

Advanced empathy: A key to supporting people experiencing psychosis or other extreme states

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Introduction

Empathy is essential for interpersonal helping and is considered a key change process in psychotherapy (Bohart, Elliott, Greenberg, & Watson, 2002). In everyday discourse, to empathise with another is to see things from their perspective and to feel with them, or, in the language of metaphor, 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 (Merriam-Webster, 2019).

This everyday definition is in accord with the psychological concept of empathy defined by Cuff, Brown, Taylor, and Howat (2016):

Empathy is an emotional response (affective), dependent upon the interaction between trait capacities and state influences. Empathic processes are automatically elicited but are also shaped by top-down control processes. The resulting emotion is similar to one’s perception (directly experienced or imagined) and understanding (cognitive empathy) of the stimulus emotion, with recognition that the source of the emotion is not one’s own. (p.7)

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 (Davis, 2018). In the field of psychotherapy, there has been a long history of considering empathy as a communicative process (Marcia, 1987). Therapists need to consider how an empathic understanding of another’s experience (including thoughts and feelings) ought to be used interpersonally in the context of helping. This paper considers that an empathetic understanding needs to be judiciously communicated back to the person in a congruent, non-judgemental way which makes a difference to them. 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!

This paper first defines and locates empathy as a foundational interpersonal skill for helping, psychotherapy, counselling, and interdisciplinary mental health care. While not a new idea, it cannot be assumed that helpers have this appreciation, so the importance of empathy is discussed, and empathy as a communicative technique is described. Genuine expressions of empathy assist in building and sustaining a therapeutic alliance, which is the strongest predictor of positive outcomes in psychotherapy (Wampold, 2015). This is equally true for people with extreme mental health or social problems (Evans-Jones, Peters, & Barker, 2009). All helpers need to listen, be attuned to the experiences of the other, and communicate a validating, insightful appreciation of their experience. This is challenging when another's experience is far removed from one's own, such as in psychosis (Parker, 2016).

Traditionally, psychosis, delusions ideas, and extreme altered states have led to therapeutic nihilism in many clinicians, with some finding it difficult to talk about delusions and psychotic experiences (McCabe & Priebe, 2008). However, there are models of care that are clearly helpful if available and which should be explored by helpers (e.g., Alanen, de Chávez, Silver, & Martindale, 2009; Hagen, Turkington, Berge, & Gråwe, 2013; Lakeman, 2014a). The second part of this paper proposes a method to communicate in an empathic and validating way with people who express ideas or have experiences that can easily derail clinicians' and therapists' efforts at making the most fundamental of human connections. Empathic communication with people experiencing psychosis or other extreme states is possible, and necessary to build an alliance to enable any kind of therapeutic relationship or deliver any kind of helpful interpersonal intervention.

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. However, the most robust finding has been that all treatments are equally effective (Luborsky et al., 2002), with only modest differences in targeted symptoms between different kinds of therapies (Marcus, O'Connell, Norris, & Sawaqdeh, 2014). This conundrum for the helping professions is known as the "Dodo Bird Verdict," a phrase drawn from Lewis Carroll'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. Such "common factors" include the therapeutic alliance, empathy, goal consensus and collaboration, positive regard and affirmation, mastery, congruence/genuineness, mentalisation, and emotional experience (Cuijpers, Reijnders, & Huibers, 2019). Common factors have been found to explain between 30-70% of the difference in outcomes in psychotherapy research, while therapy-specific factors (e.g., technique, sticking to the manual) account for 10-15% of the variance in outcomes (de Felice et al., 2019).

The therapeutic alliance is perhaps the most researched cluster of common factors (Nienhuis et al., 2018). The therapeutic alliance was originally conceptualised as a reality-based collaboration between person and therapist (Greenson, 1965) and later as reciprocal positive feelings, as well as agreement on tasks and goals (Bordin, 1979). It

has been found to be the strongest predictor of positive outcome in mental health care generally (Flückiger, Del Re, Wampold, & Horvath, 2018). The quality of the relationship may even predict response to psychotropic medication (Zilcha-Mano, Roose, Barber, & Rutherford, 2015). Focusing on building and maintaining an alliance is pivotal to successful therapy outcomes across almost all approaches to psychotherapy (Flückiger et al., 2018).

Empathic communication has been found to be a strong predictor of therapeutic alliance and of positive outcomes of therapy (Elliott, Bohart, Watson, & Greenberg, 2011). Indeed empathy (while a component of the therapeutic alliance) has been found to be a stronger predictor of outcome than alliance generally, as have shared goals between therapist and patient, and aspects of collaboration (Wampold, 2015). Empathy can provide a shared understanding from which a common formulation and goals emerge. A further powerful predictor of the effectiveness of talking therapies and pharmacotherapy is expectation (Thiruchselvam et al., 2019). For example, if people expect that talking or medications will help, there is an increased likelihood that the intervention will. Empathic communication may raise expectations that the helper really understands the person, thus engendering an expectation that whatever is offered will be helpful.

Empathy as the Foundation of Therapy

One way of making sense of the Dodo Bird Verdict 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 almost become 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 (1961), 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 (i.e., the goals of therapy). Rogers’ influence 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 people learn how to be in the world and come to know others, and thus saw it as a tool in analysis (Verducci, 2000). However, Rogers stressed the need for the therapist to be fully present, listen attentively, and communicate empathy accurately. Being empathetic is being therapeutic. While Rogers’ conditions may not be sufficient in themselves to resolve 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 (2002), one of the foremost psychotherapeutic writers of recent times who is renowned for his contributions to group psychotherapy and existential psychotherapy, empathy is a pivotal skill for any therapist. 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 (2014) states that empathy “as a value is a radical commitment on the part of helpers to understand clients as fully as possible” (p. 51). He also adds that it is a further commitment to understanding the context of their lives and “...to understand the dissonance between the client’s point of view and reality” (p. 51).

The Preconditions and Components of Empathy

Empathy has at least four components: moral, emotive, cognitive, and behavioural (Morse, Bottorff, Anderson, O’Brien, & Solberg, 1992). Empathy is arguably the basis of human morality. Being able to appreciate the perspectives, thoughts, and feelings of others is a prerequisite 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 empathetically is innately helpful; it assists in building and sustaining relationships.

The emotive component of empathy is the ability to subjectively perceive others’ emotions. Social animals, particularly primates, have evolved the capacity of displaying and reading emotional states. The discovery of mirror-neurons 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) (de Waal & Preston, 2017).

Observing a caregiver engaging face-to-face with an infant and being attuned and responsive to their emotions is in part watching mirror neurons in action. The degree to which the caregiver is attuned to the emotions of an infant and communicates empathetically impacts on the infant’s attachment and capacity to regulate their emotions (Jonsson et al., 2001). 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) (Decety & Jackson, 2006). Infants can learn to discriminate emotions in others at a very early age based on facial expressions and other affective cues. Parental empathy with a child predicts a secure attachment (Stern, Borelli, & Smiley, 2015) and children with secure attachment are more empathic and pro-social (Kestenbaum, Farber, & Sroufe, 1989). Not surprisingly, people with secure attachment (both therapist and clients) are more likely to form stronger therapeutic alliances in psychotherapy (Diener & Monroe, 2011).

The face may be the window to the soul, but it does not tell the whole story. Many people struggle with identifying people’s emotions when there is blunting of affect (e.g., in Parkinson’s disease) or incongruity in affect (e.g., when some people experience psychosis). People may of course note the incongruity in affect when a person says they are happy when clearly they are not, yet to make sense of the emotional state (rather than just feeling it) requires the cognitive skill of perspective-taking (Decety & Jackson,

2006). The social cognitive processes of perspective-taking and face processing begins in infancy and continues to develop throughout adolescence (Fuhrmann, Knoll, & Blakemore, 2015).

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 (i.e., 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 is homeless or unemployed. Recently, a genre of television has emerged (as illustrated by the programmes *Filthy Rich and Homeless*, *Go Back to Where You Came From*, and *First Contact*) in which people are handpicked for their lack of contact and often fixed attitudes towards a population (e.g. homeless people, refugees, 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 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 (Dearing & Steadman, 2009). 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, encouraging participants to develop a sense of universality or an understanding that they are not alone (Yalom, 1995). 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 the 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) does not necessary lead to improved or better relationships (Cabral & Smith, 2011).

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 are put aside; and listening carefully to the other (Lakeman,

2014b). 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; however, preoccupation with such tasks can be an obstacle to empathic listening or responding. Empathic listening is a purposeful, conscious activity which requires practice and one does not learn to do it by practising 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 can be worthwhile for psychotherapist and counsellors to consider what might get in the way of them being fully present with another. Questions to consider include:

- 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 of this person?
- Are there distractions? How are these affecting me and how can I deal with them?
- Am I anxious, fearful or experiencing other emotions that need attending 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 (which is no easy thing to do as people are awash with feelings all the time). Some emotions and experiences may feel uncomfortable. 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 (Luft & Ingham, 1961), including mindfulness, meditation, personal therapy, supervision, and 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 (as long as they are genuine) (Duff & Bedi, 2010). 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. It involves listening for experiences, feelings, behaviour, gaps, areas of avoidance, and for things that are unsaid. It is concerned with "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 (2014) suggests that an “empathy statement” can be expressed in the following way: “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 (Yalom, 2002). 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.

If the reasons for the person’s feelings are unclear, helpers can at least acknowledge the person’s 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 (Greenberg, 2004) 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 and Extraordinary Experiences

People diagnosed with mental illness, including those who experience “extreme states” or 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, do not appear grounded in shared reality, or display incongruity between their emotional expression and verbal communication. There may be times when the person has little awareness of their own emotional experience and how it relates to their intrapsychic experience. This sensing and sharing of meaning of which the client may have little awareness is what Egan (2014, p. 176) calls “advanced empathy”. Extending an empathetic response to people’s experience of intrapsychic experience far removed from consensual reality or experience might also be considered advanced.

Biogenetic explanations for psychosis and other mental illness have been found to lead to unfortunate side-effects, including a lack of motivation to empathise with the person as symptoms of a brain disease are seen as beyond the person's control and inherently meaningless (Kvaale, Haslam, & Gottdiener, 2013). Such explanations can lead to social distancing (Angermeyer et al., 2015), which might also exacerbate feelings of loneliness that have been found to be strongly associated with experiences of psychosis (Michalska da Rocha, Rhodes, Vasilopoulou, & Hutton, 2017). 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 is likely to reflect 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) may be startling, if not terrifying, to the individual (Bentall, 2014). Often too, people may experience a constellation of symptoms involving perceptions, thoughts, and feelings. The focus of empathy is the "here and now" feelings associated with the experience, in order to validate those feelings and to help the person cope with the experience.

Models have been developed with varying degrees of empirical support to explain particular symptoms of psychosis and how to address them. Most cognitive behavioural models of psychosis (e.g., Garety & Freeman, 2013; Nelson, 1997) 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 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 (Alanen et al., 2009; Lakeman, 2001). 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.

Voices and Other Unusual Perceptual Experiences

Empathising with people experiencing psychosis proceeds in much the same way as with anyone else: with an attitude of curiosity, attentive listening, and asking 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 can be useful for helpers 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 in which they

are most likely to occur. Some research suggests that distress associated with hearing voices is related to how intrusive and dominating they are (Sorrell, Hayward, & Meddings, 2010). 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?” and “I notice you appear a little distracted... are the voices intruding again?”)

People may also develop beliefs about the identity of voices, the knowledge they possess, and their powers. 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 (Birchwood, Meaden, Trower, Gilbert, & Plaistow, 2000). Beliefs about the voices’ identities and powers may be the careful target of cognitive behavioural therapy. However, it is acceptable for helpers 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 is not necessarily a problem if they are able to differentiate that it “sounds like” not that “it is” that person. Even if the voice is perceived as a person, 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, which can sometimes develop or reinforce delusional beliefs. These require a more emphatic reinforcement of reality (see below). Two insights which address problems with reasoning that can be reinforced along with expressions of empathy are: (1) having a thought does not make it a fact (“I thought.... But I really know that...”), and (2) having a strong feeling does not mean that something will happen (“I feel.... But I know that...”). For example, a helper could say something like, “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 (American Psychiatric Association, 2013). Sometimes delusions can be bizarre, that is, clearly implausible or not comprehensible. More often than not they do make sense but cannot be reasoned away (at least not when people are experiencing a psychotic episode or mood). People hold these beliefs quite tenaciously. The standard textbooks on psychiatry (see for example *The Diagnostic and*

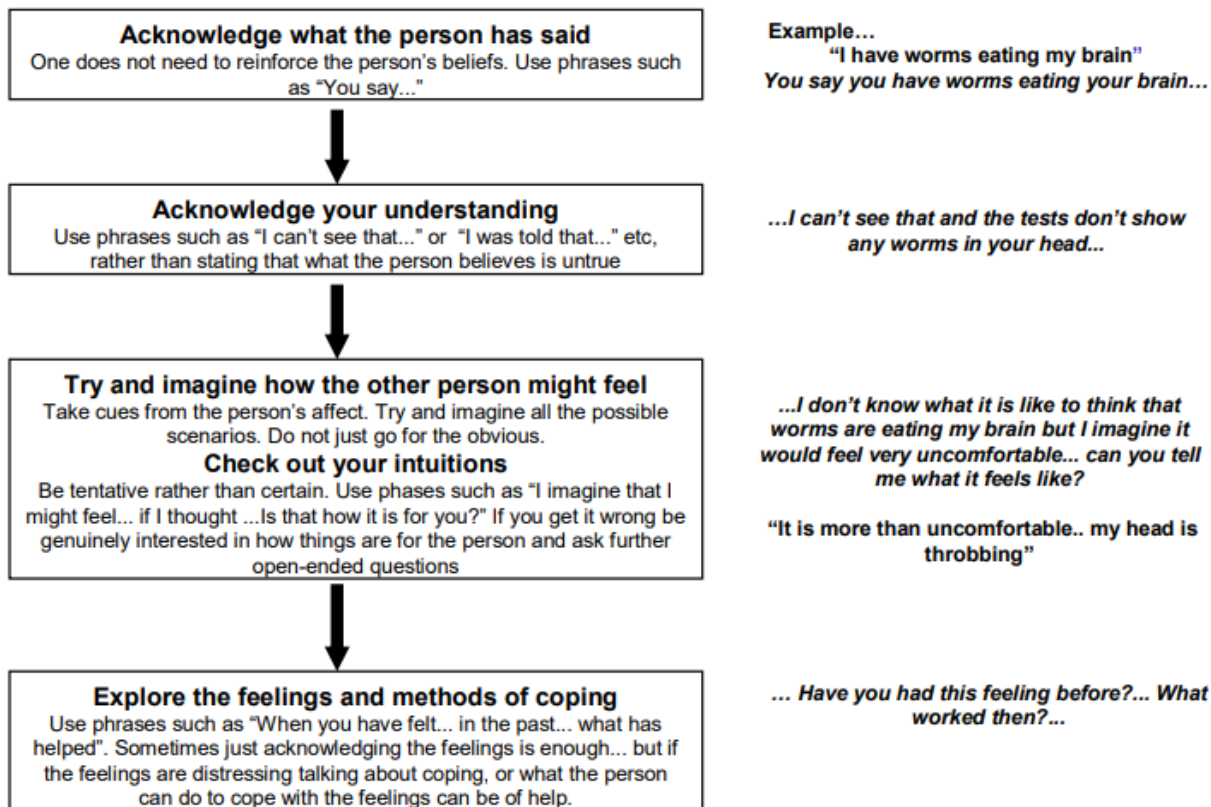
Statistical Manual of Mental Disorders [5th ed.; DSM–5; American Psychiatric Association, 2013 p. 87]) tend to go to some lengths describing types of delusions based on their content (e.g., persecutory, grandiose, erotomanic, nihilistic, somatic), but rarely do they offer any practical advice on how one ought to respond. The longstanding advice to new people in the field is “don’t argue, don’t reinforce,” which generally leads to invalidating manoeuvres to change the topic or distract the person from the very thing that may at that moment matter most to them. Like all beliefs and experiences, delusions generate emotions in the present and these can be acknowledged empathetically.

The content or themes of delusions and hallucinations is intertwined with emotion and mood states (Freeman & Garety, 2003). Often the mood may precede the automatic thoughts and formation of beliefs. For example, people who feel great (as in hypomania) are likely to develop delusions of grandeur and those who feel depressed are likely to have delusions of guilt. It is these feelings that are real and affecting, and which 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.

Principles of Responding to Disturbing Beliefs

Psychotherapeutic approaches to address problematic symptoms in psychosis have been developed. However, when the psychosis is acute (i.e., the neurobiological system is activated and the mood state is active) or there are other complicating factors (e.g., extreme arousal or disorganised thinking), supportive, containing, and empathetic responses may be the only psychotherapeutic tools available (Lakeman, 2006). 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 while also acknowledging one’s own understanding is outlined in Figure 1.

Figure 1: A model of empathy for people who express disturbing beliefs.



Source: Lakeman (2006, p. 6)

Like the empathy formula, the advice outlined in Figure 1 should be used judiciously and not applied rigidly. First, 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, "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?"), which 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 cannot 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 (e.g., seen, heard, been told); perceptions cannot easily be argued with, and this is honest and congruent. Be brief and concrete in order to rapidly get to the crux of the matter (i.e., the emotions or feelings that are associated with this belief). In the case above, if the person has had a test such as CT scan which did not 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").

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 the belief that one is dying). Craft an empathic statement linking the belief or experience to the emotion. Clearly, as in most human interactions, this should not be approached in a formulaic way.

Often, the empathic statement is enough and nothing more is needed from the helper; thoughts and feelings do not always demand action. The conversation might however lead to how one may cope with aspects of that experience (see for example handouts on coping with voices at: <https://testandcalc.com/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.

Conclusion

Communicating empathically is a foundational skill for counselling, psychotherapy, and indeed for fostering and maintaining relationships generally. While most people have the capability to communicate empathically, it may not be well developed, or other agendas or issues may impede their capacity to extend this basic gesture to those in great need. People who experience extreme states, perceive the world differently from others, or express delusional or disturbing ideas may challenge helper’s capacities to respond empathically or derail their good intentions. The insights derived from theory and research about psychosis and psychotic states can be very useful in assisting helpers to respond in helpful ways to people. However, the foundation of the therapeutic encounter with people in these extreme states is the capacity to empathise, which can be developed by all people who may offer assistance. This paper builds on the foundational concept of empathy to propose a more advanced form of empathy, which is at the heart of being therapeutic with people in extreme states. People who may experience the world differently to others need helpers, allies, and professionals who strive to understand their world, who can communicate in a validating and empathic manner, and who assist them in their endeavours to cope and recover.

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