION, TARGET OF ADVERSE DISCRIMINATION OR PERSECUTION (p.724); and PROBLEMS RELATED TO OTHER PSYCHOSOCIAL, PERSONAL AND ENVIRONMENTAL CIRCUMSTANCES: RELIGIOUS OR SPIRITUAL PROBLEM (p. 725; see also *conscience-in-objection* below). There may also be encounters with persons (perhaps learners in psychiatry, pastoral counseling or marriage and family therapy) who engage in reflective supervision or collateral therapy that involves *gender work*, and who become more confounded in the process, however it would be more appropriate to call their condition *gender aporia*.

The DISRUPTIVE, IMPULSE CONTROL AND CONDUCT DISORDERS appear next in DSM 5. This chapter includes conditions involving self control of emotions and behaviors… OPPOSITIONAL DEFIANT DISORDER, INTERMITTENT EXPLOSIVE DISORDER, CONDUCT DISORDER, ANTISOCIAL PERSONALITY DISORDER, PYROMANIA , KLEPTOMANIA, *inter alia*. Although all the disorders in the chapter involve problems in both emotional and behavioral regulation, the source of variation among the disorders is the relative emphasis on the problems in the two types of self control. (p. 461). Regarding PI-IN-CONSCIENCE found in many CONDUCT DISORDERS much has already been covered under the TRAUMA- AND STRESSOR-RELATED DISORDERS particularly in our consideration of TYPES OF PI THAT WEAKEN, CONSTRICT AND THWART CONSCIENCE FUNCTIONING AND IMPEDE FURTHER CONSCIENCE FORMATION.

DYS-AUTONOMOUS PI-IN-CONSCIENCE

COMMENTS

Salience of PI in the domain MORAL VOLITION puts one in mind of a *dys-autonomous conscience*. Antecedent temperamental factors such as '*the difficult child*' and suboptimal *temperamental fit* of the child with the caregiver are considerations, in addition to the formal diagnosis of OPPOSITIONAL DEFIANT DISORDER. According to DSM 5, OPPOSITIONAL DEFIANT DISORDER has an average prevalence of 3.3% and co–occurs with ATTENTION DEFICIT HYPERACTIVITY DISORDER and CONDUCT DISORDER (p. 464). Criterion A has three notable divisions. **Angry/Irritable Mood** has relevance in the conscience domain MORAL EMOTIONAL RESPONSIVENESS **Argumentative/Defiant Behavior** implicates PI in the conscience domains of MORAL VALUATION (AUTHORITY) and MORAL VOLITION and **Vindictiveness** implicates MORAL VALUATION (PEERS). This psychiatrist has seen very few cases without any co-morbidity, probably owing to referral bias favoring candidates for psycho-pharmacotherapy. In rare cases without co-morbidity that have been refractory to non-pharmacological interventions (such as shoring up parenting skills and adopting '*Would You Rather--?*'[16] approaches), sometimes medications are requested and accordingly a CONSCIENCE SENSITIVE PSYCHIATRIC EVALUATION has been conducted. Sometimes use of stimulant or alpha adrenergic agent will confer benefit by 'lengthening the fuse' and allow work to proceed with conscience sensitive tasks which had been the occasion of vexation and resentment prior to medication. A stretch of MORAL IMAGINATION is sometimes possible that emphasizes the counselor's respect for the youth's autonomy (which the youth may perceive as under constant threat). The VALUE MATRIX is used to determine which mandates in which compliance is currently ensured by external authority but nonetheless judged as having worth by the child. This is followed with an invitation to use a figurative CRYSTAL BALL OF CONSCIENCE or, especially at the turn of the year, to make a NEW YEAR'S CONSCIENCE PREDICTION as to the mandate (in which compliance is currently ensured by external authority) will most likely become the child's own (i.e. become internalized) in the course of the next twelve months.

Earlier, we had occasion to mention the inferential work that is required to make explicit PI-IN-CONSCIENCE in INTERMITTENT EXPLOSIVE DISORDER and have little to add here.

We turn our attention now to types of PI-IN-CONSCIENCE that might presage ANTISOCIAL PERSONALITY DISORDER in adults.

[16] The term "'*Would you rather*--?' approaches" for promoting deliberate consideration of options, was appropriated from the title of a lighthearted children's book which looks at choosing, its real and perceived limitations: Burningham J (1978): **Would You Rather** ... Thomas Y Crowell, New York.

ANTIPATHETIC/REFRACTORY/REPUDIATING TYPES OF PI -IN -CONSCIENCE

A. Context:

We have come to appreciate that in the alembic of conscience formation there are myriad *gene x environment* interactions. However also among the ingredients put in the alembic, we find choices must count for something. On the way to attaining and deferring gratifications, *choices* have been made and will continue to be made in behavior and attitude. *Habits* (whether virtuous or vicious) have been and will continue to be formed. Habitual learning like any learning, we know, has changed the brain. Some habits will be formed with more and some with less conscious attention, mindfulness or deliberation.[17] Over learned pathways will be hard not to follow, but new pathways can still be deliberately chosen, and deliberate choices also will change the brain.

Among the DISRUPTIVE BEHAVIOR DISORDERS, it remains to be seen whether the DSM 5 diagnosis of CONDUCT DISORDER WITH LIMITED PROSOCIAL EMOTIONS (C-U) will be the one considered most likely to be associated with ANTISOCIAL PERSONALITY DISORDER (ASPD) in adulthood. [18] Could the identification of ANTIPATHETIC/REFRACTORY/REPUDIATING TYPES OF PI IN CONSCIENCE in the youth-span (irrespective of a diagnosis of CONDUCT DISORDER) improve prediction of ASPD in adulthood?

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.

B. Conscience dysfunction is characterized by preponderance of the following:

- Moral engagement and moral imagination are rejected or actively repudiated.*
- Mistrust is not only present but also may be cultivated in self and in others to gain advantage.
- Emotional responses to what society deems right and wrong, good or bad are incongruous but also intense (as in expressed contempt), there may be predatory aggression.
- Values are exclusively self-serving and cognitive processes are used to justify the rightfulness of this stance.
- Will power is used to intimidate or control others in the service of self.

Consideration also needs to be given to:

- The degree of acquiescence in *persistence* in following a trajectory that will entail harm (e.g. in cases of habitual offenders), particularly when it can no longer be explained solely by reduction to survivalist mode;

[17] In terms of their correlations with neurobiological structures and activities in the brain, just how (and when), deliberate *choices* eventuate into *habits* is even more mysterious than how (and when) externally supported *habits* begin to alter *attitudes*. For further reading see: **Dual Process Theories** (Kahneman & Sunstein , 2006) The dual processes are: **System I (Intuitive):** Automatic, Effortless, Associative, Rapid, Opaque process, and Skilled and **System II (Reflective)** Controlled, Effortful, Deductive, Slow, Self-aware, and Rule-Following. Also see Galvin et al, (2009): The psychobiology of conscience; signatures in brain regions of interest. Access at: http://shaw.medlib.iupui.edu/

[18] However, CONDUCT DISORDER with age of onset before ten years of age and accompanying ADHD are already considered risk factors for ASPD. Child abuse or neglect, unstable or erratic parenting, or inconsistent parental discipline may increase the likelihood that conduct disorder will evolve into [ASPD] (p. 661).

- The possibility that harm's way is actually the chosen trajectory in which case it may progress via amoral valuation or immoral valuation (as opposed to demoralization) to a disposition heedless of harm or to a disposition to do deliberate harm.

*Care should be taken by the counselor in relying excessively on this feature when encountering those who are engaging in moral philosophical explorations or experiments in belief systems (such as radical egoism) or are 'trying on possible selves' (sometimes for effect). In such cases the conscience may be better described as being in the Confused Stage, perhaps for a protracted period of time, or may be Anomalously Formed (see below) with the presumption that it is not subject to psychopathologic interference at all. Ascertaining the presence of the other features should help make the distinction.

CIRCUMSCRIBED TYPES OF PI-IN-CONSCIENCE

A. CONTEXT

Among the types of CONSCIENCE FUNCTIONING DISORDER for which criteria were proposed in 2006 Barb Stilwell documented the need for a DEFICIENT, ISOLATED TYPE. She emphasized shame over behavior that was 'out of character' and lead to various deceptive practices to avoid detection. She had in mind such conditions as gambling, pyromania and habitual use of pornography.

In DSM 5 habitual but circumscribed harmful behaviors have been dispersed in different chapters. GAMBLING DISORDER now appears among the SUBSTANCE-RELATED AND ADDICTIVE DISORDERS (see below) but it is also near ASPD and CONDUCT DISORDER for four reasons:

(1) strong comorbidity of substance use disorder, "pathological gambling' and antisocial disorders;
(2) convincing genetic literature: "behavioral disinhibition' = measurable phenotype with high heritability that underlies antisocial disorders, substance use disorders, gambling and may be different manifestations of one underlying problem;
(3) considerable evidence for shared neurobiology; imbalance of motivation/reward system vs inhibitory systems and
(4) such a placement with consideration of adjacencies may improve cross-talk: animal and clinical research
(O' Brien, 2013)

PYROMANIA and KLEPTOMANIA, on the other hand, are contained in the chapter dedicated to DISRUPTIVE, IMPULSE-CONTROL AND CONDUCT DISORDERS. According to DSM 5 the diagnosis of pyromania should not be given when firesetting occurs as part of conduct disorder, a manic episode, or antisocial personality disorder (p.477). In this psychiatrist's practice fire-setting has only been found in the context of the aforementioned exclusionary conditions so no commentary beyond what we find in DSM 5 can be offered.

GAMBLING DISORDER, KLEPTOMANIA and INTERNET GAMING DISORDER (contained in SECTION III CONDITIONS FOR FURTHER STUDY)[19] have several things in common: relief of negatively experienced inner states, attempts to resist the impulse and deceptive practices. For the individual both disposed and stressed, a circumscribed type of PI-IN-CONSCIENCE may be associated with a pattern of behavioral disinhibition or surrender to such impulsive urges.

For example, this type of PI-IN CONSCIENCE might be discerned in the context of KLEPTOMANIA. In DSM 5 Criterion A for KLEPTOMANIA (p.478) is [r]ecurrent failure to resist impulses to steal objects that are not needed for personal use or for monetary value (PI IN MORAL VOLITION). While, according to Criterion B and C, there is an increasing sense of tension immediately before committing the theft and pleasure, gratification, or relief at the time of committing the theft, we also find, among the associated

[19] We can only speculate whether there is, among the many putative toxic effects of earlier and more extensive exposures to screen media, a massive injection of moral consternation the sequelae of which might become discernible at younger and younger ages thereby altering the progression through –by acceleration, deceleration (or bypassing?)— the stages we were able to identify in our 1980's cohort of relatively advantaged youth. It remains to be seen whether the term 'relative advantage' that includes family wealth disposed upon electronics and the correlated increase in parental reliance upon electronic devices to occupy very young children will prove distinctly disadvantageous for conscience formation. In corollary, will psychopathological interference in conscience functioning have an entirely different cast when catastrophes occur?

features, the individual frequently fears being apprehended and often feels depressed and guilty about the thefts (MORAL EMOTIONAL RESPONSIVENESS).

B. Conscience dysfunction is characterized by preponderance of the following:

- The person may indicate he or she would have a fuller sense of being a good person if only it weren't for the particular habitual behavior. The pattern is not in keeping with the person's more general conscience functioning.
- Principal moral attachment relationships may be strained by the persistence of the habitual behavior. There may be a strong need to avoid disapprobation or to compensate for anticipated disapprobation by efforts to otherwise please principal moral attachment figures.
- There may be activation of moral emotional responses including fear of punishment, shame or guilt associated with the habit in question vying with pride in accomplishing feats of subterfuge.
- Efforts are made to control the behavior. The individual describes being overmastered by his or her urge. Deceptive practices are employed to avoid detection.

CONSCIENCE-IN-RECOVERY

A. Context

The next chapter we come to in DSM 5 is devoted to SUBSTANCE-RELATED AND ADDICTIVE DISORDERS. Rather than discuss the PI-IN-CONSCIENCE associated with acute intoxication and 'seeking the high,' with its associated deceptions and violating behaviors, or the PI attributable to the conditions co-morbid with substance related disorders, under this head we will discuss *conscience-in-recovery.* Of the TWELVE STEPS familiar to us (Keegan and Moss, 2008) there are six (Steps 1, 4, 8, 9 and 10) that do not mention God or a Power greater than ourselves. One more of the TWELVE STEPS that does mention God or a Power greater than our selves (Step 5), prescribes an activity of conscience. Each of these six steps is readily identified with one or more domains of conscience. Here's the mapping:

STEP OF TWELVE STEPS	CONSCIENCE DOMAIN
STEP 1: We admitted we were powerless over alcohol (our addiction) —that our lives had become unmanageable.	MORAL VOLITION
STEP 4: We made a searching and fearless inventory of ourselves.	MORAL VOLITION MORAL EMOTIONAL RESPONSIVENESS I MORAL VALUATION
STEP 5: We admitted to God, to ourselves and to another human being the exact nature of our wrongs.	MORAL EMOTIONAL RESPONSIVENESS II
STEP 8: We made a list of all persons we had harmed and became willing to make amends to them all.	MORAL EMOTIONAL RESPONSIVENESS II
STEP 9: We made direct amends to such people whenever possible except when to do so would injure them.	MORAL EMOTIONAL RESPONSIVENESS II MORAL IMAGINATION MORAL VALUATION
STEP 10: We continued to take a personal inventory and when we were wrong promptly admitted it.	MORAL VOLITION MORAL VALUATION MORAL EMOTIONAL RESPONSIVENESS II

STEPS 2, 3, 6, 7, 11 and 12 take us beyond the moral realm into the spiritual. It is worthwhile reflecting upon how the TWELVE STEPS so neatly convey the potential interaction of what is moral and what is spiritual. However, from the secular point of view of the medical model which governs CONSCIENCE SENSITIVE PSYCHIATRY a boundary has been reached: namely, it must be left to the

individual to reflect upon whether the steps involving conscience can be negotiated without petition to and reliance upon God or a Power greater than our selves.

B. Restoration of conscience functionality should be conceptualized on a scale of intensity rather than severity and is characterized by preponderance of the following:

- Upon conscience sensitive inquiry, persons in recovery relate an awareness of being overmastered by the use of substances; awareness of increasing activity of conscience after a hiatus or dormant period.
- Recognizes moral attachment figures and moral stakeholders with whom reparative relational work might commence. Decisions about which relationships to strengthen with family and friends are enlightened by considerations of how supportive the relationships will be in sustaining abstinence. There is evidence of seeking a favorable balance in concern for and contact with others who might be the occasion of set-backs. There is awareness of becoming a potential moral attachment figure or role model for others (e.g. younger siblings) and concern to sustain abstinence for their sake as well as one's own.
- Acquires skill in appropriate management of guilt feelings and expressions of remorse. Others in the youth-space are able to distinguish more genuine moral emotional responses from sporadic afflictions of conscience in which expressions of remorse are self serving or subverted by self pity. There is humility in facing the issues.
- The acceptance of abstinence sustaining house rules and requirements imposed by authorities and caregivers becomes more internalized.
- Moral volition is directed into help seeking strategies and resolution to renew recovery efforts in the face of setbacks.

CHARACTER PI- IN-CONSCIENCE

Comments

We have defined domains of conscience discernible at developmental stages. Once again, the empirically established domains of conscience in the youth-span are: CONCEPTUALIZATION OF CONSCIENCE, MORALIZED ATTACHMENT, MORAL EMOTIONAL RESPONSIVENESS (I AND II), MORAL VALUATION (AUTHORITY, PEER, SELF) and MORAL VOLITION. We have referred to conscience as *the heart of the personality.* Yet, our characterizations of the obsessional conscience and the repudiated conscience in the context of personality disorders notwithstanding, we share with many child and adolescent psychiatrists certain reluctance in diagnosing PERSONALITY DISORDERS in most of the youth-span.

THE ALTERNATIVE DSM 5 MODEL FOR PERSONALITY DISORDERS (p.761ff) may usher in a new era in which our developmental discernments will have clinical relevance for our colleagues working in the later life-span. We believe with some inferential and translational work, the domains of conscience may be susceptible of mapping as moral psychological developmental bases for the areas of PERSONALITY FUNCTIONING in the proposed alternative model. In the proposed alternative, the ELEMENTS OF PERSONALITY FUNCTIONING are placed in two divisions (Table 1 p.762) **SELF**: IDENTITY and SELF DIRECTION, and **INTERPERSONAL**: EMPATHY and INTIMACY. Our conjectural mapping [20] follows:

DOMAINS OF CONSCIENCE		PERSONALITY FUNCTIONING (IN MORAL ASPECTS)
CONCEPTUALIZATION OF CONSCIENCE	>	IDENTITY
MORAL ATTACHMENT	>	EMPATHY
	>	INTIMACY
MORAL EMOTIONAL RESPONSIVENESS	>	INTIMACY
	>	EMPATHY
MORAL VALUATION	>	SELF DIRECTION
MORAL VOLITION	>	SELF DIRECTION

[20] A similar mapping of conscience domains onto Cloninger's *Temperament and Character Factors* was conjectured in Galvin et al, 2001.

This conjectural mapping might be subjected to longitudinal study for validation.[21]

In describing the *contours of conscience* we may also speak of the *most salient domain* and the *least conspicuous domain* as represented in a conscience image or narrative. An additional study might be focused on how the relative salience of domains of conscience functioning influences and/or is influenced by the FIVE BROAD DOMAINS OF PERSONALITY TRAIT VARIATION (p.773): NEGATIVE AFFECTIVITY VS EMOTIONAL STABILITY, DETACHMENT VS EXTRAVERSION, ANTAGONISM VS AGREEABLENESS, DISINHIBITION VS CONSCIENTIOUSNESS, and PSYCHOTICISM VS LUCIDITY and their twenty five facets (Table 2, p.775).

The last type of PI-in-Conscience about which we will comment, briefly, occurs in the context of DSM 5 PARAPHILIC DISORDERS (p. 685 ff). Adult males with PEDOPHILIC DISORDER may indicate that they become aware of strong or preferential sexual interest in children around the time of puberty…. [However] [a]ttempting to diagnose pedophilic disorder at the age at which it first manifests is problematic because of the difficulty during adolescent development in differentiating it from age-appropriate sexual interest in peers or from sexual curiosity. Hence Criterion C requires for diagnosis a minimum age of 16 years and at least five years older that the child or children in Criterion A. (p. 699). Specifically, we are not to include an individual in late adolescence involved in an ongoing sexual relationship with a 12 or 13 year old (p. 697). Children and adolescents, with personal history of sexual abuse and who sexually abuse other children and younger adolescents are sometimes referred to as *sexually reactive* and are apt to have co-morbid diagnoses already discussed [recall in particular CONDUCT DISORDER Criterion A7: has forced someone into sexual activity (p. 470)]. There appears to be an interaction between pedophilia and antisociality, such that males with both traits are more likely to act out sexually with children (p. 699).

CONSCIENCE SENSITIVE EVALUATION AND TREATMENT in this field has been pioneered by Psychotherapist Niki Delson in California (Delson, 2003). Descriptions of PI–IN-CONSCIENCE in sexually reactive youth in residential care based upon our conscience sensitive inquiries are deferred pending further study.

TYPES OF INTERFERENCE LEADING TO SEQUESTRATION AND/OR ANOMALOUS FORMATION OF CONSCIENCE

A. Context:

There is not a current psychiatric diagnostic context for this type of interference with human flourishing per se. It nonetheless contributes greatly to human misery and will be encountered by clinicians and counselors. In the Definition of Mental Disorder which appears in Use of the Manual, DSM 5 makes clear that socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual. Some may well dispute that this type of interference should be so clearly distinguished from psychopathological interference. In any event, most will concur that the two kinds of interference in human flourishing may be closely intertwined, insofar as zealotry and bigotry are certainly not proof against mental disorders. The conscience of this person may have been formed with deliberate encouragement or simple modeling from principal moral attachment figures or from adopted idols. In the domain of MORAL VALUATION there has been incorporation of the dys-value of intolerance. The person may be disposed to varying degrees to dehumanize others based upon specifiable features such as: sex, sexual orientation, race, religion or creed, ethnicity, age, intelligence, level or kind of education, socioeconomic class, or political persuasion. The person may be a passive recipient of these dys-values and dispositions from caregivers, may exhibit any degree of obduracy in continuing to cultivate them or may, on the contrary, be moving towards subjecting dys-values and attitudes to reevaluation perhaps because of reflection on corrective encounters with persons subjected to the discrimination or changes in principal moral attachment figures or adopted idols. In such cases the crisis in conscience and identity may actually lead to dysfunction or disorder. Borrowing terminology from the stages of changes model cited in addiction medicine (Prochaska et al, 1991; Hughes, 2003) it may be useful to consider readiness for change as *pre-contemplative*, and *contemplative* prior to efforts towards cessation. In the pastoral counseling or therapeutic encounter support for persons ready for change might take the form of motivational interviewing in which awareness of the VALUE GAP is heightened via use of the VALUE MATRIX.

[21] The five point Level of Personality Functioning Scale (p.775) strikes us as very compatible with the five point scale of severity of psychopathologic interference in Conscience Functioning.

B. Conscience dysfunction is characterized by preponderance of the following:

> In response to conscience sensitive inquiries and tasks, there is evidence of moral awareness, engagement and imagination. The empirically established conscience domains may be more or less at age expectable stages with respect to the *in group* but others are excluded from the same degree of moral consideration on the basis of discrimination. We sometimes refer to this constricted circle of recognized moral stakeholders as a *limited ambit of conscience*. Challenges to expand the ambit of conscience by either included or excluded persons are seen as boundary violations, and justification for vigilance and preemptive actions. Hyper-vigilance in protecting perceived entitlements may erode even those functions preserved within the limited ambit of conscience.

TYPES OF INTERFERENCE IN RESPONSE TO SEQUESTRATION AND/OR ANOMALOUS NURTURANCE OF CONSCIENCE AND CONSCIENCE-IN-OBJECTION

A. Context:

These crises in moral identity are not seen to be pathological but are seen to require considerable energy in their resolution, will often entail grief over lost relationships, persistent discomfort in those that can be preserved and an assumption of the allostatic burden associated with the stress of change. We are not apt to see this type of interference until a person 'comes of age' but it can certainly be seen well after emergence from the Confused Stage of Conscience. Examples of persons we have in mind would include those who are responding to inter-generational transmission of exclusive hetero-normative or homophobic values, those responding to authoritative insistence based upon faith tradition limiting choice of or severance from life partners, those experiencing stifling of unique individual flourishing (e.g. pursuing a career or profession) and those who have experienced moral consciousness raising regarding war, civil rights, distribution of wealth and power, stewardship of natural resources, ecological concerns or obligatory practices within a profession, *inter alia.* In these cases there may be encoded OTHER PROBLEMS RELATED TO THE SOCIAL ENVIRONMENT: SOCIAL EXCLUSION OR REJECTION, TARGET OF ADVERSE DISCRIMINATION OR PERSECUTION; PROBLEMS RELATED TO CRIME OR INTERACTION WITH THE LEGAL SYSTEM: VICTIM OF CRIME, CONVICTION IN CIVIL OR CRIMINAL PROCEEDINGS WITHOUT IMPRISONMENT, IMPRISONMENT OR OTHER INCARCERATION and PROBLEMS RELATED TO OTHER PSYCHOSOCIAL, PERSONAL AND ENVIRONMENTAL CIRCUMSTANCES: RELIGIOUS OR SPIRITUAL PROBLEM.

B. Conscience-in-objection is characterized by preponderance of the following:

- Upon conscience sensitive inquiry, an espousal of belief is made that one ought to pursue goodness in self, relationships, and the world, there is an awareness that one's moral vision is at loggerheads with received social wisdom.
- Upon conscience sensitive inquiry or conscience sensitive tasks such as the moralized genogram, there is evidence of estrangement in one or more principal attachment relationships due to moral conflict. There may be a strong desire to mend the relationship or arrive at rapprochement with expressed resignation in the form of 'we have been trying to agree to disagree' or 'we do not discuss it.'
- Upon conscience sensitive inquiry there is indication of anxiety, anger and/or grief over moral conflicts within self or over relationships with others, but also efforts to sustain empathic responsiveness.
- Upon conscience sensitive inquiry or conscience sensitive tasks such as the value matrix, value dissonance: questioning of values or behavior that were formerly accepted as right or wrong; questioning of behavior in self, others, or the world formerly not considered in moral terms.
- Upon conscience sensitive inquiries regarding awareness of change and growth in conscience, there is evidence of efforts expended to counteract urges and to control behaviors that would show disruption in respect for authority and disruption in self-worth.

In developing this description, we are indebted to Guest Interviewees over the years in our course **Conscience Centered Psychiatric Ethics** as well as **Conscience Project** Participants Jere Odell and, Sister Mary Satala and Meg Gaffney. Learn more about Conscientious Objection in the Healing Professions at http://bioethics.iu.edu/conscientious-objection/

CONCLUDING REFLECTION

Reflection and deliberation change the brain but maybe not straightaway. Transformation may occur by nearly imperceptible increments. So we offer a hedge against the demoralization that can overtake those working 'in the field', by which is meant the youth- space in which conscience in adversity must be healed and tended: psychiatrists, counselors, psychotherapists, and those who are actually in the youth-span –are all workers 'in the field' alike. So an invitation is issued to reflect upon a fictional convict beloved by readers for the moral beauty that eventually pours forth from the alembic of his conscience.

In **Les Misérables**, Jean Valjean is famously depicted as making a moral transformation after the good bishop mercifully *enables* (the word is used advisedly) Jean to avoid the legal consequences that would inevitably follow from his theft of the silver. In the musical version, in which songs do not fail to stir us heart and soul while they also carry the plot forward, there is perforce a compression of the transformation. In the novel it will take Jean rather more time before his moral energies are no longer fully absorbed by counter-vicious efforts and he becomes, by contrast, astonishingly virtuous in his recognition that even the unintended harms he has done or could do to others simply by omissions on his part requires amendatory behaviors at great risk to himself. There is one encounter after the familiar one with the good bishop with particular import for us 'in the field'. It is omitted from film and musical versions. In the encounter a set-back occurs that brings about a profound moral aporia for Jean. The encounter also makes the reader who is naïve to the story anxiously wonder whether any change has really occurred in Jean at all. It is found in chapter XIII entitled "Petit Gervais."

> [Jean] turned his head and saw coming along the path a little Savoyard, a chimneysweep, about ten years old, singing, with a small hurdy-gurdy at his side, and a pack on his back. One of those cheerful boys who go from place to place, with their knees poking through their trousers.
>
> Still singing, the boy stopped from time to time, playfully tossing up a few coins he had in his hand, probably his entire fortune. Among them was a forty-sous piece.
>
> Without noticing Jean Valjean, the boy stopped beside the thicket and tossed up his handful of coins; until that moment he had skillfully caught them on the back of his hand.
>
> This time the forty–sous piece got away from him and rolled toward the thicket, near Jean Valjean.
>
> Jean Valjean put his foot on it.
>
> The boy, however, had followed the piece with his eye and had seen where it went.
>
> He was not frightened and walked right up to the man.
>
> It was a totally secluded place. There was no one to be seen on the plain or on the path. The only sound was the faint cry of a flock of birds of passage, flying across the sky at an immense height. The child turned his back to the sun, which made his hair like threads of gold and flushed the savage face of Jean Valjean with a lurid glow.
>
> "Monsieur," said the little chimney sweep, with a childish confidence composed of ignorance and innocence, "my money?"
>
> What's your name?" said Jean Valjean.
>
> "Petit Gervais, Monsieur."
>
> "Go away," said Jean Valjean.
>
> "Monsieur," repeated the boy, "give me my coin."
>
> Jean Valjean looked down and did not answer.
>
> The child began again. "My money, Monsieur!"
>
> Jean Valjean's eyes remained fixed on the ground.
>
> "My money!" exclaimed the boy, "my silver coin! My money!"
>
> Jean Valjean did not seem to understand. The boy took him by the shirt collar and shook him. And at the same time he made an attempt to move the big, iron-tipped shoe standing on his treasure.
>
> "I want my money, my forty sous!"
>
> The child began to cry. Jean Valjean raised his head. He remained seated. He was troubled. He looked at the boy with an air of bewilderment, then reached out toward his stick, and said gruffly, "Who is it?"

"Me sir," answered the boy. "Petit Gervais! Me! Me! Give me my forty sous, please! Take away your foot, sir, please!" Then becoming angry, small as he was, and almost threatening: "come on, will you move your foot? Why don't you move your foot?"

"Ah! You still here!" said Jean Valjean, and rising hastily to his feet, without releasing the piece of money, he added, "You'd better get moving."

The boy looked at him in terror, then began to shake from head to foot, and after a few dumfounded seconds, took off and ran with all his strength, not daring to turn his head or cry out.

Soon, however, he stopped, out of breath, and Jean Valjean, still distracted, heard him sobbing.

In a few minutes the boy was gone.

The sun had set.

Jean, the reader is informed, had not eaten all day and probably had a fever. On one interpretation of this encounter, after nineteen years of hard labor, Jean is so conditioned to be in survival mode that his immediate reaction, tacit and procedural, to the errant forty-sous is to ensure he controls it with his foot, availing himself of the boy's loss as his gain. However, the C-U habituation that Victor Hugo so wonderfully describes in his character is now met with profound moral confusion because of his encounter with the bishop.

At that instant he noticed the forty-sous piece that his foot had half buried in the ground, now glistening among the pebbles. It was like an electric shock. "What is that?" he said, between his teeth. He drew back a step or two, then stopped, unable to dislodge his gaze from the spot his foot had covered the instant before, as if the thing that glistened there in the shadows were an open eye staring at him.

~

APPENDIX

CONSCIENCE SENSITIVE INQUIRIES AND TASKS

A CONSCIENCE SENSITIVE PSYCHIATRIC EVALUATION or A CONSCIENCE SENSITIVE MEDICAL EVALUATION can be conducted in one hour.[22] The counselor who wishes to conduct CONSCIENCE SENSITIVE INITIAL ASSESSMENTS will likely adopt and adapt some of the following ideas as well.

CONSCIENCE SENSITIVE INQUIRIES may be embedded opportunistically within the:

- HISTORY OF PRESENT ILLNESS (e.g. with respect to SUICIDALITY, A CONSCIENCE SENSITIVE INQUIRY might be crafted in the form of *'You've told me about the circumstances leading to your suicide attempt and you've told me about some of the 'becauses' for your attempt. I wonder if you could tell me about a time in the past when you've had an urge to commit suicide but you were able to resist the urge—How? What were your 'becauses' for staying alive?'*),
- PERSONAL HISTORY (e.g. with respect to substance use A CONSCIENCE SENSITIVE INQUIRY might take the form of *'You've told me about recreational drugs you would use like marijuana and some you would not use like heroin. What are some of the becauses behind your **do's** and **don'ts** in making these choices?'*)
- REVIEW OF SYSTEMS (e.g. with respect to SEXUALITY, A CONSCIENCE SENSITIVE INQUIRY might be crafted in the form of *'You've told me that you first became sexually active at age 14 years and that you've had three sexual partners and that you usually practice safe sex by using condoms. Are there some **do's** and **don'ts** you think are important about your sex life? What are some of the values you have come to realize about being sexual?'*)

Aside from making inquiries opportunistically, this psychiatrist follows his RELIGIOUS/SPIRITUAL HISTORY TAKING with formal CONSCIENCE SENSITIVE INQUIRIES, one or two for each DOMAIN OF CONSCIENCE. These routine inquiries can be treated analogously to LEVEL ONE inquiries in the CROSS CUTTING SYMPTOM MEASURES IN DSM 5 except that they are inquiries directed to the youth, not the parent/guardian. In DSM 5 CROSS CUTTING SYMPTOM MEASURES are scored 0 to 4 with a score of 2 (Mild) or greater being threshold for further inquiry. A rating of The Scale of Severity of PI-IN-CONSCIENCE of 2 (Mild) or greater would also be threshold for further—LEVEL TWO— inquiry, if not by the initial evaluator by the conscience sensitive counselor/therapist who would deepen and expand the inquiry or conduct CONSCIENCE SENSITIVE TASKS.

In pre formatted psychiatric evaluation forms this psychiatrist has identified the DOMAINS OF CONSCIENCE with abbreviations allowing ample blank space after each to either record verbatim the responses to the inquiries or to record surface level interpretive comments such as "MER congruous with self ascribed R or W doing." In very little time, it becomes as procedural as providing the familiar stimuli for eliciting mental status findings.[23]

LEVEL ONE CONSCIENCE SENSITIVE INQUIRIES

CONCEPTUALIZATION OF CONSCIENCE [see Stilwell Conscience Interview (SCI) Q1and Q2]: *Have you heard of the word conscience? How would you describe yours?*

ALTERNATIVE: *Is there a part of you that helps you figure out right from wrong, good from bad? Tell me how it works.*

ALTERNATIVE : *How do you tell what would be right and what would be wrong, what would be good and what would be bad?*

[22] This psychiatrist, like many colleagues, has been employed in many work-spaces that have a *de facto* definition of 'productivity' = 'revenue generativity', largely based upon reimbursement patterns to which institutions that bear our professions must attend in order to ensure institutional survival. Accordingly, we are often limited by the rules of engagement to psychiatric evaluation, treatment planning and pharmacotherapy. This GUIDELINE assumes these constraints. The CONSCIENCE SENSITIVE PSYCHIATRIST may not always be so fortunate –as this psychiatrist has – to be able to use the CONSCIENCE SENSITIVE EVALUATION as the beginning of a CONSCIENCE SENSITIVE TREATMENT PLAN. However it is hoped that colleagues in pastoral counseling and psychotherapy will often be in a position to do so.

[23] Related to rules of engagement and imposed constraints, an entirely new frontier lies ahead in making *electronic medical record keeping* friendly to those who employ CONSCIENCE SENSITIVE APPROACHES.

Have you noticed any changes in your conscience lately? Does it seem more or less active? (this psychiatrist often employs an informal visual analog scale by holding his hands apart motioning appropriately while asking: *does it seem like it's off somewhere on vacation or maybe too quiet and you wish it would be busier*; *on the other hand, does it seem very busy, pestering, nagging, or even tormenting you or, or does it seem somewhere in between?*).

If changes in the form of excess or attenuated activity are reported: *Tell me more about what you mean.*

MORALIZED ATTACHMENT [see SCI Q 8, Q 9 and Q 10]: *Do you feel like a good person most of the time?*
Who cares most about whether you turn out to be a good person or not? How does that person show you he or she cares?

MORAL EMOTIONAL RESPONSIVENESS [see SCI Q 3A]: *When you have done something that in your eyes is the right thing to have done-- a good thing--what is that like inside you, body and mind?*

Have you noticed any changes in what you've just described? Does it (reference the feeling or inner state) *seem more or less intense or strong? More or less likely to happen? More or less likely to last?* (Informal visual analog scales may be employed).

What if no one knows about your good deed? Is it the same or different inside you?

MORAL EMOTIONAL RESPONSIVENESS [see SCI Q 3B]: *Now what about when you've done something that in your eyes is the wrong thing to do—a bad thing-- what is that like inside you, body and mind?*

Have you noticed any changes in what you've just described. Does it (reference the feeling or inner state) *seem more or less intense or strong? More or less likely to happen? More or less likely to last?*(informal visual analog scales may be employed).

What if no one knows about your bad deed? Is it the same or different inside you?

MORAL VALUATION (see SCI Q 12): *You've told me about what happens inside you when you do something right. What are some right-doings or good deeds that would make you feel that way?*

We also talked about what happens inside you when you've done something you believe is wrong. What are some wrong-doings or bad deeds that would make you feel like that?

What are some do's and don'ts you have in your life—rules you try to follow?

MORAL VOLITION: *You've told me that you thought x was wrong. Have there been times when you had an urge to do x but you succeeded in resisting the urge? How were you able to do that?*

Other LEVEL ONE CONSCIENCE SENSITIVE INQUIRIES are those the youth has been asked to check on a checklist or on a self report instrument. CONSCIENCE SENSITIVE ITEMS on dimensional ratings of behavior include for example Achenbach Youth Self Report (Achenbach. 1985) item 26:"*I don't feel guilty after doing something I shouldn't"* or item 52 *"I feel too guilty."* The Stilwell Structured Conscience Interview, mentioned earlier, is also LEVEL ONE CONSCIENCE SENSITIVE INQUIRY.

LEVEL TWO CONSCIENCE SENSITIVE INQUIRIES

LEVEL TWO CONSCIENCE SENSITIVE INQUIRIES deepen and expand the interview about conscience. They require more time than can generally be allotted for psychiatric evaluation. Accordingly, when it is clear that a threshold has been crossed and deeper inquiry is indicated some of the classic SCI queries are reserved by this psychiatrist for a later clinical encounter. These include SCI Q5 regarding REPARATION AND HEALING, SCI Q 6 and Q7 regarding EARLY MORAL MEMORIES, SCI Q13 regarding MANDATE AUTHORS, SCI Q14 regarding VALUATION AND DEFENSES (also see CONSCIENCE SENSITIVE TASK: VALUE MATRIX below) and SCI 15 regarding SELF EVALUATION AND VOLITION as well as asking for examples and using any of the additional probes available in the SCI.

LEVEL TWO CONSCIENCE SENSITIVE TASKS

The **CONSCIENCE SENSITIVE TASKS** are:

DRAW A PICTURE OF YOUR CONSCIENCE (see SCI Q 11).

THE MORALIZED GENOGRAM

THE MORALIZED TIME LINE

THE VALUE MATRIX

MORAL EMOTIONS IN VARYING CONDITIONS OF APPROBATION AND DISAPPROBATION

LETTERS OF APOLOGY OR GRATITUDE

CRYSTAL BALL OF CONSCIENCE OR THE NEW YEAR'S CONSCIENCE PREDICTION

DEMORALIZATION AND HARM PREVENTION PLANNING

Clinically applied **CONSCIENCE SENSITIVE TASKS** are described in:

Galvin M, Gaffney M and Stilwell B (2005): Preliminary observations and reflections on conscience sensitive group therapy. In **Conscience Works**, an On-line Periodical, *Theory, Research and Clinical Application*, 2(2): 1-23. http://shaw.medlib.iupui.edu/

Galvin, M., Fletcher, J. and Stilwell, B. (2005): Conscience sensitive psychiatry: clinical applications: retrieval of life affirming values. In **Conscience Works,** an On-line Periodical, *Theory, Research and Clinical Application*, 1(2): 1-5. http://shaw.medlib.iupui.edu/

See also: Galvin et al, 2006; Galvin et al, 2010.

Descriptions of CONSCIENCE SENSITIVE TASKS can also be found in a format adapted for professional education in:

A GUIDE TO CONSCIENCE. Access at http://shaw.medlib.iupui.edu/conscienceguide2-20-07.pdf

The last CONSCIENCE SENSITIVE TASK in a format adapted for professional education can be found in a power point presentation entitled **DEMORALIZATION AND HARM PREVENTION PLANNING.** Access at http://shaw.medlib.iupui.edu/

See also: Gaffney and Galvin (2012).

GLOSSARY OF TERMS

ALLOSTATIC LOAD (BURDEN): the physiological profile influenced by repeated or chronic life stressors (see for example: McEwen, 1998)

CONCUPISCENCE: an ardent, usually sensuous, longing; here referring to longing to participate in killing or other destructive activities that are ordinarily prohibited in society but are sanctioned in war. Convictions of --or troubling doubts about --having experienced this kind of longing associated with a sense of shame are sometimes disclosed by returning warriors (See: Verkamp, 2006).

CONSCIENCE: The word itself might be rendered literally as: *to come to know together*. **It is fundamental to our work that we do not presuppose or impose any particular definition of the term but simply ask others to provide their personal definitions. Our task has been to study these personal definitions and, informed by developmental theories and findings, to discern patterns. Operationally, the definition of conscience is given in narrative or image when a person is asked to describe or draw his or her personal conscience or the part of (or process in) the person that helps the person figure our right from wrong or good from bad. Personal definitions we have heard are shaped by many factors, level of maturity being especially important, but also character and environmental circumstances. Hence, we refer to *contours-of-conscience* (which may, after all, prove to have something to do with character traits), *conscience-in-advantage* (or –*disadvantage*), *conscience-in-adversity*, *conscience-in-catastrophe*, *conscience-in-recovery*, and *conscience-in-objection*, inter alia. Our chief concern in this GUIDE is with discerning psychopathological interferences that cause delays, rough going or even blockades along the pathways of conscience functioning. Conscience can sometimes cause its own 'interferences' along the pathways of psychopathology as when a disorder, even a psychiatric disorder, may actually be the occasion for moral flourishing. Our GUIDE does <u>not</u> explore the possibilities that conscience functioning could in itself dispose to psychiatric disorder. Those possibilities exist and await descriptions that will not expunge conscience language by eliminating modal operators such as 'should' or attempt to advance theories of personality that fail to recognize the heart of personality, that is to say the way we *come to know together.***

CONSCIENCE DOMAINS: Dimensions or aspects of functional conscience which are interrelated but sufficiently distinct to merit their own descriptions and which may show different degrees of salience in different developmental periods or with a degree of salience that is sustained throughout the youth span. We may speak of the *most salient domain* or the *least conspicuous domain* as represented in an image or narrative. The empirically established domains of conscience in the youth-span are: CONCEPTUALIZATION OF CONSCIENCE, MORALIZED ATTACHMENT, MORAL EMOTIONAL RESPONSIVENESS (I AND II), MORAL VALUATION (AUTHORITY, PEER, SELF) and MORAL VOLITION.

CONSCIENCE FORMATION: essentially identical to CONSCIENCE DEVELOPMENT**. The implication of 'development', for some, it has been pointed out (in the context of whether or not to adopt the term *spiritual development*) is an inevitable or predictable process, as well as a presumption of growth from less to more (Yust et al, 2006).** CONSCIENCE DEVELOPMENT **is characterized by progression through invariant hierarchical stages and does share with other developmental phenomena discernible unfolding in complexity. There is however no inevitability that progressions will occur in the absence of nurturance,** MUTUAL RECIPROCAL ORIENTATION **(Kochanska et al, 2006) and at some points at least the impetus of agency.**

CONSCIENCE FUNCTIONING: those aspects of PERSONALITY FUNCTIONING **which shape patterns of** MORAL ENGAGEMENT**.**

CONSCIENCE RELEVANT___: an explicit assessment or evaluative comment by some-one other than the person whose conscience is of interest or items endorsed by someone other than the person whose conscience is of interest. For example a psychologist whose evaluation includes summary remarks regarding conscience. More broadly, it is denotes any inferences about conscience that are or can be drawn from knowledge of general psychological domains, psychopathological conditions and their neurobiological underpinnings.

CONSCIENCE SENSITIVE____: an interrogatory given orally or in writing or an activity proposed in which there is explicit reference made to the person's own conscience in age appropriate terms. Examples are CONSCIENCE SENSITIVE INQUIRY **and** CONSCIENCE SENSITIVE TASK**. It also denotes an overall approach informed by conscience development that incorporates specifiable conscience sensitive interrogatories or tasks as in** CONSCIENCE SENSITIVE PSYCHIATRY, CONSCIENCE SENSITIVE GROUP THERAPY, CONSCIENCE SENSITIVE MEDICAL EDUCATION, CONSCIENCE SENSITIVE MORAL EDUCATION **or** CONSCIENCE SENSITIVE SPECIAL EDUCATION.

CONSCIENCE STAGES: the established STAGES OF CONSCIENCE **are** EXTERNAL **(modal age 6 and under),** BRAIN/HEART **(modal age 7-11),** PERSONIFIED **(modal age 12-13),** CONFUSED **(modal age 14-15) and INTEGRATED (modal age 16-17).**

CONTINUUM OF CASUALTY: degrees of impairment attributable to harmful acts or events. Originally, the term was used in the context of a CONTINUUM OF CARETAKING CASUALTY **(Sameroff and Chandler, 1975) to describe deleterious tendencies of parents with respect to child rearing.**

DIATHESIS/STRESS MODEL: is a psychological theory that attempts to explain behavior as a predispositional vulnerability together with stress from life experiences.

ENDOPHENOTYPE: a heritable biomarker that is associated with a clinical PHENOTYPE**. Endophenotypes may be more strongly associated with genetic markers than are clinical phenotypes. (Mrazek, 2010)**

INFERENTIAL/TRANSLATIONAL WORK: the effort required to draw an inference from and conduct the translation of particular knowledge of a general psychological domain, a psychopathological condition and/or its neurobiological underpinnings to illuminate CONSCIENCE FORMATION**,** CONSCIENCE FUNCTIONING **and the psychopathological interference thereof.**

MORAL ENGAGEMENT: we have not characterized this empirically as a domain of conscience. At an intuitive level it seems a necessary ingredient for there to be the many, many often miniscule negotiated accommodations and committed compliances that must take place each and every day between caregiver and child in order for conscience formation to proceed. The term is also used in the context of more mature conscience functioning to refer to a person becoming more fully aware of the moral dimensions of experiences or events and/or taking a more active role as a moral agent or advocate.

MORAL IMAGINATION: we have not characterized this empirically as a domain of conscience although it works within those domains that have been so characterized. In this document the term refers to how the imaginative faculty is or can be put at the service of CONSCIENCE FUNCTIONING**. Specifically we have in mind conjuring up and rendering an image of conscience, considering how 'what if' or *possible world* scenarios might reconfigure principal** MORAL ATTACHMENTS**, shift** MORAL EMOTIONAL RESPONSIVENESS **and alter moral mandates: e.g. 'What if your partner does decide to break with you, what will be the *becauses* you have for staying alive?' 'What if the people around you actually disapproved of what in your eyes appeared good and right, how would that change the way you feel in response to the good deed?' or 'What if you lived in a world in which you wouldn't go to jail for smoking marijuana, what would be your *becauses* or not using it then?' Elsewhere, we have considered** MORAL IMAGINATION **in literary and philosophical explorations of the metaphorical nature of moralized cognition as explicated by Martha Nussbaum and Mark Johnson, *inter alios.***

NOSOLOGY: the systematic classification of diseases.

PERSONALITY FUNCTIONING: as defined in DSM 5 are cognitive models of self and others that shape patterns of emotional and affiliative engagement (p.826) **in the proposed ALTERNATIVE DSM 5 MODEL FOR PERSONALITY DISORDERS** (p.761 ff) **the ELEMENTS OF PERSONALITY FUNCTIONING appear in two divisions** (Table 1 p.762)**: SELF:** IDENTITY and SELF DIRECTION**;** and **INTERPERSONAL**: EMPATHY and INTIMACY**.**

PERSONALITY TRAIT VARIATION: in the proposed ALTERNATIVE DSM 5 MODEL FOR PERSONALITY DISORDERS (p.761 ff) tendencies to feel, perceive, behave , and think in relatively consistent ways across time and across situations are called PERSONALITY TRAITS

PHENOCOPY: refers to the identification of a phenotypic characteristic in an individual that is the result of an environmental factor rather than a genetic variation. This characteristic may be quite similar to a phenotype that is the result of a genetic expression (Mrazek, 2010, pp. 42-43)
PHENOTYPE: a trait or characteristic that is the result of gene expression. Environmental influences can result in modification of the PHENOTYPE (Mrazek, 2010)
PREPONDERANCE: superiority in weight, power or numbers. By the time of DSM III-R in several areas of classification (Disruptive Behavior Disorders, Psychoactive Substance Use Disorders and Personality Disorders) the diagnostic criteria had been revised to form an index of symptoms of which a certain number, but no single one, was required to make the diagnosis. This [was called] a *polythetic* format, in contrast to a *monothetic* format in which *each* of several criteria must be present for the diagnosis to be made (p.xxiv). Since our typology is not a classification of disorders but rather a systematic way of understanding what conscience is like in the context of disorders, neither a polythetic nor a monothetic format need be adopted. 'Preponderance' conveys our opinion that more discernment should be employed in weighting the bulleted criteria and not simply checking off a certain number of them.
SUPER-EGO LACUNAE: lacunae are holes. In the 1950's Johnson and Szurek propounded a psychodynamic hypothesis in which the superego of the delinquent child was said to have become defective by virtue of the child's unconscious acting out of parental antisocial wishes (See: Lewis, et al, 1981).
THEORY OF MIND (ToM): is not any formal epistemological theory of mind but rather the ability anyone has to theorize both about others, and, as we believe essential for study of conscience, about oneself, to attribute mental states—beliefs, intents, desires, pretending, knowledge, etc.—to oneself and others and to understand that others have beliefs, desires and intentions that are different from one's own. Psychologist Baron-Cohen is often cited in the literature on autism for proposing an inability to develop THEORY OF MIND **as the essential problem in the developmental psychopathology of autism. Many developmental psychologists identify the emergence of this ability in the child at around 4 years of age.**
TYPE: a number of things (in this case: consciences) sharing a particular set of characteristics that causes them to be regarded as a group.
TYPOLOGY: a systematic classification or study of types.
YOUTH-SPAN: that part of the lifespan from 'zero to three' onwards into adulthood.
YOUTH-SPACE: used primarily in the context of encounters that caregivers and youth workers have with youth in the milieu of therapeutic residential and foster settings, and in transitioning from one level of care to another. The term might also be employed to describe home-visits, neighborhood and on grounds schooling or in school psycho-educational activities.

REFERENCES

Achenbach T. **Assessment and Taxonomy of Child and Adolescent Psychopathology**. Newbury Park , CA: Sage.

American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Washington, DC, American Psychiatric Association, 1980.

American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition-Revised, Washington, DC, American Psychiatric Association, 1987.

American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Washington, DC, American Psychiatric Association, 1994.

American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Washington, DC, American Psychiatric Association, 1994.

American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, Arlington, VA, American Psychiatric Association, 2013.

Burningham J (1978): **Would You Rather...** Thomas Y Crowell, New York.

Cleckley H (1964): **The Mask of Sanity**, 4th edition. St Louis: Mosby

Delson N (2003): **Using Conscience as a Guide**: Enhancing Sex Offender Treatment in the Moral Domain. Holyoke, MA: NEARI Press.

Gaffney M, Galvin M. Techniques in Conscience Sensitive Medical Education. **MedEdPORTAL**; 2012. Available from: www.mededportal.org/publication/9166

Galvin M (6/3/94): Biopsychosocial sequelae of maltreatment conceptualized in a multiaxial diagnostic system. Summer Institute on Advances in Nursing Practice, Exploring the Neurobiological Frontiers in Child and Adolescent Psychiatric Mental Health Care, Indianapolis, IN.

Galvin M, Stilwell B, Shekhar A, Kopta M and Goldfarb S (1997): Maltreatment, conscience functioning and dopamine beta hydroxylase in emotionally disturbed boys. **Child Abuse and Neglect, the International Journal**. 21(1): 83-92.

Galvin, M.R., Stilwell, B.M., Adinamis, A. & Kohn, A. (2001): Conscience sensitive diagnosis of maltreated children and adolescents. In **Conscience Works,** an On-line Periodical, *Theory, Research and Clinical Application*, 1(1): 1-81. http://shaw.medlib.iupui.edu/

Galvin M, Gaffney M and Stilwell B (2005): Preliminary observations and reflections on conscience sensitive group therapy. In **Conscience Works**, an On-line Periodical, *Theory, Research and Clinical Application*, 2(2): 1-23. http://shaw.medlib.iupui.edu/

Galvin, M., Fletcher, J. and Stilwell, B. (2005): Conscience sensitive psychiatry: clinical applications: retrieval of life affirming values. In **Conscience Works,** an On-line Periodical, *Theory, Research and Clinical Application*, 1(2): 1-5. http://shaw.medlib.iupui.edu/

Galvin, M., Fletcher, J. and Stilwell, B. (2006): Assessing meaning of suicidal risk behavior in adolescents: three exercises for clinicians. **J. Am. Acad. of Child and Adol. Psych,** 45(6): 745-748.

Galvin M, Stilwell B, Gaffney M, Hulvershorn L (2009): The psychobiology of conscience; signatures in brain regions of interest. **Conscience Works**, An On line Periodical, *Theory, Research and Clinical Applications*, 3(1): 1-36. http://shaw.medlib.iupui.edu/

Galvin M, Stilwell B, Fletcher J (2010): Conscience sensitive psychiatry clinical applications: retrieval and incorporation of life affirming values in a personalized suicidality management plan. **Annals of the American Psychotherapy Association,** 13(3): 14-23.

Goenjian A, Stilwell B, Steinberg A, Fairbanks L, Galvin M, Karayan I, Pynoos R (1999): Moral development and psychopathological interference in conscience functioning among adolescents after trauma**. J. Am. Acad. Child & Adol. Psych.** 38 (4): 376-384**.**

Huffine C vs. Dunne J (March/April, 2006): Should conduct disorder be eliminated from the diagnostic and statistical manual of mental disorders, a debate. **American Academy of Child and Adolescent Psychiatry News.**

Hughes J (2003): Motivating and helping smokers to stop smoking. **J Gen Intern Med.** 18: 1053-1057

Hugo V (unabridged trans. by L Fabnestock and N. MacAfee based upon the original trans by C Wilbour, 1862)**: Les Misérables,** New York, Signet Classic: 1987.

Johnson A and Szurek S (1952): The genesis of antisocial acting out in children and adults. **Psychoanal. Quart.** 21: 323-343.

Johnson M (1993): **Moral Imagination**, Implications of Cognitive Science for Ethics, University of Chicago Press, Chicago, pp.185-216.

Kahneman D & Sunstein C (2006): Cognitive psychology of moral intuitions. In J-P Changeux, A Damasio, W Singer and Y Christen (eds.) **Neurobiology of Human Values**. Germany: Springer Verlag, pp. 92-95.

Keane D (1997): **The Best of Delores Keane**, Torc Music Ltd.

Keegan K with Moss H (2008): **Chasing the High,** A First Hand Account of One Young Person's Experience with Substance Abuse. Oxford: Oxford University Press.

Kochanska G, Forman D, Askan M, Dunbar S (2005): Pathways to conscience: early mother-child mutually responsive orientation and children's moral emotion, conduct and cognition. **Journal of Child Psychology and Psychiatry**. 46, 19-34.

Lewis D, Shanock S and Balla D (1981): Parents of delinquents. In **Vulnerabilities to Delinquency,** D.O. Lewis (ed.), New York: SP Medical & Scientific Books.

Macdonald J (1963): The threat to kill. **Am J Psychiatry** 120: 125–130.

McEwen B (1998): Protective and damaging effects of stress mediators. **N Engl J Med**. 338:171–179.

Mrazek D (2010): **Psychiatric Pharmacogenomics**. Oxford: Oxford University Press.

Nussbaum M (1990): **Love's Knowledge,** Essays on Philosophy and Literature, Oxford University Press, Oxford.

Prochaska J, and Goldstein M (1991): Process of smoking cessation: implications for clinicians. **Clin Chest Med.** 12: 727-35.

Redl F. (1966)**: When We Deal With Children.** New York: The Free Press

Regier D (5/18/2013): DSM-5: what you need to know. Master Course, D Kupfer and D Regier, Directors. **American Psychiatric Association 166th Annual Meeting**, San Francisco.

Sullivan J (2010): Treatment of modern warriors; a need for conscience sensitive therapy: a clinician's reflections upon reading **The Moral Treatment of Returning Warriors in Early Medieval and Modern Times.** In **Conscience Works:** an On-line Periodical, *Theory, Research and Clinical Application.* 3(2): 1-7.

Stilwell B and Galvin M (1985): Conceptualization of conscience in 11-12 year olds. **J. Am. Acad. Child Psych.** 24(5): 630-636.

Stilwell B, Galvin M, and Kopta M (1991): Conceptualization of conscience in normal children and adolescents ages 5 to 17. **J. Am. Acad. Child & Adol. Psych.** 30(1): 16-21.

Stilwell B and Galvin M (l0/28/93a): Clinical assessment of the conscience: delays and deficiencies in psychopathology. Workshop, **Annual Meeting American Academy of Child & Adolescent Psychiatry**, San Antonio

Stilwell B and Galvin M (1993b): Clinical assessment of the conscience: delays and deficiencies in psychopathology. **Scientific Proceedings of the Annual Meeting American Academy of Child and Adolescent Psychiatry**, Vol. IX: 16.

Stilwell B, Galvin M, Kopta M, and Norton J (1994): Moral-emotional responsiveness: a two-factor domain of conscience functioning. **J. Am. Acad. Child & Adol. Psych.** 33(l): 130-139.

Stilwell B, Galvin M, Kopta M, and Padgett R (1996): Moral valuation: a third domain of conscience functioning. **J. Am. Acad. Child & Adol. Psych**. 35(2): 230-239.

Stilwell B, Galvin M, Kopta M, Padgett R and Holt J (1997): Moralization of attachment: a fourth domain of conscience functioning. **J. Am. Acad. Child & Adol. Psych.** 36(8): 1140-1147.

Stilwell B, Galvin M, Kopta M, and Padgett R (1998): Moral volition: the fifth and final domain leading to an integrated theory of conscience understanding. **J. Am. Acad. Child & Adol. Psych.** 37(2): 202-210.

Stilwell B (2003): Trauma, moral development, and conscience functioning. In **Conscience Works,** an On-line Periodical, *Theory, Research and Clinical Application*, 2(1): 1-4

Stilwell B, Galvin M and Gaffney M (2006): Progress in conscience sensitive psychiatry: assessment, diagnosis and treatment planning. In **Conscience Works,** an On-line Periodical, *Theory, Research and Clinical Application*, 2(1): 5-30. http://shaw.medlib.iupui.edu/

Stilwell B (2006): Conscience functioning disorder (unpublished document).

Verkamp B (2006): **The Moral Treatment of Returning Warriors in Early Medieval and Modern Times**. Scranton, Ill: Univ. of Scranton Press.

Yust K, Johnson A, Eisenberg Sasso S and Roehlkepartain E (2006): Traditional wisdom: creating space for religious reflection on child and adolescent spirituality. In: **Nurturing Child and Adolescent Spirituality**, Perspectives from the World's Religious Traditions, K. Yust, A, Johnson, S. Eisenberg Sasso, E. Roehlkepartain (eds), Oxford: Rowman & Littlefield Publishers, Inc.