Advanced empathy: The key to effective helping in mental health care

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Empathy is essential for interpersonal helping and is considered a key change process in psychotherapy (1). To empathise with another is to see things from their perspective and to feel with them, or to use the metaphors 'to walk in their shoes' or to 'look from their window'. It is widely understood and defined as "… the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner" (2). Empathy connotes more than a sympathetic relating to another person's observed mental state or the automatic mirroring of contagious emotion whether sorrow, fear or triumph (3). Empathy is a deliberate rather than passive process and involves perceptual, cognitive, emotional regulation and communicative processes. To be usefully employed in the process of helping, an empathic understanding of another's experience (including thoughts and feelings) needs to be communicated back to the person in a congruent, non-judgemental way which makes a difference to them. Indeed, it is this communication of understanding this sense of being not only heard but understood that makes empathy so powerful. Everyone wants to be understood!

Empathy, the therapeutic alliance and the Dodo Bird Verdict

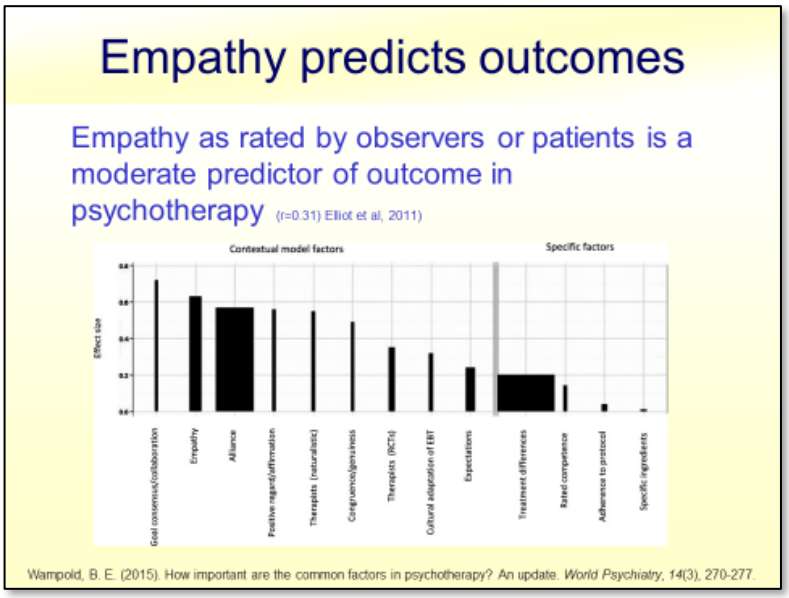
For decades researchers have been attempting to compare different forms of psychotherapy, counselling or talking therapies for different problems. The most robust finding has been that by and large all treatments are equally effective (4) with only modest differences in targeted symptoms between different kinds of therapies (5). This conundrum for the helping professions is known as the "Dodo Bird Verdict" drawn from Lewis Carol's novel Alice's Adventures in Wonderland in which the Dodo proclaimed "Everybody has won and all must have prizes". This has led to a prolonged exploration of what these effective therapies might have in common. Common factors have been found to explain between 30-70% of the difference in outcomes in psychotherapy research whilst therapy specific factors (technique, sticking to the manual etc) accounts for 10-15% of the variance in outcomes (6).

The 'therapeutic alliance' was originally conceptualised as a reality-based collaboration between person and therapist (7), and later as reciprocal positive feelings, agreement on tasks and goals (8) and has been found to be the strongest predictor of positive outcome in mental health care generally (9).

The quality of the relationship may even predict response to psychotropic medication (10). Based on a rich body of research, focusing on building and maintaining an alliance is pivotal to successful therapy outcomes (9). Empathy has been found to be a strong predictor of alliance and outcome of therapy (11). Indeed empathy (whilst a component of the therapeutic alliance) has been found to be a stronger predictor of outcome than alliance generally, as have shared goals and aspects of collaboration (12). Empathy can provide a shared understanding from which a common formulation and goals emerge. Without it people may be talking past each other. A further powerful predictor of the effectiveness of talking therapies and pharmacotherapy is expectation (13). If people expect that talking or medications will help there is an increased likelihood that they will. Empathic communication may raise expectations that the helper really understands the person thus engendering an expectation that whatever they offer may be helpful.

Empathy as the foundation of therapy

One way of making sense of the Dodo effect is that the common factors of therapy have become interwoven into the training of all schools of therapy and indeed most of the helping professions. The term 'therapeutic relationship' has become almost a cliché. All therapists and would be helpers ought to demonstrate such values as respect, warmth, empathy, compassion, and strive to develop a collaborative relationship.



Carl Rogers the father of 'Person Centred' counselling identified 'accurate empathy' along with the communication of 'unconditional positive regard' and 'genuineness'/congruence as being essential and sufficient conditions for personality growth (the goals of therapy) (14). The influence of Rogers on the practice of therapy and indeed on the helping professions has been immense. Others such as Harry Stack Sullivan (in the early 20th century) identified empathy as a key interpersonal process through which we learn how to be in the world and come to know others, and thus it is a tool in analysis (15). However, Rogers stressed the need for the therapist to be fully present, listen attentively and communicate empathy accurately. Being empathetic is being therapeutic. Whilst Roger's conditions may not be sufficient in themselves for every kind of psychological or interpersonal problem that people present with, after 50 years of research they are still considered necessary for efficient resolution of people's problems and thus emphasised in most training programmes for helpers.

For Irvin Yalom, one of the foremost psychotherapist / writers of recent times and renowned for his contributions to group psychotherapy and existential psychotherapy, empathy is a pivotal skill for any therapist (16). Yalom suggests that empathy is best used in the 'here and now', that is in relation to thoughts and feelings that are evoked in the present. He also asserts that the therapist needs to accurately enter the patient's world and asserts that people profit enormously simply by being "fully seen and fully understood". Gerard Egan author of the skilled helper (to which I will refer to often for the remainder of this text) (17) states that empathy is always useful as "…a mode of human contact, a

relationship builder, a conversation lubricant, a perception-checking intervention, and a mild form of social influence" (p.89).

The preconditions and components of empathy

Empathy has at least four components: moral, emotive, cognitive and behavioural (18). Firstly, to the moral component. Empathy is arguably the basis of human morality. Being able to appreciate the perspectives, thoughts and feelings or others is a pre-requisite for knowing right from wrong. Using this understanding in a helpful way is a moral imperative in the helping professions. Despite the capability to empathise not everyone is disposed towards communicating empathetically. It requires a consideration of and focused attention on the other person, and at least temporarily, suspending attention on oneself. Communicating empathically is innately helpful, it assists in building and sustaining relationships.

The emotive component of empathy is the ability to subjectively perceive other's emotions. Social animals, particularly primates have evolved the capacity of displaying and reading emotional states. The discovery of mirror-neurones that activate in response to both the execution and observation of certain behaviours probably accounts for such behaviour and can help account for this component of empathy and automatic emotional contagion seen in both humans and animals (particularly to fear) (19).

Observing a caregiver engaging face-to-face with an infant and being attuned and responsive to their emotions is watching mirror neurons in action. The degree to which the care giver is attuned to the emotions of an infant and communicates empathically impacts on the infant's attachment and capacity to regulate their emotions. The caregiver needs to be able to regulate their own emotions and not be overwhelmed by the emotions of the other (a more mature and evolved emotional competency associated with empathy) (20). Infants can learn to discriminate emotions in others at a very early age based on facial expressions and other affective cues (18). Parental empathy with a child predicts a secure attachment (21) and children with secure attachment are more empathic and pro-social (22). Not surprisingly people with secure attachment (both therapist and clients) are more likely to form stronger therapeutic alliances in psychotherapy (23).

The face may be the window to the soul but it doesn't tell the whole story. Many people struggle with identifying people's emotions when there is blunting of affect (for example in Parkinson's disease) or incongruity in affect (for example when people may experience psychosis). People may of course note the incongruity in affect when a person says they are happy when clearly they are not, however to make sense of the emotional state (rather than just feeling it) requires the cognitive skill of perspective taking (20). The social cognitive processes of perspective taking and face processing begins in infancy and continues to develop and are improve throughout adolescence (24).

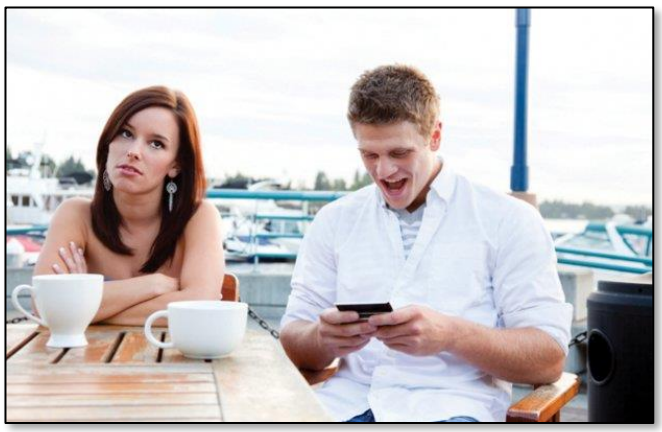
One may have the capacity to see things from another's perspective, but this is far from an automatic process. Indeed some people may rigidly adhere to their own view of the world and project it on to

another. Thus, they may be perplexed by another's emotional response or worse, invalidating of it (the other "shouldn't feel that way"). To elicit the experience of another (their unique constellation of responses to a situation) requires curiosity and considerable skill in listening, observation and analysis.

If the other's experience is far removed from one's own then it stands to reason that it requires more cognitive effort to take their perspective. For example if one comes from a very wealthy or privileged background it may be hard to empathise with another who may be homeless or unemployed. Recently a genre of television has emerged (as illustrated by "Filthy Rich and Homeless"; "Get Back to Where You Came From"; "First Contact") in which people are handpicked for their lack of contact and often fixed attitudes towards a population (e.g. homeless people, refugees or indigenous people) and are then immersed in the experience of those groups. Aside from the discomfort of participants, the entertainment value arises from the shift in perspective and increased capacity to empathise that often occurs for participants. Projecting stereotypes onto others impedes getting to know people as individuals. Various manifestations of mental illness or experiences such as psychosis may pose particular challenges for people in empathising with that experience. Thus immersive experiences such as 'voice hearing' simulation may be employed to assist in developing cognitive empathy (25). Similarly reading biographies, listening to people's stories, and conferring with people with lived experience can all be helpful in enhancing the cognitive capacity to empathise.

There is obviously an understanding of others that is borne of shared experience. This is one reason why support groups which bring together people with shared experiences are useful and participants develop a sense of universality or an understanding that they are not alone (26). A shared experience does not necessarily mean that people can or do empathise with people as individuals. It is possible that people with similar experiences may project their own experiences, expectations or thoughts onto another without really apprehending the individual's unique perspective. The good news is that skills of listening with empathy can be learnt; one doesn't need to have had the same or similar experiences or indeed hold the same view as the other person. Psychotherapy research confirms that matching an individual with similar traits e.g. ethnicity or gender doesn't lead to improved or better relationships (27).

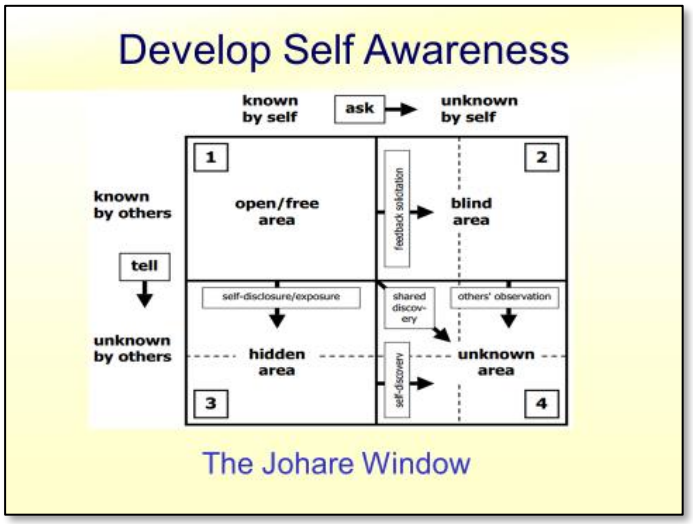
Listening and attending with empathy



Listening to understand requires being fully present with another person in the moment. This requires a humble, curious or 'unknowing' stance in which preconceived ideas, agendas and expectations need to be put aside; and listening carefully to the other (28). Health professionals often have agendas which can get in the way of empathic listening. Assessing for symptoms, completing a risk assessment or undertaking a diagnostic interview may be necessary and be done with sensitivity but can get in the way of empathic listening. Empathic listening is a purposeful, conscious activity which requires practice and one doesn't learn to do it by practicing another skill (such as assessment). Where other agendas need to take precedence, it is therapeutic to leave some time for empathic listening and an empathic statement.

It is worthwhile considering what might get in the way of being fully present with another. Here are some questions to consider:

- What is stopping me from being with this person in the present?
  - Am I thinking about the future or the past?
  - Am I preoccupied with a particular task or agenda?
  - Am I concerned about the time?
  - Can I deal with the emotions and experience?
- Are there distractions? How are these affecting me and how can I deal with them?
- Am I anxious, fearful or have other emotions that I need to attend to?
- What are my attitudes, thoughts and feelings towards this person?
- Does this person remind me of someone else and am I responding to them in a way I might to this other person?
- What does my non-verbal behaviour communicate to this person?



An additional skill is being able to distinguish one's own emotions from those of the other person (no easy thing to do as we are awash with feelings all the time). Some emotions and experiences we may feel uncomfortable with. For example, feelings of anger, shame and remorse may be close to home, and some experiences may be very affecting. Engaging in exercises to increase one's self-awareness (29) for example mindfulness, meditation, personal therapy, supervision or seeking feedback from others (including clients) is helpful in fine tuning the process.

As well as being present, the helper needs to build rapport and trust with the other person. Behaviours which assist in building an alliance include simple gestures such as greeting the person with a smile, making encouraging statements, and making positive statements about the client so long as they are genuine (30). The helper then attends carefully, both physically (consider posture, eye contact, body language) and psychologically, listening with the aim to build understanding of the person's point of view.

Building understanding requires careful listening. Listening involves more than simply hearing. We listen for experiences, feelings, behaviour, gaps, areas of avoidance and for things that are unsaid. In particular, we are concerned about "core messages", those thoughts and experiences that are having an impact on feelings in the present. All the while the helper attends, affirms and responds with curiosity and interest.

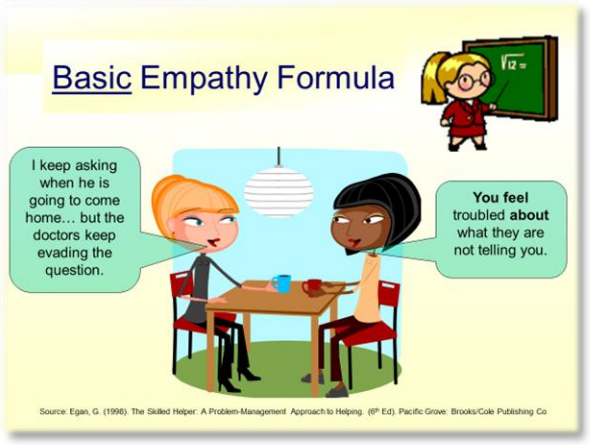
Communicating Empathy

Empathy is best employed after listening carefully and when the listener believes they may have some understanding of the core message or experience right now. Egan suggests that an "empathy statement" can be expressed in the following way (17):

You feel… (accurately naming the correct emotion and intensity)

…. when or because …. (accurately describing the experience / situation or behaviour that gave rise to the experience)

One does not need to rigidly follow this formula but an empathic statement will communicate accurately the current emotion and intensity as well as the thoughts or other experiences that are associated with it. It is important to be tentative rather than dogmatic in expressions of empathy. Even the most experienced therapist can misread the other's experience and jump to conclusions (16). The statement might be expressed as, or followed by, a question (e.g. "does that seem right?"). The person needs to have the opportunity and feel enabled to correct the helper if they have not been accurate.



Match the right feeling and intensity

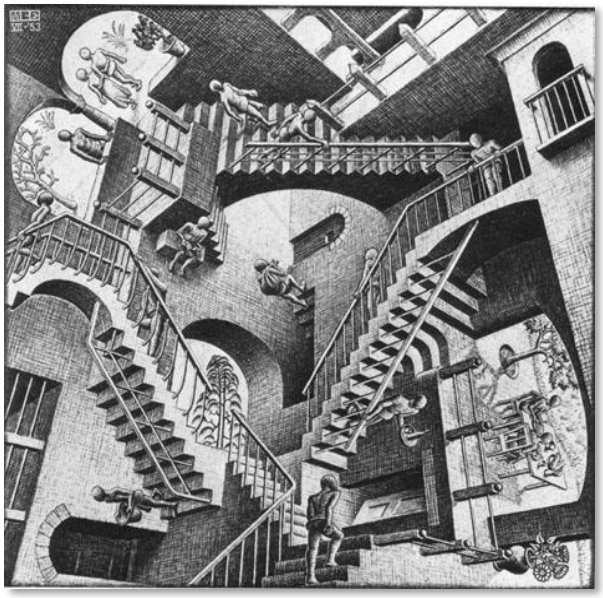
Mad	Sad	Glad	Afraid	Confused	Ashamed
Bothered	Down	At ease	Uneasy	Curious	Uncomfortable
Ruffled	Blue	Secure	Apprehensive	Uncertain	Awkward
Irritated	Somber	Comfortable	Careful	Ambivalent	Clumsy
Displeased	Low	Relaxed	Cautious	Doubtful	Self-conscious
Annoyed	Glum	Contented	Hesitant	Unsettled	Disconcerted
Steamed	Lonely	Optimistic	Tense	Hesitant	Chagrinned
Irked	Disappointed	Satisfied	Anxious	Perplexed	Abashed
Perturbed	Worn out	Refreshed	Nervous	Puzzled	Embarrassed
Frustrated	Melancholy	Stimulated	Edgy	Muddled	Flustered
Angry	Down hearted	Pleased	Distressed	Distracted	Sorry
Fed up	Unhappy	Warm	Scared	Flustered	Apologetic
Disgusted	Dissatisfied	Snug	Frightened	Jumbled	Ashamed
Indignant	Gloomy	Happy	Repulsed	Unfocused	Regretful
Ticked off	Mournful	Encouraged	Agitated	Fragmented	Remorseful
Bristling	Grieved	Tickled	Afraid	Dismayed	Guilty
Fuming	Depressed	Proud	Shocked	Insecure	Disgusted
Explosive	Lousy	Cheerful	Alarmed	Dazed	Belittled
Enraged	Crushed	Thrilled	Overwhelmed	Bewildered	Humiliated
Irate	Defeated	Delighted	Frantic	Lost	Violated
Incensed	Dejected	Joyful	Panic stricken	Stunned	Dirty
Burned up	Empty	Elated	Horrified	Chaotic	Mortified
Outraged	Wretched	Exhilarated	Petrified	Torn	Defiled
Furious	Despairing	Overjoyed	Terrified	Baffled	Devastated
Blind rage	Devastated	Ecstatic	Numb	Dumbfounded	Degraded

If the reasons for the person's feelings are unclear at least acknowledge their feelings, being mindful about getting the intensity right (for example there is a difference between being annoyed and being enraged). Acknowledging a person's feelings and assisting them to enhance their capacity to cope with

emotions (called in psychological terms, 'emotion focused coping') is the goal of some therapies (31) and dealing with or regulating strong emotions may be the primary issue. Acknowledging the feelings may provide an opening to explore in greater depth why those feelings arise. For the most part empathy will be a sufficient response but identifying the thoughts and behaviours associated with the feelings may provide opportunities to solve problems (interpersonal or practical) or address self-defeating thinking (as in cognitive behavioural therapy).

Empathy can be used in many ways. In therapy it is used to maintain an alliance, keep the focus on important issues, summarise progress and validate the other person. In everyday relationships or in less formal helping relationships it is called for whenever there are strong emotions or interpersonal difficulties. Expressions of empathy can disarm, reduce conflict and preserve relationships.

Advanced Empathy: Disturbing Beliefs & Extraordinary Experiences

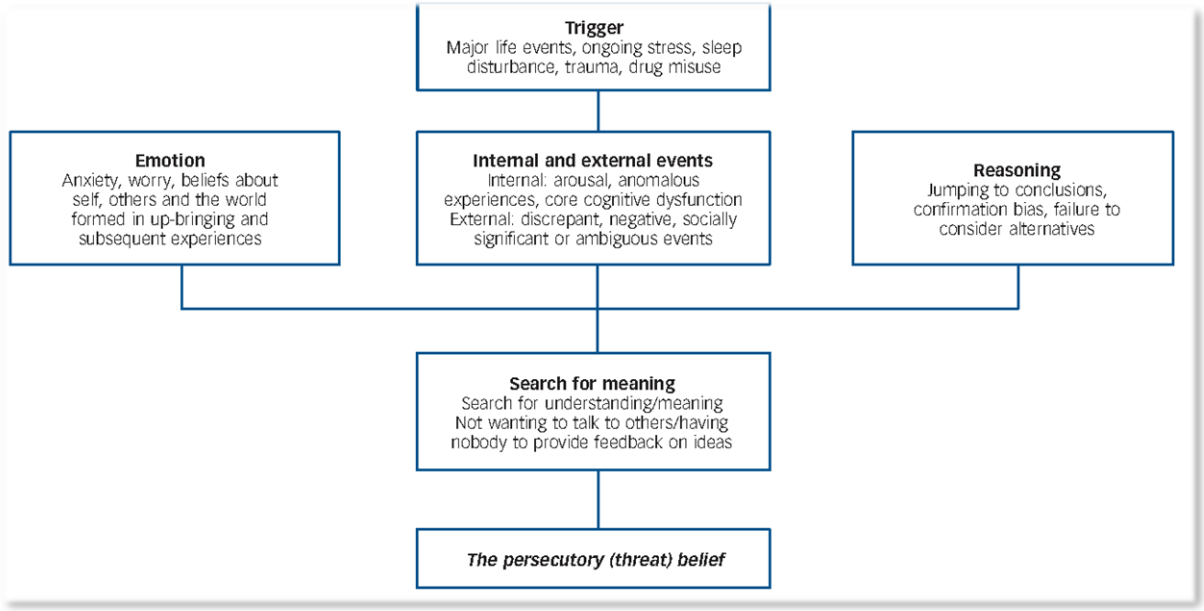


People diagnosed with mental illness, those who experience "extreme states" or experience extra-ordinary experiences such as "hearing voices" require acknowledgement, validation and understanding as much as anyone. Some people express thoughts or feelings that are disturbing to others, don't appear grounded in shared-reality, or there is incongruity between their emotional expression and verbal communication. Some people including health-professionals perceive these experiences as symptoms of a brain disease, beyond the person's control and inherently meaningless. Such explanations lead to social distancing (32) which might also exacerbate feelings of loneliness that have been found to be strongly associated with experiences of psychosis (33). Potential helpers may also be fearful or see little point in exploring the depths and origins and nature of the experience. A failure to empathise with people experiencing psychosis reflects a failure of perspective taking on the part of the helper.

Psychotic experiences include a range of cognitive and perceptual experiences that fall outside the usual sphere of experience. Such experiences whether transient or more enduring (as in those with diagnosed with a psychotic illness such as schizophrenia) are often startling, if not terrifying, to the individual. Often too, people may experience a constellation of symptoms involving perceptions, thoughts and feelings. The focus of empathy is to focus on the 'here and now' feelings associated with the experience, in order to validate those feelings and to help the person cope with those experiences.

Models have arisen with varying degrees of empirical support to explain particular symptoms and to address them (see for example the explanatory model of how persecutory delusions develop). Most cognitive behavioural models of psychosis (34) suggest that once psychotic activity is triggered (for whatever reason) a psychotic mood or feeling state is generated which in turn leads to an interaction with pre-existing beliefs and a misinterpretation of events due to particular biases in cognition. People who experience psychosis are often in a heightened state of arousal and jump to conclusions rapidly (a subcortical 'better safe than sorry' response). People who develop paranoid delusions have also been found to have a tendency to blame others for external events, and people who hear voices have been found to have a tendency to attribute internal experiences (such as their own thoughts) to external

sources (35, 36). Because of these potential problems it is exceptionally important to gain trust and rapport with the person. Accurate empathy, and Roger's ideals of being genuine, congruent and conveying unconditional positive regard are particularly important. Communication needs to be clear, concrete and unambiguous to avoid misinterpretation.



Garety & Freeman (2013) -How Persecutory Delusions Develop (37)

Voices and other perceptual experiences

Empathising with people experiencing psychosis proceeds in much the same way as with anyone else with an attitude of curiosity, careful, attentive listening and clarifying questions to understand the experience. People may need reassurance, encouragement and kind words to lubricate the conversation and relationship. Some experiences such as hearing voices or experiencing misperceptions may be relatively easy to empathise with as they are experienced as "not me" and can be discussed as an external perception. It is OK to ask about the experience, how they are different to other perceptual experiences, how intrusive these experiences are, how dominating, the content of the voices, the frequency of occurrence and the circumstances when they are most likely to occur. Some research suggests that distress associated with hearing voices is related to how intrusive and dominating they are (38). Indeed, in research I conducted on how people cope with voices, intrusiveness was the issue that most demanded a coping response. When I spoke with voices hearers they also said that it was good to talk about the experience and sadly for some it was the first time (39). An empathic statement can generally follow the empathy formula e.g.

> "*You feel frustrated when the voices are loud because you can't get things done… What might be helpful to allow them to give you a break?"*
>
> *"I notice you appear a little distracted… are the voices intruding again?"*

People may also develop beliefs about the identity of voices, their knowledge and power. Because voices are self-generated they unsurprisingly will know all about the individual including their fears, fantasies and vulnerabilities. Arising from this people may develop a belief that the voices are omnipotent which is often distressing (40). Beliefs about the voices' identity and power may be the

careful target of cognitive behavioural therapy. However, it is OK to gently reinforce the insight that voices are self-generated in the context of empathising with people's distress e.g.

> *"You must feel so distressed when the voices tell you that you are fat and ugly… because they are generated in your brain they will know what you are concerned about or what will make you upset."*

People may ascribe an identity to voices which isn't always a problem if people are able to differentiate that it "sounds like" not that "it is" a particular person. Even then it may not be problematic e.g.

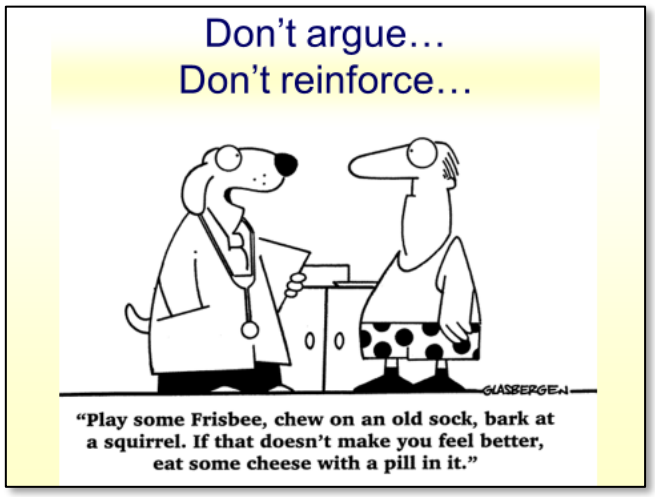
> *"Even if it may be generated in your mind, it gives you great comfort when your grandmother speaks to you when you are feeling sad."*

People do have automatic thoughts arising from hallucinatory experiences and from these, people sometimes develop or reinforce delusional beliefs. These require a more emphatic reinforcement of reality (see below). Two insights which address problems with reasoning (see Appendix A for others) that can be reinforced along with expressions of empathy are:

- Having a thought does not make it a fact (I thought…. But I really know that….)
- Having a strong feeling doesn't mean that something will happen (I feel…. But I know that….)

> *e.g. "You often notice those banging noises in your roof, particularly when you are alone at night. You begin to feel frightened and think that someone is breaking into your house. It's easy to jump to that conclusion when you are scared. However, feeling scared doesn't mean that someone is breaking into your house. How can we help you feel safer and less anxious at night?"*

Delusional Ideas

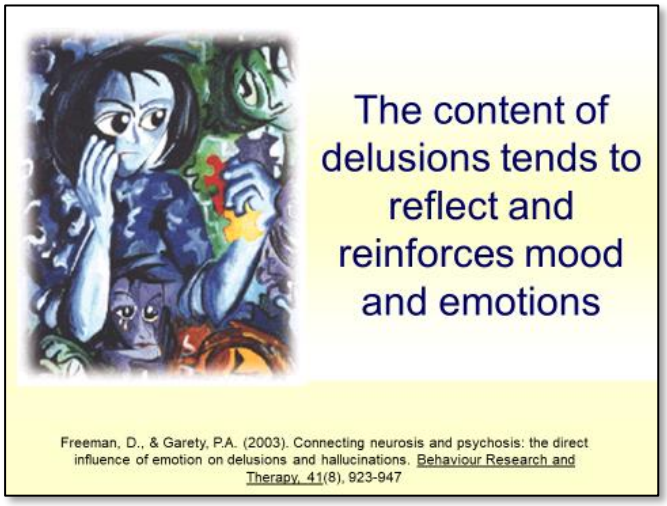


Delusional ideas have long been particularly challenging to health professionals, and often cause distress to others. Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence (41). Sometimes delusions can be bizarre, i.e. clearly implausible or not comprehensible. More often than not, they do make sense but one can't reason them away (at least not when people are experiencing a psychotic episode). People hold these beliefs quite tenaciously. The standard text books on psychiatry (see for example the extract from the DSM 5 below, p.87) tend to go to some lengths describing types of delusions based on their content, but rarely do they offer any practical advice on how one ought to respond. The longstanding advice is "Don't argue… Don't reinforce" which inevitably leads to various manoeuvres to change the topic or distract the person from the very thing that may at that moment matter most to them. Delusions like all beliefs and experiences generate emotions in the present and these can be acknowledged empathetically.

Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence. Their content may include a variety of themes (e.g., persecutory, referential, somatic, religious, grandiose). *Persecutory delusions* (i.e., belief that one is going to be harmed, harassed, and so forth by an individual, organization, or other group) are most common. *Referential delusions* (i.e., belief that certain gestures, comments, environmental cues, and so forth are directed at oneself) are also common. *Grandiose delusions* (i.e., when an individual believes that he or she has exceptional abilities, wealth, or fame) and *erotomanic delusions* (i.e., when an individual believes falsely that another person is in love with him or her) are also seen. *Nihilistic delusions* involve the conviction that a major catastrophe will occur, and *somatic delusions* focus on preoccupations regarding health and organ function.

Delusions are deemed *bizarre* if they are clearly implausible and not understandable to same-culture peers and do not derive from ordinary life experiences. An example of a bizarre delusion is the belief that an outside force has removed his or her internal organs and replaced them with someone else's organs without leaving any wounds or scars. An example of a nonbizarre delusion is the belief that one is under surveillance by the police, despite a lack of convincing evidence. Delusions that express a loss of control over mind or body are generally considered to be bizarre; these include the belief that one's thoughts have been "removed" by some outside force (*thought withdrawal*), that alien thoughts have been put into one's mind (*thought insertion*), or that one's body or actions are being acted on or manipulated by some outside force (*delusions of control*). The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity.

Source: The Diagnostic and Statistical Manual 5 (2013, p.213)



The content or themes of delusions and often hallucinatory content is intertwined with emotion and mood states (42) (see table below). Often the mood may precede the automatic thoughts and formation of beliefs. For example, people who may feel great (as in hypomania) are likely to develop delusions of grandeur and those who may be depressed are likely to have delusions of guilt. It is these feelings that are real and affecting and they often further prime people to seek evidence which confirms their thoughts and feelings in a cycle of emotional reasoning. Seemingly innocuous and unrelated evidence may be rallied to support the belief which further reinforces the feeling. Thoughts and beliefs may not be grounded in consensual reality but the feelings associated with those thoughts and beliefs are real and require acknowledgment.

The themes of emotions and delusions

Emotions	Main theme of emotion	Delusion with shared theme
Anxiety	Anticipation of physical, social, or psychological threat	Reference ('People are watching me') Persecution ('People are saying negative things behind my back to get at me')
Depression	Loss, low self-esteem, guilt, shame	Guilt ('I've brought ruin to my family') Persecution ('I'm being persecuted because of what I've done in the past') Catastrophe ('The world is going to end and it's all my fault')
Anger	Deliberately wronged, frustration at not reaching goal	Persecution ('People are doing things to annoy me')
Happiness	Success, achievement, high self-esteem	Grandiose ('I've got special talents and am related to a famous person')
Disgust	Finding something offensive, revulsion, dislike	Persecutory ('My food is being poisoned') Hypochondriacal ('My insides are rotting') Appearance ('My body is ugly and misshapen')
Jealousy	Fear of losing another's affection	Jealousy ('My wife is sleeping with other men in our bed while I lie asleep')

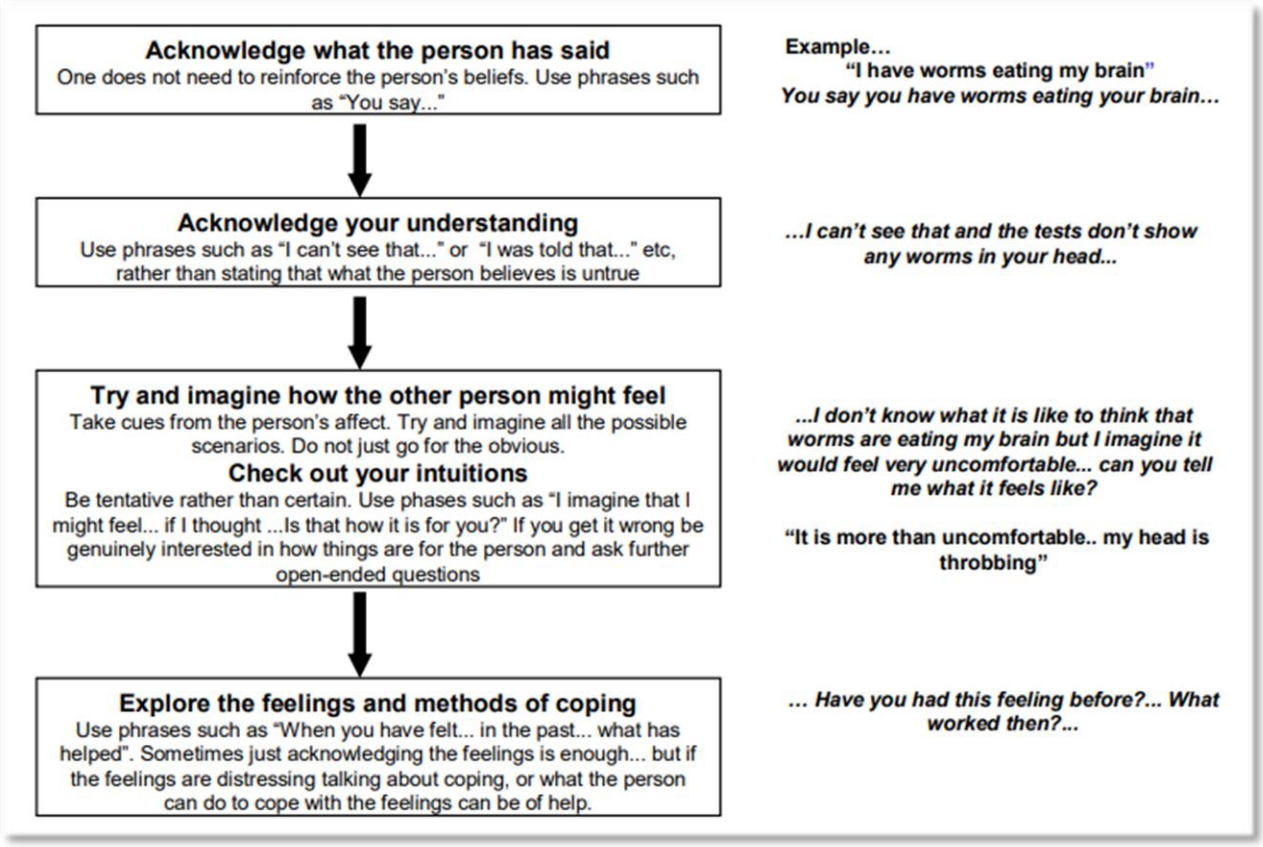
Source: Freeman & Garety (2003, p.933).

Principles of Responding to Disturbing Beliefs

A number of psychotherapeutic approaches to address problematic symptoms in psychosis have been developed. However, when the psychosis is acute or there are other complicating factors (such as extreme arousal or disorganised thinking) supportive, containing, empathetic responses may be the only psychotherapeutic tools available (43). People in this state may also share delusional or unusual ideas in the context of everyday interactions. Being mindful of the adage "don't argue" with a delusion, it is tempting to try and avoid talking about them, but this is an invalidating response. A simple formula for expressing empathy whilst also acknowledging one's own understanding is outlined below.

Like the empathy formula this response should be used judiciously and not applied rigidly. Firstly, attempt to acknowledge what the person has said. This can be implied in the remainder of the response or explicitly stated (as in the example below, "You say you have worms eating you brain"). Or it might be framed in a more exploratory way with the view of seeking clarification e.g. "You feel as if something is in your head?" This provides the opportunity for clarification of the experience. Remember that not every strange utterance is a delusion.

If after clarification, your understanding or reality is different from the other person's, then share your understanding, framing it in such a way that it can't be refuted. Stating that the person is wrong or attempting to bluntly refute evidence for a delusional belief will likely lead to an argument or create a rift in the relationship. It can be helpful to state what you have perceived (seen, heard, been told etc); perceptions can't easily be argued with and this is honest and congruent. Be brief and concrete as you want to rapidly get to the crux of the matter ie the emotions / feelings that are associated with this belief. In the case above if the person has had a test such as CT scan which didn't show any pathological signs then state this or some variation e.g. "That is very unlikely given that the scan showed that everything was normal".



A model of empathy for people who express disturbing beliefs. Source: Lakeman (2006, p.6)

Empathising with a delusional or odd belief requires the skill of perspective taking. That is, an active effort to experience the world from the client's perspective. Consider, what it might feel like to hold that belief or have that experience. It may appear obvious that a person feels a certain way and this may lead to some other emotion focused questioning e.g. "I can see that you are holding your head and you look in pain… does your head hurt?". The aim is to arrive at an accurate appraisal of the person's emotions which requires a tentative, cautious approach as unusual thoughts or beliefs may be associated with a range of emotions e.g. believing that one is being consumed may be associated with revulsion, fear or other thoughts such as that one is dying. Craft an empathic statement linking the belief / experience to the emotion.

Often the empathic statement is sufficient and nothing more is needed from the helper. Thoughts and feelings don't always demand action. The conversation might however lead to how one may cope with aspects of that experience (see for example the handout on coping with voices), particularly the associated feelings. People may need reassurance that they are safe or further exploration around what might make them feel safe or ameliorate distress. Frequent encouragement and positive comments in their efforts at dealing with their experience will assist in maintaining a good working alliance.

Advanced Empathy Worksheet

A. What did the person say?

B. Describe the person's experience:

Thoughts

Beliefs

Feelings (now)

Perceptions

Behaviour

Relevant background which contributes to this experience:

C. How would you feel if you had the experience described above?

Match emotion and intensity

D. What are your perceptions of the person's situation or understanding of the facts of the matter?

Create an empathic statement which acknowledges what the person has said (A), your perceptions (D) and links the person's experience (B) to their feelings (C).

Note if C appears at odds with the person's feelings / affect then frame the statement as a question.

Appendix A: Useful Insights from CBT in Schizophrenia

- Believing something to be true does not necessarily mean that it is true.
- Because something seems obviously and evidently true does not necessarily mean that it is true.
- Just because I intuitively 'feel' something to be true does not necessarily mean that it is true, however certain I may feel about it.
- Believing something to be true that is not actually true is very common indeed, so it is not a weird or peculiar thing to do.
- We all hold some beliefs that do not accurately reflect reality. We are not aware of their inaccuracy when we believe them.
- Holding inaccurate beliefs does not matter unless it causes us a problem.
- It is OK/good to realise I was wrong about a particular belief and to change it accordingly.
- We can imagine things that are impossible in the real world.
- Because I can imagine something happening does not mean that it will happen - nor does imagining it happening in any way increase the likelihood of it happening.
- My brain is capable of misinterpreting things and giving me the wrong information.
- Our brains are capable of producing very strange experiences; these experiences may be completely convincing at the time but be completely wrong or even impossible in the 'real' world.
- Anyone can get an 'odd' experience as a result of their brain not functioning accurately.
- I am not 'weird' or peculiar if I hear voices - it's just an extreme of what happens to lots of people.
- Hearing voices or having odd ideas only matters if they bother or upset me.
- I can get an automatic thought about anything at all. Everyone's brain produces all sorts of automatic thoughts, including pleasant and unpleasant ones, sensible and silly ones. No one can control what automatic thoughts come to their mind.
- Therefore I should not feel guilty or ashamed of the ideas that go through my mind or the beliefs that develop from them.
- Similarly, I should not feel guilty or ashamed of what my voices say

Source: Nelson, H.E. (1997). Cognitive behavioural therapy with schizophrenia: a practice manual.Cheltenham, U.K.: Stanley Thornes, p. 82

Coping with voices

Hearing voices is an extra-ordinary but relatively common experience. Hallucinations are associated with a wide range of medical and psychiatric conditions but people without any discernible illness can also experience them. Medication or treatment of an underlying illness may completely remove voices or diminish their frequency, volume or intensity. There are also many non-pharmacological things that people have found helpful to reduce distress associated with voices and to control the experience.

Attitude: It is natural to feel stressed when one begins to hear voices but it is important not to panic. Voices are generated by the mind; therefore they can seem to know a lot about you, your feelings and impulses. However, **they cannot harm you** and they have no power or authority. Accept the voices and try and adopt a scientific attitude to them. That is, experiment with strategies to cope with, control them and even learn from them.

Distinguish voices from other perceptions: Whilst voices can appear very similar to hearing people who are physically present there are often differences. Consider how the voices are different e.g. does the volume change when you walk away from the apparent source? Are they physically impossible? For example, are they voices of friends, family or acquaintances who are not present?

Stay healthy: Non-prescribed and illegal drugs like cannabis, speed, excessive coffee, and alcohol can make the experience of hearing voices worse and affect your ability to cope with them. Do things to remain healthy e.g. eat well, exercise, and make time to relax. Controlling anxiety is considered very important in coping with voices.

Self-Monitor: Many people can identify particular times of the day, places, thoughts, states of mind, moods or intentions that precede episodes of hearing voices. If patterns are recognised then you may be able to avoid the situation or deal with the emotion that triggers the voices. In some instances the content of voices may reflect unconscious conflicts. For example, for some people the intention to eat triggers voices saying derogatory things about the person's appearance reflecting unconscious concerns about body image. A qualified psychotherapist or mental health professional may be of assistance in working through such conflicts.

Control strategies: A large number of strategies can assist in controlling hallucinations but what works for one person may not work for another. There is some consensus that activities which are meaningful, demand attention, require listening, talking and moving are most helpful. Here are just a few examples:

- **Talk** – Most people find that voices diminish when they talk to others or even when they talk when alone. If alone try reading an interesting book out loud, sing or whistle to a favourite tune. In public if you feel compelled to respond to voices, consider using a mobile phone. Try playing card games or puzzles whilst talking out loud.
- **Listen to music** – Listen to music that is enjoyable to you. MP3 players with headphones are considered particularly helpful. Maintain a list of uplifting anti-voice music.
- **Read** out loud – Reading something interesting can be helpful. Reading or summarising what has been read out loud can be even better
- **Earplugs** – Some people find that using inexpensive wax earplugs provides temporary relief from voices. Experiment with blocking different ears (start with the right ear first if right handed).
- **Avoid** places or situations where there is a lot of **un-patterned background noise** e.g. busy roads, or places where there is a lot of background noise, as these may increase the intensity of voices.
- **Dismiss the voices** – Some people find that firmly telling the voices to stop or that they will be attended to latter provides some relief.
- **Talk to other voice hearers about what helps –** Other people that have coped with the experience of hearing voices have often-developed novel coping strategies. They may not work for you but they may be worth trying or adapting to your needs. Organisations such as the Mental Illness Fellowship have recourses and self-help books dealing specifically with hearing voices.

For some people it is not the hearing voices but rather the beliefs that arise about the voices that is problematic. Some people have a tendency to ascribe special qualities to or accept the wisdom of voices without question. Keep an open and sceptical mind and talk to a mental health professional about your assumptions about voices and seek advice about coping.

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