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Original Contribution

The author of this next article, Ronald Koegler, M.D., has had a long and fascinating association with affect theory. A member of the far-flung Tomkins clan, and a distant cousin of Silvan Tomkins, Dr. Koegler wrote the Editor when he learned of our efforts to teach these theories and develop a new system of psychotherapy. His personal perspective has been forged in the heat of a successful career as a forensic psychiatrist, often seeing prisoners being held for court-ordered evaluation. Whereas most of our readers work with patients who have come to us voluntarily, a significant fraction of those interviewed by Dr. Koegler speak with him under considerable duress because they are frightened that whatever they say may be used against them. As the result of these interviews, and the many court cases he has seen in which therapists have been accused of improper involvement with their patients, he has evolved the attitude toward personal disclosure and social familiarity described herein.

Each of us develops a highly personal system of conducting an initial interview and providing psychotherapy. As Dr. Koegler points out so clearly, a solid working knowledge of affect theory allows the skilled therapist to intervene at levels perhaps more difficult to approach from other standpoints, and such an increase in power requires a new sense of discipline. The *Bulletin of the Tomkins Institute* welcomes letters in response to this or any other article, and encourages dialogue on any related area of psychotherapy.

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Affect Theory and the Psychiatric Evaluation: Lowering the Empathic Wall

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Sullivan (1954) defined psychiatry as "the field of the study of interpersonal relations" (p. ix), and, although most psychiatrists now spend much of their time dealing with the effects of drugs on mental processes, the study of interpersonal relations has not become less important since Sullivan's time. The advent of managed care may have made long-term psychotherapy an endangered enterprise, but it has required psychiatrists, psychologists, and other mental health professionals to determine the need for (and justify) psychotherapeutic intervention. Our litigious society has also forced an increase in the number of psychiatric evaluations needed in order to determine liability and the nature of psychological damage. The "psychiatric evaluation" whether performed by psychiatrist or psychologist, is a term now often used to mean a comprehensive evaluation leading to a diagnosis under DSM-IV and perhaps to an answer for certain insurance or legal questions. Sullivan referred to the "psychiatric interview" when he was describing this initial evaluation, regardless of whether it was followed by therapeutic interviews.

The affect theory of Silvan Tomkins enables us to extend Sullivan's insights about the initial interview and describe the interactions between what he called interviewer and interviewee with reference to the innate affects. Every human interchange involves what Sullivan called parataxic distortion and Freud defined in terms of transference and countertransference. It is for this reason that Sullivan (1954) described psychiatry as "peculiarly the field of participant observation" (p. 18), and it is our own growing appreciation of the nature and importance of the affective responses of the participants that has prompted this communication.

Tomkins (1962) pointed out that the culture of academic psychology had ignored what we now understand as the facial display of innate affect simply because these mechanisms, seen so clearly in the infant, can be suppressed or dissembled by the adult. Otherwise gifted interviewers, trained to focus their attention on words, have for years failed to nurture the observational skills that can yield so much information from the body movements and facial expressions that accompanied these words. The intense affective atmosphere of the initial interview can reduce habitual masking and reveal much that the interviewee had thought secret; even the absence of affective reaction can prove quite important. Even the silent patient communicates by gesture; statements like "the interviewee didn't communicate well" tell more about the naïveté of an interviewer who expected feelings to be expressed only in words than the

shamed and frightened subject. Tomkins (1991) notes how parents and the culture at large gradually train the growing infant and child to contain and control affective expression. Psychiatrists and psychologists are adults who have also gone through this process of socialization—only if we are able to reverse it and recapture some of the affective freedom of childhood are we able to resonate with and understand the emotions being expressed by the interviewee. It is unlikely that anyone will express more than the most superficial of feelings if the interviewer is felt to be cold and unsympathetic.

Enelow and Swisher (1986) suggest that much can be learned from the "body language" of the patient: "Posture can reflect openness (relaxed arms at sides, slightly slouched in a chair) or a closed, defensive distrustful attitude (arms closed, hugging oneself, sitting up very straight). Slumped shoulders and a bowed head are marks of depression. Anxiety is often signaled by the patient's shifting around, finger tapping, foot and leg movements, or gripping the arms of a chair with white knuckles" (p. 36-7). Although we might quibble that slumped shoulders and bowed head are more about shame than depression, we would agree that the experienced interviewer integrates verbal and non-verbal cues, encouraging the further expression of thoughts and feelings by conveying appropriate concern. Through identification (what would I feel were I in this situation?) and empathy (what do my own affects tell me about what is being broadcast by this other person?), we infer what is going on at a level far deeper than that conveyed by mere words.

Empathic listening must be situated within a matrix of strict discipline, for it is often difficult to know how a stranger may experience the sudden intimacy made possible by such skill. Indeed, the recent increase in lawsuits and professional license hearings arising from charges of boundary violations have had a chilling effect on the empathic behavior of psychotherapists, especially those who see individuals for brief evaluation. Nevertheless, it would be a mistake to believe that any initial evaluation could produce optimum results when the evaluator acts *only* as a reflecting wall, a questioner without expressed feelings, or a cool and detached investigator. Even in a forensic evaluation, it is usually helpful and more productive for the evaluator to express understanding of the discontent expressed by the person claiming to have been harmed or wrongly accused.

Nathanson (1992) has written that "the normal adult has built a shield for protection from the affective experience of the other person" (p.111) in order to avoid contagion, and he describes this shield as empathy's wall. During evaluations, the interviewer must drop this "empathic wall" from moment to moment in order to know where to look next. Each method and style of psychotherapy is characterized by highly specific attitudes about the degree of affective resonance recommended during therapeutic interactions, ranging from the close empathyic linkage acceptable within the more supportive forms of treatment and the more remote style seen in traditional psychoanalysis.

In concert with developed knowledge and clinical skill, the ability to empathize in this controlled fashion can result in a superior evaluation. Again, the key word is "controlled." There can be no boundary violations—no touching, use of first names, no unnecessary self-disclosure. While some may protest that they have been on a first-name basis with many patients for years with no untoward results, this technique should be reevaluated in these litigious times, if for no other reason that it will give the appearance of inappropriate behavior to a jury or judge. This complicated subject is discussed at length in the section on language of Gutheil and Gabbard (1993). When patients make clear that they are made significantly more uncomfortable by our refusal to use their first name, this fact should be noted in the clinical record as our reason for this departure from optimal therapeutic distance.

What is permissible? The skilled evaluator can certainly show interest (without the excitement), and mirror, at a lower level, the distress-anguish expressed in relation to perceived wrongs. Hopefully, the examiner will not express surprise-startle upon hearing of deviant sexual behavior, or criminal acts, or serious drug use, and certainly avoid the expression of dissmell or disgust! Sullivan (1954) writes that it is important to "get an impression in the interview situation of how greatly the patient is gifted with real humor, with the capacity for maintaining a sense of proportion as to his place in the tapestry of life" (p. 172). It helps, too, if the examiner has a sense of humor and can test the interviewee's response to humor. Thus, the expression of enjoyment-joy can be very appropriate in the form of smiles or low-level laughter. Out here in California, of course, a sudden shaking of the earth can lead to very appropriate fear-terror in both interviewer and interviewee, after which both must scurry to safety.

It is often best to put the notes, feelings, and initial impressions aside after the evaluation, especially when the interviewee is seen only once. This provides time for the empathic wall to rise to a normal level; the examiner can look at the findings and the results of any psychological testing in a more objective fashion than would be possible were a report dictated immediately after the evaluation (despite the occasional and unfortunate requirement for such action). While it is true that some examiners believe they can raise and lower the empathic wall within minutes, others may need an interval of several days, depending on the nature of the questions to be answered. Decisions made as the result of the evaluation may have a serious effect on the future of the interviewee; it is essential that evaluation conclusions be formulated in an objective atmosphere.

Encouraged by the examiner's interest and empathic support for whatever distress-anguish and anger-rage is expressed, the subject of the examination may tend to exaggerate or at least provide only one view of the situation. When testing results are analyzed and reports from other observers reviewed, the picture will often change. In the case of a forensic evaluation, the final report may cast doubt on the examinee's story, resulting in both distress-anguish and anger-rage, now directed toward the examiner!

Were this an initial examination for psychotherapy, the evaluation might be extended over several visits and there would be no formal report. Nevertheless, the therapist would need to raise the empathic wall after each session, make objective plans for psychotherapeutic treatment, and develop a tentative timetable for attempts to provide insight (at least in the case of the non-fragile, non-psychotic patient). For the fragile patient, it might be more appropriate to develop a plan for working with positive affects in supportive therapy.

Often we therapists are accused of "pretending" to show interest, "pretending" to share anguish, to resonate with the affective component of the interviewee's version of events. We must look into ouselrves to see whether we are indeed feigning interest in order to seduce the examinee into revealing feelings at a deeper level. I believe that if the examiner approaches the interview in an objective fashion, much as a juror is supposed to do, there can be no pretense. We neither believe nor disbelieve the story communicated to us; our responsibility is to resonate with the feelings expressed. We resonate with the affective portion of the other person's perceived reality. As Pirandello has Delia Morelo say in *Each In His Own Way*, "Truth? What is truth? Nothing is true!" (p. 305). At that moment in the interview, the statement of the interviewee is "true" if sincere, and the affective response of the examiner is "true" if sincere. Both participants in this dyad may develop a different slant on "truth" a few moments or days later. One need only refer to "love" or "transference" as models for the fleeting and often mercurial nature of "truth."

The examiner resonates with whatever affect is expressed by the examinee simply because that affect has been triggered by the other's experience of the events being described. An infant may feel abandoned and express distress-anguish when mother has merely left the room for a moment, or perceive a friendly dog as a source of danger that triggers fear-terror, or a strange taste as disgusting when none of these worst cases may be "true." The competent parent resonates with the affect expressed by the infant, provides solace for that affect, searches for the probable cause, and acts as an affective anchor. Similarly, the examinee may perceive that he or she has been humiliated deliberately at work and exhibit anger-rage via the *attack-other* pole of the compass of shame during the interview. We examiners are fellow humans who have all experienced shame and shame-rage; we resonate with these affects, understand them, and handle them within the therapeutic or diagnostic situation in a way that fosters the development of disciplined empathy.

One can err in either of two directions and provide inadequate treatment or evaluation: 1) Should the examiner be unable to lower the empathic wall, the depth of understanding is severly limited; 2) Through what is often called "overidentification," we may fail to raise the empathic wall at the completion of the interchange and thereby become unable to provide a balanced perspective of the problems presented.

Good interviewers learn to lower the empathic wall under good control—temporarily, and within limits—as the result of both good instincts and good training. Looked at from the standpoint of the affect theory of Silvan Tomkins, the effective interview involves a complex mixture of skill and talent—the talent and wit to make sense of intrinsically difficult material, and the skills that allow one to steer a course between interaffectivity and the space for private thought provided by the empathic wall. Our own empathic wall has to be just right—not too fixed, not weak and likely to crumble; anything outside the optimal range requires us to seek personal therapy. But a clear understanding of affect, interaffectivity, and the empathic wall will help the average professional to become a more effective interviewer.

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