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Thoughts on Diagnosis: A Winnicottian Perspective

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Before discussing the role and function of diagnosis in psychoanalytic treatment I would like to reiterate how we understand language and models. Language, as we know, is metaphorical; basically I understand that to mean that everything is a model. Different models, i.e. classical drive theory, our conceptualizing of the self, postmodern relational paradigms etc. are not right or wrong; they simply open different vistas. Any theoretical model is like an interpretation - it opens up some possibilities while foreclosing others. I am using the term, possibilities, in view of its usage by both Alfred North Whitehead as well as physicists who speak the language of quantum physics. As I understand quantum physics, it speaks of a particular act of observation, which a theoretical model makes possible, as, in fact, actualizing, that is, creating possibilities. Life is constantly a mix of alternate seemingly contradictory possibilities, sometimes a blur of possibilities - all at once. To simplify a very complicated subject we can say, along with the physicist John Wheeler: the questions we ask determine the answers we get. The models we use determine the world we live in.

1. If I have a major focus that I would like to convey it is that diagnosis is basically external to the clinical experience and consequently observational. It is type of shorthand for colleagues as well as for us. It can become an obstacle, in the clinical setting, when it replaces hearing a patient's story primarily as the unfolding of random possibilities. If we hear a patient's story as confirming our diagnostic categories we do so, I believe, at the cost of conceptualizing their experiences as expressing alternate lines of development, alternate possibilities. In my experience, categorizing a patient's communication into preexisting theoretical thought-bins, so to speak, leads, all too frequently, to a stilted or formulaic technical response on the part of the analyst
2. Reading D.W.W., I came to understand conflict and defense, phantasy and desire, as intimately and essentially tied to developmental experiences. Rather than focusing on a linear or genetic model of psychic determinism, I began to think of the array of developmental experiences simply as predisposing us to both random as well as related developmental experiences. Childhood and adulthood were marked not so much by maturation of various ego functions and structures (although from one model obviously so), but rather by the activation of a certain set of possibilities - consequent upon other previous set(s) of possibilities.
3. Didactically both Freud and Winnicott spoke of the contributions of heredity, environment and the developing individual - what I am suggesting, for today's discussion, is that we regard all these various perspectives as one, under the model of possibilities. I say this because I believe that insofar as it is possible we have to keep all these perspectives simultaneously active as we listen, as we allow our minds to wander, and as we interact in the clinical setting. The varying and overlapping personal histories a patient relates as the analysis proceeds, the varying and overlapping histories we conceptualize, actualize, I believe, what Winnicott meant by creating the found world. An analyst's particular and

idiosyncratic presence, as well as that of the patient's, forecloses the possibility of categorization. Categorization in terms of diagnosis, as I mentioned above, is a second moment; so to speak, it is looking at this process I have just described and organizing it into some coherent form.

4. It is frightening, as F. Roustan reminds us, to be in a land without signposts - a land where language may fail us and may have to fail us. And so I find myself thinking, while trying to simply observe the unfolding possibilities: obsessive or depressed or paranoid or schizoid. Clinically, however, it is better to ask, if we are going to ask anything, if a patient can own their aggression and therefore feel that are alive or not, can they play or not. One of Winnicott's most profound, if apparently paradoxical observations was to note that an analysis may go on for years on the false assumption that the patient is alive.
5. We work best, I believe, when we are able to cross identity with a patient. Cross identifying has a great deal to do with listening extra, extra carefully to a patient and not to just to their echoes within us. When I am able to quietly listen, I like to believe that I know what the word understanding means. Within a compassionate atmosphere of listening and responding, a patient may find that they can be responsive to various possibilities which come from what we analysts call the unconscious - not only because something has been lifted, repression, but because something has been given us, creativity. And when we experience ourselves as creative, in whatever form, we feel and know we are alive.
6. Let me return, for a minute, to the role of diagnosis as an observational function. From one point of view this is rather obvious, from another I find that I am slow to employ diagnosis as I might have in my earlier years of practice. This, in itself, is no guarantee of anything but I think my personal predisposition comes from my reading of Winnicott as well my readings in Buddhism. I find myself reluctant to use any theoretical construct that speaks of a singular self, or of a stable "I." I have found myself thinking and more recently writing that the "I" is an imaginative, cultural construct. That is, in our civilization we teach people to have an "I." (We are not too happy with an unstable "I.") If I can extend this line of reasoning a little: a theoretical model that posits a substantial self also theorizes or conceptualizes mind as something inside us. I mention this very complex topic simply to indicate that models create varying possibilities. An alternate model of what we call mind is suggested by Winnicott's notion of transitional phenomena, as well as his essay on *Psyche/Soma*. That is, thinking about mind as a manifestation between people and what we call the external world - language as its obvious indicator. Employing this last model, one would be predisposed to see diagnosis not as relating so much to the individual's psychological state but rather as indicating historical, social and environmental context(s). More simply put: what may be seen as neurotic or psychotic in one epoch may not be so thought of in another.

7. If a patient is able to realize the possibilities of loving a little better and of working a little better, after the love and work of analysis is through, then both parties, in the analytic interchange, have created their found world again. In our culture, and every culture has its particular norms, this is regarded as a good outcome to analytic work. I do not believe that emotional insight, or theoretical understanding, as personally enlightening as they may be, in themselves, for either analyst or patient, guarantees an increased capacity to love and to work. It can, instead, simply increase our narcissism, a possibility that tends to narrow our future possibilities and our experience of process. Ideally to love and to work means we are thrown, so to speak, self-forgetfully into the world. When chronologically early, probably annihilating life experiences, make love and work impossible we have to search for new possibilities - for a New World, for a new beginning, to use M. Balint's term. Initially the therapist is that New World. What possibilities our interventions will actualize greatly affect the creation of the patient's world. In therapy both analyst and patient are like Adam - naming the world. It helps, in particular, if we analysts have a firm hold on the relativity of our actions (therapeutic and otherwise) since there are a myriad of worlds we humans can live in.

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