

A DEVELOPMENTAL APPROACH TO DIAGNOSIS

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ABSTRACT: Symptoms and behavioral manifestations alone provide insufficient diagnostic information. A more comprehensive diagnostic approach is recommended, and the works of the ego psychologists Hartmann, Mahler, Jacobson, and the Blancks are utilized to demonstrate the process of formulating a descriptive developmental diagnosis. The clinical material presented addresses the complexity of the diagnostic task and focuses on the need for a precise assessment of the degree of structuralization and the level of ego organization achieved. The patient discussed conforms neither to a classically neurotic arrangement nor to a characteristically borderline organization. The capacity for and nature of the transference is highlighted as a significant diagnostic tool.

In this paper I will be discussing the theory and technique of formulating a descriptive developmental diagnosis. The theoretical framework for this undertaking is based on an integration of classical psychoanalytic theory with the more recent contributions of developmental ego psychology. The importance of this diagnostic work will be demonstrated by the use of clinical material. Diagnosing is our initial therapeutic task; it is a prelude to successful treatment. Without a clear, accurate, and precise diagnosis, we are at a loss to know either what we are treating or how to treat it.

The DSM III serves certain important functions. Symptoms and behavioral manifestations provide some diagnostic information. However, these criteria alone are insufficient. Rather, to arrive at a developmental diagnosis one must turn to the work of Hartmann (1958), Mahler et al. (1975), Jacobson (1964), and, of course, the Blancks. The diagnostic task is then deepened. It involves assessing the level of ego organization, determining whether the patient has a fully developed, neurotic structure or whether incomplete development has resulted in structural deficits, iden-
tifying how the patient experienced the subphases and how this affected negotiation at subsequent phases, etc.

To demonstrate the value of this more comprehensive diagnostic approach, I will discuss a patient whose clinical picture is a complicated one. It conforms neither to a classically neurotic arrangement nor to a characteristically borderline organization. Rather, his particular course of development has resulted in a mixed bag of neurotic and less-than-neurotic features. Patients who fall into this neither/nor diagnostic category can too often be mistaken for being either neurotic or borderline, depending on the clinical picture presented as well as the particular orientation of the analyst. Diagnostic errors result in technical errors.

Mr. Davis, whom I will be discussing in more detail, could have been all too easily mistaken diagnostically as neurotic. He is a 35-year-old professional man, twice divorced, with no children from either marriage. Intelligent and well-educated, he has worked steadily (though neither happily nor at his potential) in a competitive field that requires a great deal of intellectual and creative talent and skill.

He was the oldest of four children born to his parents, with one sibling born just before his second birthday and the others three and five years later. His father was a self-made man who rose to top-level positions in the corporate world. To little D. he was a remote and awesome figure, powerful and much admired, frightening and unavailable. His mother was a housewife whose desire to raise a family was strong. His role as her favorite was one that he reports strongly rejecting as he experienced her involvement with him as excessive and intrusive. Predictably, Mr. D. vividly recalls heated and frequent arguments between mother and son during his adolescence.

The significant pattern that emerges from his childhood, and indeed persists into adulthood, is his chronic underachievement. Characteristically, he approaches certain thresholds, often enjoying brief periods of success and achievement at that level. These cannot be sustained, however, and are followed by defeat and failure. At each developmental phase from puberty, when he began high school, to young adulthood, when he began college and married for the first time, to adulthood proper, when he entered his profession and married for the second time, a step was taken, couldn't be sustained, and was followed by loss and failure. For example, Mr. D. recalls that his underachiever position during grade school was reversed during high school. His freshman year was one of glory and achievement in all areas. He excelled academically, had a girlfriend, engaged in competitive sports, and felt like he belonged. However, his father's business required that the family relocate within that year and Mr. D. experienced the move with anger and defeat. He felt that he had been pulled out of the school at the height of his success. The remainder of his high school years was characterized by academic underachievement, isolation, and feeling lost, inadequate, and inferior. In his words, he just couldn't measure up.

We could speculate Mr. D.'s underachieving to be a defense against unconscious oedipal strivings, the castration threat as the powerful source of anxiety, his conflicts around success to be intersystemic, neurotic ones. But such speculation remains only conjecture until sufficient evidence from the patient's material serves to confirm or revise our initial thoughts. Only careful exploration can reveal how and on what level(s) Mr. D. experienced these life events. This requires