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THE SIGNIFICANCE OF EMPATHY IN COUNSELLING

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***Abstract*:** The objective of this research is to investigate how empathy is constructed. The literature displays substantial evidence that empathy is a key component of the therapeutic alliance across theories and that empathy is required in the counselling process. Also taking into account the various interpretations of empathy in psychotherapy and counselling, as well as Carl Roger's contribution to the creation and understanding of empathy. Some authors examine some lasting challenges in the study of empathy in Empathy Considered: New Directions in Counseling. Some people see of empathy as a tighter contagion in which the therapist feels some of what the client feels, while others think of it as a hermeneutic process for understanding the other's thinking. Rogers (1957) encourages empathy. The importance of empathy in counselling was strengthened and has proven to be constant when unconditional positive regard was used as a core component of treatment.

Keywords: **empathy, counselling, psychotherapy, therapy**

I. INTRODUCTION

Empathy is a wide concept that relates to an individual's cognitive and emotional responses to another's perceived experiences. Empathy boosts one's chances of assisting others and displaying compassion. According to the Greater Good Science Center, a research Centre that examines the psychology, sociology, and neuroscience of well-being, "empathy is a building block of morality—it helps people follow the Golden Rule if they can put themselves in someone else's shoes." "It's also an important component of good relationships since it helps us grasp other people's views, needs, and intentions."

Though they may appear to be the same thing, empathy and sympathy are not the same thing. "Empathy is often defined as understanding another person's experience by imagining oneself in that other person's situation," according to Hodges and Myers in the Encyclopedia of Social Psychology. "One understands the other person's experience as if it were being experienced by the self, but without the self actually experiencing it." The boundary between self and other is maintained. Sympathy, on the other hand, is defined as "the sensation of being moved by another person or responding in tune with that person."

Empathy has been described in different ways: walking in another's shoes, entering into another person's frame of reference or having the ability to experience life as the other person does by entering the person's world of thoughts, feelings, emotions and meanings.

In counselling, empathy is a statement of the respect and regard the counsellor holds for the client whose encounters might be very not quite the same as that of the counsellor. The client needs to feel "held", comprehended as well as regarded. To hold a client remedially implies the guide is fit to acknowledge and uphold the client through any issues, concerns, issues she/he can bring. The capacity to empathize with one more is improved

by a ready mindfulness of looks, non-verbal communication, signals, instinct, quiets, etc.

EMPATHY

Empathy is the ability to truly understand what others are going through, to see things from their point of view, and to put yourself in their shoes. It's essentially imagining another person's point of view and feeling how they should feel. When you observe someone else suffering, you may automatically put yourself in their shoes and feel compassion for what they are going through. While most people are extremely sensitive to their own emotions and sensations, getting into another person's thoughts can be a little more difficult. Individuals with the ability to feel sympathy can "walk a mile in another's shoes," as it were. It allows people to understand what other people are going through, seeing someone else in pain and responding with indifference or even outright aggression seemed to be completely vast for some. However, the way that some people respond in this way clearly demonstrates that sympathy isn't a widespread reaction to other people's suffering.

There are several types of empathy that a person can experience:

Affective empathy is defined as the ability to understand and respond appropriately to another person's feelings. Such fervent comprehension could make someone anxious for someone else's well-being, or it could make them feel agony in their own body.

Somatic empathy entails having a physical reaction to what another person is going through. Individuals can sometimes fully understand what another person is going through. When you observe another individual being humiliated, for example, you may flush or have a queasy stomach.

Cognitive empathy entails being able to comprehend another person's psychological condition and what they could be thinking while going through the same experience. This is linked to the term "hypothesis" used by analysts.

Empathy appears to be ingrained in our minds and bodies, as well as in our evolutionary history. Empathy in its most basic manifestations has been documented in our ape ancestors, dogs, and even rats. Empathy has been linked to two different brain pathways, and scientists believe that some components of empathy can be traced back to mirror neurons, brain cells that fire in the same manner they would if we performed the activity ourselves. Empathy has a genetic basis, according to research, yet studies suggest that people can improve (or limit) their natural empathy capacities.

EMOTIONAL AND COGNITIVE EMPATHY

Empathy is divided into two sorts, according to researchers. Empathy can be classified as an emotional or cognitive reaction, especially in social psychology. According to **Hodges and Myers**, **Emotional empathy** is made up of three parts. "The first is sharing an emotion with another person... The second component, personal distress, refers to one's own distress as a result of witnessing another's suffering... "The most usually related with the study of empathy in psychology is the third emotional component, experiencing compassion for another person," they explain.

It's vital to remember that the suffering experienced as a result of emotional empathy doesn't always reflect the other person's experiences. While empathic people are distressed when someone falls, they are not in the same bodily pain as the person who has fallen, according to Hodges and Myers. When it comes to issues about compassionate human behavior, this form of empathy is extremely important. There is a link between experiencing empathic concern and being eager to assist others. According to Hodges and Myers, "many of the most noble examples of human action, such as assisting strangers and stigmatized persons, are regarded to have empathic roots." The question of whether the desire to help is motivated by altruism or self-interest continues to be debated.

Cognitive empathy is the second type of empathy. This refers to a person's ability to recognize and understand the emotions of others. According to Hodges and Myers, cognitive empathy entails "having more full and accurate knowledge of the contents of another person's mind, including how the person feels." Cognitive empathy is more akin to a skill: humans learn to detect and understand the emotional states of others as a means of processing their own emotions and behaviors. While the specific mechanism through which people experience empathy is unknown, there is a growing corpus of research on the subject.

Empathy appears to evolve throughout time as part of human development, and it has evolutionary foundations. According to the Greater Good Science Center, "elementary kinds of empathy have been discovered in our ape ancestors, dogs, and even rats." Humans begin to show symptoms of empathy in social interactions around their second and third years of life, according to developmental studies. "There is substantial evidence that prosocial actions such as altruistic

assistance evolve early in life," according to Jean Decety's article "The Neurodevelopment of Empathy in Humans." Infants as young as 12 months old begin to console distressed victims, and 14- to 18-month-old children engage in spontaneous, unrewarded helpful activities."

While both contextual and genetic factors influence a person's ability to empathize, we tend to maintain the same amount of empathy throughout our lifetimes, with no signs of ageing. "Empathy Across the Adult Lifespan: Longitudinal and Experience-Sampling Findings," according to the study. "Empathy was linked to a positive well-being and interaction profile regardless of age."

And it's true that we experience empathy for evolutionary reasons: "Empathy most likely originated in the context of the parental care that all animals share." Human infants communicate their wants to their caregivers by smiling and crying. According to the **Greater Good Science Center**, "females who responded to their offspring's needs out-produced those who were cold and distant." This could account for disparities in human empathy between men and women.

PSYCHOLOGY AND EMPATHY

Empathy is a key concept in the study of psychology. According to **Good Therapy**, an online association of mental health specialists, persons with high levels of empathy are more likely to perform well in society, experiencing "bigger social circles and more meaningful relationships." Empathy is essential for successful interpersonal interactions of all kinds, including those in the home, the business, and beyond. As a result, a lack of empathy might be a sign of antisocial personality disorder or narcissistic personality disorder. Furthermore, developing empathy for clients is a vital aspect of successful treatment for mental health professionals such as therapists. "Highly empathic therapists can assist persons in treatment in confronting prior experiences and gaining a better knowledge of both the positive and negative aspects of their lives."

CULTURE OF EMPATHY

Carl Ransom Rogers (January 8, 1902 – February 4, 1987) was a significant figure in American history "American psychologist who was one of the forerunners of the humanistic psychology movement. Rogers is widely regarded as one of the founding fathers of psychotherapy research, and the American Psychological Association recognized him with the Award for Distinguished Scientific Contributions in 1956 for his groundbreaking work. (Source: Wikipedia) "He had a significant impact on the study of empathy. His work on empathy and reflective listening has influenced a lot of empathy research in psychology and psychotherapy. Richard E. Farson and Carl R. Rogers "Active listening is a powerful tool for influencing people's behaviour. Despite widespread belief that listening is a passive activity, clinical and scientific evidence clearly reveals that attentive listening is a very powerful tool for individual and group personality transformation. Listening causes people to modify their attitudes toward themselves and others, as well as their underlying beliefs and personal philosophy. People who have been listened to in this fresh and unique method develop emotional maturity, are more receptive to their experiences, are less defensive, democratic, and authoritarian." Empathic Understanding with Accuracy "Accurate empathetic comprehension means the therapist is entirely at ease in the patient's universe." It is a sensitivity that is present in the "here and now," the present moment. It involves perceiving the client's inner world of private personal meanings "as if" it were the therapist's own, but without losing the "as if" character. In the moment-to-moment encounter of therapy, accurate sensitivity to the client's "being" is critical; nevertheless, it is of limited service to the individual if the therapist gets at this perceptive and empathic knowledge of the patient's experience when he drives home at night. If the therapist has another chance, such delayed empathy or insight may be useful.

Carl Rogers Dialogues

"First and foremost, the therapist must establish a strong, accurate empathy. The therapist must be entirely at ease in the client's universe to have accurate empathic comprehension. It's a sensibility that exists in the here and now, in the present moment. It's perceiving the client's inner world of secret personal meanings as if it were your own, while always remembering that it isn't. Accurate sensitivity to the client's being is of vital importance during the moment-to-moment encounter of therapy; but, it is of little benefit to the individual if the therapist gets at this perceptive and empathic knowledge of the client's experience only after the interview. If the therapist gets another chance to respond to the same subject, such a delayed revelation may be useful, but its usefulness would be in creating the moment-to-moment answer to the client's current living of this later relationship. Another important aspect of correct empathic understanding is the capacity and sensitivity required to express these inner meanings to the client in a way that permits them to be "his"

experiences. The perceptive part of correct empathy is sensing the client's anxiety, bewilderment, wrath, or rage as if it were a feeling you might have (but aren't currently experiencing). The essence of the communication part of correct empathy is to transmit this perception in a language that is tuned to the client, allowing him to more clearly sense and construct his anxiety, perplexity, wrath, or indignation. Perhaps the most striking contrast between an accurate empathetic comprehension of the client's conflicts and difficulties and the more common. The contrast between a correct empathetic comprehension of the client's conflicts and issues and the more common diagnostic formulation of the client's experiences is perhaps the most striking. The implication of this diagnostic understanding, which is so distinct but so prevalent, is "I understand what's wrong with you" or "I understand the dynamics that cause you to act this way." External and, in some cases, impersonal evaluative understandings are used. Empathic understanding appears to be significant in allowing the client to more freely experience his internal sensations, perceptions, and personal meanings when it is accurately and compassionately articulated. When someone is in touch with his inner experiences, he can recognize where his experience differs from his concept of himself and, as a result, where he is attempting to live by a false conception. Recognizing inconsistencies is the first step toward resolving them and revising one's definition of self to accommodate previously ignored experiences. This is one of the most important ways that change can occur and a more complete integration of self and behaviour can begin.

Rogers (Rogers, 1986) "Empathy, in my opinion, is a therapeutic agent in and of itself. It is one of the most powerful components of therapy since it liberates, verifies, and reintegrates even the most terrified client into society. A person belongs if he or she is understood."

To **Person-Centred Psychology**, Tony Merry extends an invitation (Whurr, 1995; pp 71 to 72) "Being empathic indicates a keen interest in the client's universe of meanings and feelings, as long as the client is prepared to share it." When the therapist hears these messages, he or she expresses gratitude and understanding, which encourages the client to go further or deeper. It is erroneous to believe that this entails nothing more than repeating the client's last words. Instead, one person acts as a warm, compassionate, and respectful companion during the often challenging study of another's inner world. Individual, natural, and unaffected responses from the therapist are preferred. When empathy is at its best, the two people are engaged in a process that can be compared to a pair dancing, with the client leading and the therapist following; the interaction's fluid, spontaneous back and forth flow of energy has its own artistic rhythm."

Person-Centred Therapy by Nat Raskin and Carl Rogers "In person-centered treatment, empathy is an active, immediate, and ongoing process. The counsellor takes every effort to go under the skin of the client, to enter inside and live the attitudes expressed rather than observing them, to grasp every detail of their changing nature, and to thoroughly immerse himself or herself in the other's views. When striving to live the attitudes of others, one cannot diagnose them or conceive of ways to make the process go faster while struggling to do so. Such insight can only be gained by paying deep, continuous, and active attention to other people's feelings at the expense of any other kind of attention.

PERSON CENTERED THERAPY

During the 1950s, humanistic therapies became popular in the United States. Carl Rogers believed that treatment may be more straightforward, friendly, and hopeful than that provided by behavioral or psychodynamic psychologists.

In contrast to **psychodynamic and behavioral techniques**, he believes that clients would benefit from being pushed to focus on their current subjective understanding rather than an unconscious motive or someone else's interpretation of the event. Rogers felt that therapists should be warm, honest, and empathetic in order for a client's condition to improve. Rogers himself best expresses the beginning point of the Rogerian approach to counselling and psychotherapy:

Rogers (1961) argued that both psychoanalysis and behaviorism are deterministic, and that we act the way we do because of how we perceive our situation. "We are the finest experts on ourselves because no one else can know how we perceive." Rogers established his idea based on his experience with emotionally troubled people and believed that we have a tremendous capacity for self-healing and personal growth leading to self-actualization, rather than the other way around. He focused on the individual's current viewpoint and how we live in the present. Rogers found that people often refer to themselves when describing their current experiences, such as "I don't understand what's going on" or "I don't feel how I used to feel." The concept of self, or self-concept, is central to Rogers' (1959) theory. "The ordered, consistent set of views

and beliefs about oneself," according to the definition. It encompasses all of the concepts and beliefs that define 'I' and 'me,' as well as the perception and valuation of 'who I am' and 'what I can do.'

As a result, our self-concept is an important part of our whole experience, influencing both our view of the world and our perspective of ourselves. For example, a woman who sees herself as powerful may act confidently and begin to see her actions as those of a confident person. However, the self-concept does not always correspond to reality, and how we see ourselves may differ significantly from how others see us. For example, a person may be fascinating to others but find himself to be uninteresting. He examines and evaluates his perception of himself as a bore, and his self-esteem reflects this evaluation. The self-esteem of the confident woman may be high, whereas the self-esteem of the man who regards himself as a bore may be low, implying that strength and confidence are highly appreciated but boredom is not.

Incongruence is present when a person joins person-centered treatment. The therapists' job is to help people get out of this condition. Because of the emphasis on the person's subjective perception of the world, Rogers (1959) dubbed his therapeutic approach client-centered or person-centered therapy. One significant distinction between humanistic counsellors and other therapists is that they refer to their clients as 'clients' rather than 'patients.' This is because they consider the therapist and the client to be equal partners rather than an expert treating a patient. Unlike other therapies, the client, not the therapist, is in charge of improving his or her life. This is a deliberate departure from psychoanalysis and behavioral therapies, both of which require a doctor to diagnose and treat the patient. Instead, the client determines for themselves, deliberately and sensibly, what is wrong and what should be done about it. The therapist acts as a friend or counsellor, listening and encouraging on an equal footing.

Rogers (1951) opposed interpretation because he believed that, while symptoms do develop from past experiences, it was more beneficial for the client to concentrate on the present and future rather than the past. Rogerians aspire to help their clients attain personal growth and eventually self-actualization, rather than simply releasing them from their past as psychodynamic therapists do. Due to the unique nature of each counselling relationship, Rogerian psychotherapy has a near-total lack of procedures. The quality of the interaction between the client and the therapist, on the other hand, is crucial.

The therapeutic relationship, not what the therapist says or does, is the most important factor.

Listening, accepting, understanding, and sharing, if such strategies exist, appear to be more attitude-oriented than skill-oriented. 'A preoccupation with applying tools is perceived [from the Rogerian stance] as depersonalizing the interaction,' according to **Corey (1991).** The Rogerian client-centered approach emphasizes the individual's ability to develop an acceptable understanding of their environment and self.

Rogers saw everyone as a "potentially capable individual" who might substantially benefit from his approach to treatment. Roger's humanistic treatment aims to improve a person's sense of self-worth, minimize inconsistencies between the ideal and actual self, and help them become more fully functional individuals.

The Fundamentals

Client-centered treatment is guided by three main concepts that represent the therapist's attitude toward the client:

1. The therapist and the client are on the same page.

2. The therapist expresses unconditional positive regard for the client.

3. The therapist communicates with the client in an empathic manner.

CONGRUENCE IN PSYCHOLOGY

Genuineness is another term for congruence. According to Rogers, the most significant attribute in counselling is congruence. This means that, unlike the psychodynamic therapist, who maintains a 'blank screen' in treatment and shows little of their own personality, the Rogerian is eager to let the client to experience them as they are. The therapist does not have a façade (as in psychoanalysis), which means that his or her internal and exterior experiences are the same. In a nutshell, the therapist is genuine. Congruence, in its most basic form, denotes an accurate external expression of the inner truth. To give a basic example, a person who screams "I'm not angry" while thudding a table will be perceived as incongruent by the other person, even if they haven't identified the notion "congruence." The emotional substance of the phrases "I'm not furious" does not match the academic content of the words. It becomes difficult to trust the communication or the communicator when communication is conducted in this manner.

With such a person or in such a scenario, one is unsure of one's position.

UNCONDITIONAL POSITIVE REGARD

The **unconditional positive regard** core condition is the next Rogerian core condition. Rogers felt that for people to grow and reach their full potential, they must be valued for who they are. This is the therapist's sincere and heartfelt concern for the client. Although the therapist may not agree with some of the client's actions, he or she does approve of the client. In other words, the therapist must have the mindset of "I'll accept you just the way you are." Even when repulsed by the client's actions, the person-centered counsellor is mindful to keep a good attitude toward the client. This entire acceptance and caring is a prerequisite for perfect honesty and transparency between people. When it is lacking, the response is likely to be a shutting down, the construction of barriers between people, and a lack of honesty, or at least absolute honesty, between people. People will only say what they feel comfortable saying, which may include self-censorship of their emotions and other responses.

EMPATHY IN THERAPY

Empathy is the ability to comprehend the feelings of a client. This refers to the therapist's capacity to understand the client's current experience and feelings sensitively and accurately [but not compassionately]. Empathy is the ability to enter another person's world without passing judgement through the use of willed imagination. In a previous post on the philosophical dimensions of empathy, empathy as a broad way of experiencing the world, and the interconnectedness of all living things. It's vital to remember that empathy does not imply agreement in this situation. Empathy is defined as the ability to understand another person's feelings without passing judgement on whether or not they are appropriate. The belief that people are fundamentally good and that, in the end, each person knows what is best for them is a crucial component of a successful person-centered therapy that is "all about love."

Following precisely what the client is feeling and communicating to them that the therapist knows what they are feeling is an important element of the person-centered counselor's job. Accurate empathetic comprehension, according to Rogers (1959), is as follows:

"Empathy, or being empathetic, is the ability to accurately sense another's internal frame of reference, as well as the emotional components and meanings associated with it, as if one were the person, but without ever losing the 'as if' condition. Thus, to sense another's pain or joy as he perceives it, and to notice the causes of that pain or pleasure as he perceives them, but never losing sight of the fact that it is as if I were injured or pleased, and so on. When this 'as if' character is eliminated, the situation becomes one of identification."

Because a person-centered counsellor places such a high value on authenticity and following the client's lead, they do not place the same focus on time and technique as a psychodynamic therapist. A person-centered counsellor may deviate significantly from traditional counselling procedures if they believe it is acceptable. We can't understand person-centered therapy just on the basis of its procedures, as **Mearns and Thorne (1988)** point out. The person-centered counsellor has a very happy and upbeat attitude toward people. The belief that people are fundamentally good and that, in the end, each person knows what is best for them is a crucial component of a successful person-centered therapy that is "all about love."

COUNSELLING PSYCHOLOGY

Counseling Psychology is a generalist health service (HSP) specialty in professional psychology that employs a wide range of culturally informed and culturally sensitive practices to assist people in improving their well-being, preventing and alleviating distress and maladjustment, resolving crises, and improving their ability to function better in their lives. It focuses on normative life-span development, with a special emphasis on prevention and education as well as amelioration, and it addresses both persons and the systems or contexts in which they operate. It specializes in employment and career-related issues.

Psychologists are aware of and capable of using evidence-based and culturally relevant intervention, assessment, preventive, training, and research procedures. They focus on the healthy aspects and strengths of their clients (whether they are individuals, couples, families, groups, organizations, or communities); environmental/contextual influences that shape people's experiences and concerns (such as cultural, sociopolitical, gender, racial, ethnic, and socioeconomic factors); the role of career and work in people's lives; and advocacy for equity and social justice.

Counseling psychologists specialize in the normal developmental and mental health issues and challenges that people face throughout their lives, as well as systemic issues (such as prejudice and discrimination) that people face in groups,

workplaces, organizations, institutions, and communities. They employ strengths-based approaches and methods to prevent and treat emotional, relational, physical/health-related, social, cultural, occupational, educational, and identity-related issues.

Rogers (1957) proposed and defined six elements that he believed were both required and sufficient for therapeutic client improvement.

These six requirements, according to Rogers, apply to all psychotherapy, not only client-centered therapy. These conditions necessitate counsellor congruence or genuineness in the therapeutic relationship, unconditional positive regard for the client (warmth), the counselor's ability to empathize with the client in this relationship, and the counselor's ability to communicate empathy and unconditional positive regard to the client. Empathy is the notion that has elicited the most attention from psychotherapy theorists and researchers among the qualities described by Rogers as both required and sufficient.

Across counselling theories, there is a lot of scholarly interest in producing empirical data to support the significance of these key factors in therapy outcome. The majority of this investigation took place in the Rogers' innovative thesis sparked the movement in the 1960s and 1970s. (Bohart & Greenberg, 1997; Duan & Hill, 1996; Bohart & Greenberg, 1997; Bohart & Greenberg, 1997; Bohart & Greenberg, 1997 Some of the relevant studies High correlations were found between the core conditions and a positive therapy outcome in a study done in the 1970s. Truax and Mitchell, for example (1971) conducted objective audiotape ratings and discovered a strong link There is a link between empathy and a successful therapeutic outcome. However, there is one point of contention. According to Bohart and Greenberg, one of the findings of this study was that it connected empathy with the process of empathetic reflection, a relationship that Rogers recognised advocated in opposition to Empathy research has been going on since the 1970s Empathy the core conditions research has been sparse (Bohart & Greenberg, 1997; Duan & Hill, 1996). However, the literature on therapeutic partnership (e.g., Bohart & Greenberg, 1997) and common factors in counselling, which include characteristics that exist across counselling theories, reflects these same essential conditions (Lambert, 1992). To determine (a) the applicability of the construct of empathy across counselling theories (Rogers, 1957), (b) the empirical validity of empathy as important to the therapeutic alliance, and (c) the current applicability of empathy in the field of counselling, we investigated the construct of counsellor empathy within the therapeutic relationship. This review does not cover the broader subjects of therapeutic alliance and common factors in counselling. Depending on the theoretical orientation under consideration, the terms psychoanalysis/analyst, therapy/psychotherapist, and counseling/cozinselor are used interchangeably. Also used are the terms patient and client.

HISTORICAL PERSPECTIVES

Although Rogers' work is a significant historical landmark on this subject, the primacy of the therapist-patient connection in psychotherapy did not begin with him. In psychoanalytic therapy, the term therapeutic working alliance was coined (Bordin, 1979). As a result, one of the formation of relationships between analyst and client is one of the most important aspects of partnership patient. Empathy, according to Freud, is a skill that provides indications about the unconscious the unconscious dynamics of the patient. The patient-analyst relationship was supposed to be a symbiotic one. Although there was a friendly exchange, empathy was not employed to create a bond that would encourage a rehabilitative emotional experience (Bohart & Greenberg, 1997). Object relations theorists in the psychoanalytic camp stressed attachment, interpersonal conflict, and other concerns relating to human relationships to a greater extent than drive and ego theorists (Hansen, 2000) Kohut (197), the creator of self-psychology, felt that the analyst may get insight into the patient's experience through vicarious introspection. According to him, Analyst assessment of client behaviour was less useful to the therapeutic experience than empathic responsiveness to the patient. Kohut went on to say that the empathic-introspective immersion is a technique used by analysts to collect information in order to explain the patient's inner experiences, data regarding the patient's inner experiences must be collected.

Rogers was influenced by Adler's conceptions of encouragement and social interest, according to Watts (1996) and Watts and Pietrzak (2000). In 1927 and 1928, Rogers worked with Adler and claimed that he was particularly impressed by Adler's ability to relate to his patients (Watts, 1996). Adler's encouragement abilities included actively listening and empathizing with clients, as well as showing respect and confidence in them (Watts & Pietrzak, 2000).

Adler's conceptions of social interest were also similar to Rogers' empathy, unconditional positive

regard, and congruence (Watts, 1996). As a result, Adler's thesis could have influenced Rogers' notion of the therapeutic relationship.

Empathy is a German word that means "to feel." Einfuhling is defined as "feeling into" another person's experience (Duan & Hill, 1996; Hartley, 1995). The therapist's sharing of the client's inner meanings and the relevance of the client's experiences is referred to as empathic resonance by Kohut (Hartley, 1995).

Rogers (1957) defined authentic empathy in the following way:

Empathy is the ability to perceive the client's world as your own, without losing the "as if" quality—and it appears to be vital to therapy. The situation we're attempting to express is the ability to perceive the client's rage, fear, or perplexity as if it were your own, but without becoming entangled in it. When the client's environment is like this, If the therapist's environment is clear to him and he is free to move around in it, he can both express his comprehension of what the client knows and speak meanings in the client's experience that the client isn't aware of.

Rogers' notion of empathy reflects a depth of knowledge of the client's situations and feelings that goes beyond introspective remarks, as seen by his definition. In a review of empathy studies, Duan and Hill (1996) addressed the ambiguity that exists in this body of knowledge. Empathy, like other facilitative traits, is clearly a more complex construct than previously imagined (Duan & Hill, 1996), making it difficult to describe and quantify. "We believe the misunderstanding reflects the multiplicity of ways in which empathy is conceptualized and argue that such variation has to be appreciated but not discouraged," Duan and Hill said (p. 261). They proposed more detailed phrases as a solution to the definition conundrum. words to represent various facets of the empathy construct They developed terms like intellectual empathy to describe the cognitive process and empathetic emotions to describe the affective side of empathy (Wan & Hill, 1996). In their investigation, these scholars made numerous references to Rogers' work. Empathy, according to Hartley (1995), implies "being with the customer". Bohart and Greenberg (1997) recognised three phases of empathy:

1. Empathic rapport is defined as the therapist's acceptance of the client's feelings and point of view.

2. The therapist investigates the client's relationships and life history in order to gain a close grasp of the client's reality.

3. Communicative attunement assists the client in symbolizing, organizing, and making meaning of his or her inner sensations

Empathic interactions are defined by some researchers as particular treatment strategies (Henry, Schacht, & Strupp, 1990).

There was a movement in study in the mid-1980s from an emphasis on the relationship to the construct of the alliance (Asay & Lambert, 1999). Within the context of alliance, constructs such as understanding and involvement, as well as warmth and friendliness, have been researched and appear to resemble Rogers' requirements (Asay & Lambert, 1999). The relational components of the common characteristics of counselling include counsellor behaviors, attitudes, or qualities that support the therapeutic connection, which are also representative of Rogers' basic conditions.

Empirical studies of psychotherapy outcome credit 30% of the outcome to these common characteristics, according to Asay and Lambert. These variables are found in a range of therapies regardless of the therapist's theoretical orientation, and they "include a host of variables that are found in a variety of therapies regardless of the therapist's theoretical orientation: such as empathy, , kindness, acceptance, risk-taking encouragement, and so on"

EMPATHY ACROSS COUNSELLING THEORIES

The notion that the construct of empathy within the counselor-client interaction extends in some way across counselling theories, as Rogers hypothesized, has received a lot of support from research and theorists (Rogers, 1957). Relationship elements that match the idea of empathy are included in the body of literature regarding the common factors of counselling that appear across theoretical approaches. Empathy is also a key component of the therapeutic partnership.

Client-centered (Glauser & Bozarth, 2001; Hartley, 1995; Rogers, 1957) and existential theories (Hartley, 1995) both place a strong emphasis on counsellor empathy (Bohart & Greenberg, 1997; Duan & Hill, 1996; Eagle & Wolitzky, 1997; Hansen, 2000; Hartley, 1995; Henry et al., 1990), and psychoanalytic theory (Bohart & Greenberg, 1997; Duan & Numerous studies on empathy and related topics have also been conducted. associated constructs in psychodynamic therapy (Harriest, Quintana, Strupp, & Henry, 1994; Henry et al.,

1990), Gestalt therapy (Pearson, 1999), and behaviour therapy (Harriest, Quintana, Strupp, & Henry, 1994; Henry et al., 1990)

Warmth, accurate empathy, and authenticity, according to Beck, Rush, Shaw, and Emery (1979), are significant contributors to counsellor efficacy in cognitive therapy. These constructs, according to Beck et al., are necessary but not sufficient for optimal therapeutic impact. They claim that "accurate empathy improves therapeutic partnership" by assisting the therapist in "making sense of the patient's unproductive actions and being less judgemental about them". Empathy, according to Beck et al., has both an intellectual and an emotional component. Empathy's role in cognitive therapy has also been studied by other researchers (Pearson, 1999; Persons & Bums, 1985).

Ellis's (1996) rational emotive behaviour therapy (REBT), a cognitive-behavioral therapy, highlighted Rogers' idea on the importance of the client-counselor interaction. REBT therapists, according to Ellis, are dedicated to assisting clients in overcoming their difficulties. Unconditional favorable esteem, in the sense that. Rogers' theory defines what is delivered to customers and how it is modelled for them. REBT therapists, according to Ellis, go a step further by actively and directively teaching clients how to unconditionally love themselves.

The therapist uses the client's relationship as a vehicle to teach him or her how to better relate to others. Although Ellis did not directly mention an empathetic experience of the client's environment, Rogers' essential requirements of unconditional positive regard and sincerity are defined in his REBT theory (Ellis, 1996). Empathy was a crucial concept for relational theorists (Gibson & Myers, 2000; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). Jordan (1991) penned the following:

Individuals suffering from a variety of falsifications and distortions of their self-perceptions seek ways to be recognised and understood, as well as to provide that for others. In the therapeutic interaction, feelings and actions that have been suppressed to avoid suffering or intensified to achieve approval can begin to emerge again. Through the improvement of empathy, therapy provides an opportunity to expand relational presence.

Relational therapists promote self-empathy and see empathy as a two-way process between the client and the counsellor that encourages the client to have a "corrective relational experience" (Jordan, 1991, p. 287). Empathy's use in constructivist and postmodern counselling theories demonstrates the concept's ubiquity in the field. According to proponents of responsive therapy and motivational interviewing (Gerber & Basham, 1999), counsellor empathy is an essential component of both theories, and solution-focused short treatment (Watts & Pietrzak, 2000) also relies on the concept of empathy. Empathy is mentioned frequently in the literature on multicultural counselling methods as an important component of the therapeutic relationship (Patterson, 1996).

These examples support Rogers' (1957) claim that his key conditions, particularly empathy, may be applied to a variety of counselling theories, including new views. Despite the fact that empathy is not a major component of every theory, there is significant evidence that it is particularly effective in the client-counselor connection.

EMPIRICAL EVIDENCE: There is a substantial body of information on the role and usefulness of empathy.

However, since the 1980s, the emphasis has shifted to the elements of the therapeutic relationship and common features in counselling, which usually contain empathy as a fundamental component. In this article, we present the findings of a meta-analysis of empathy studies as well as current reviews in order to clarify the research on empathy's significance in therapeutic outcomes. Patterson (1984) conducted a meta-analysis of empirical investigations on the psychotherapy constructs of empathy, warmth, and sincerity. Within the same review, there are varying standards for methodology, processes, and data analysis; overemphasis of studies that accord with the reviewer's bias; and rejection of good results in studies that yielded mixed results. Patterson was a harsh critic of the study. He noted a number of issues with this study, including reviewer bias in the study selection process.

Patterson (1984) went on to list issues with research studies themselves. The inexperience of the therapists involved in the trials, the small number of therapists and clients in the studies, the little proportion of variance in outcome criteria explained by therapist characteristics, and the lack of consistency in outcome measurements were among the critiques. Patterson (1984) remarked that notwithstanding the strong criticisms of both the research and the reviews, the scope of the evidence is nothing short of incredible. There are few things in psychology where the evidence is as robust as this. The evidence for the importance, if not sufficiency, of the therapist's conditions of

appropriate empathy, respect, or warmth, as well as therapeutic authenticity, is indisputable. Patterson's (1984) findings backed up the importance of empathy and the other fundamental variables for a successful therapeutic outcome.

The amount of study on the construct of empathy had diminished more than a decade later (Duan & Hill, 1996). Fewer than a dozen research on empathy have been published in major counselling psychology journals since 1985. Empirical evidence of the association between empathy and client change abounds in research papers undertaken from the 1960s through 1989, according to Duan and Hill. Client perceptions of empathy are more closely associated to client-rated counselling outcome than counsellor perceptions, according to other studies (Duan & Hill, 1996) Other study completed between 1978 and 1992, according to Duan and Hill (1996), cast doubt on the efficacy of empathy in counselling outcomes. These research questioned the value and purpose of empathy in psychotherapy, concluded that empathy was probably insufficient unless in rare circumstances, and claimed that empathy was more significant for moderate diseases than for serious issues (Duan & Hill, 1996).

Patterson's (1984) acknowledgment of the methodological challenges that beset the field of empathy research was mirrored by Duan and Hill (1996). Unreliable and incorrect measures of empathy, a lack of a cause-and-effect relationship between empathy and result, and difficulties distinguishing between the various components of the notion of empathy were among the issues identified by Duan and Hill. In order to test their hypothesis about their categorization of the many characteristics of empathy, Duan and Hill made proposals for additional definition and research in the area of empathy.

Overall, empirical data strongly supports that the application of empathy and associated constructs by counsellors within the therapeutic partnership has a significant impact on therapeutic result. There has also been a case made that empathy is a vital component of the therapeutic interaction, although there is no clear answer as to whether or not it is required.

CURRENT APPLICATION: The current study trend is to identify empathy as a component of the therapeutic bond, which is thus recognised as a common characteristic among counselling modalities. Duncan and Moynihan's (1994) essay on the deliberate use of the client's frame of reference to achieve good outcomes is another current understanding of empathy. "The therapist's attempt to operate within the client's frame of reference manifests empathy."

Empathy may be seen when the therapist responds in a way that is consistent with the client's frame of reference" (Duncan & Moynihan, 1994, p. 295). Duncan and Moynihan's article was viewed by Bozarth (1997) as offering an operational idea similar to Rogers' (1957) conception of empathy. The article's writers make a passing reference to Rogerian impact on their idea. Beutler (2000) based his application of empirical methods to clinical practice on a survey of hundreds of empirical studies and follow-up validation investigations with a sample of 250 outpatients with a range of diseases. Beutler's purpose was to find change principles that were independent of any theoretical perspective. This research yielded a set of ten basic principles for psychotherapy practice, as well as eight ideal and improving criteria. The nature of the therapeutic relationship and the relevance of the bond between client and counsellor are discussed in the first optimal and improving guideline. "Therapeutic improvement is greatest when the therapist is skilled and gives trust, acceptance, acknowledgment, collaboration, and respect for the patient within an environment that simultaneously fosters risk and provides maximum safety," according to Beutler (p. 1005). He went on to say that the first rule is most likely the foundation for the remaining seven criteria that make up his guidelines. Beutler's guideline appears to reflect therapist behaviour that is similar to counsellor empathy definitions. Interest in multicultural counselling (Patterson, 1996), integrationist and eclectic theories (Norcross & Goldfried, 1992), and constructivist counselling (Gerber & Basham, 1999; Watts & Pietrzak, 2000) has created fertile ground for new concepts and new interpretations of existing concepts. Even if the nomenclature may appear antiquated, empathy is a crucial notion in all of these philosophies. "Rogers' theories have become so prevalent that their impact is felt in practically all of the newer types of counselling and therapy," Cowan and Presbury (2000) write.

Despite the difficulties in defining and measuring empathy, our examination of the literature shows that empathy or a related interpersonal element is included in all counselling theories to some level. Many of the hypotheses discussed earlier in this page rely on it. Despite, that the majority of the evidence supported the necessity of empathy as a component, Rogers' key requirements of authenticity, empathy, and unconditional positive regard as adequate for therapeutic change have not been widely recognised, despite their success

(Bohart & Greenberg, 1997). Empathy, on the other hand, remains a crucial term in therapy. Empathy is as relevant in the twenty-first century as it was in 1950s when Rogers first defined the impact of empathy in the therapeutic interaction, with origins in psychoanalytic thought and constructivist theory.

II. REVIEW OF LITERATURE

REYNOLDS W. & SCOTT B. (1999) *re-visioning empathy:* According to the paper, empathy is an interpersonal ability that is influenced by the helpful person's views and behaviour. It entails the client being aware of the helper's communication in order for them to know if they are being understood. Since the evidence suggests that empathy is an important component of a helping relationship, there is a need to develop an operational definition of the notion that is applicable to clinical nursing. This is related to the Patients Charter's recommendation that clients take responsibility for their own health, tell experts what they want, and be treated as a person rather than a case.

Richard M. Frankel (22.04.2017) *The Evolution of Empathy Research: Models, Muddles, and Mechanisms***:** This paper focus on the accuracy and impact of empathic communication as shown by psychological and social/communicative components of empathy communication in a patient's reaction The two perspectives on empathy, as a trait or capacity, and as something that is co-created interaction, which are paradoxical and a source of debate and disagreement in the research literature. Currently, there is a gap between cognitive empathy and empathetic communication models. The assumptions, claims, and methodologies are all confusing. As we grapple with the paradox of how to construct an integrated biopsychosocial model of empathy, we can take comfort in the fact that empathy researchers, like Bohr and Einstein, share a shared core of scientific and personal respect for one another and how best to assist healthcare workers in successfully responding to individuals in need.

Keith Tudor (1957) *understanding empathy:* This paper suggests the varied meanings of empathy have not been made plain in the transactional analysis literature, and a greater knowledge of Carl Rogers' work on empathy in the context of his necessary and sufficient conditions for therapy widens empathy's understanding and uses in TA. The purpose of this essay was to clarify diverse perspectives on empathy in transactional analysis, which also serves as context for a separate article on a cocreative perspective on empathy.

Edwin Kahn and Arnold W. Rachman 2000 *Carl Rogers and Heinz Kohut: A historical perspective*: According to this paper there may be more similarities between Kohut and Rogers than between Kohut and other of his psychoanalytic predecessors, as the article has covered numerous areas where Rogers' contributions are a precursor to some of the discoveries in self psychology. Rogers' notions of empathy in the therapeutic connection ("becoming the client's other self"), for example, foreshadow Kohut's understanding of the archaic requirements of narcissistic patients, as observed by Stolorow (1976). Rogers' thesis that unconditional positive regard and empathy foster positive self-esteem and congruence foreshadows Kohut's theories about self-cohesion and the necessity of mirroring in self-development. Both Kohut and Rogers were able to break free from psychoanalysis' early emphasis on interpretation and learn to listen with sympathetic comprehension to what the patient or client was saying or as the client put it. With more freedom (but also Kohut), Rogers emphasized the therapeutic relationship's human quality. Rogers aimed to make the therapeutic connection more equal, and Kohut emphasized this concept with his new listening posture.

STACEY L. SINCLAIR and GERALD MONK *The Evolution of Empathy Research: Models, Muddles, and Mechanisms:* This paper, integrates Foucauldian and poststructuralist contributions to empathy as a therapeutic practice Integrating a discursive dimension to empathy practice accomplishes the recognised benefit of liberal humanism understandings of empathy, in our opinion. A discursive approach, informed by the conceptual tools of discourse, positioning, and deconstruction, allows clients to engage in high-level reflexivity about discursive patterns in their lives while also allowing counsellors to connect and empathize with clients in a respectful and socially just manner. It is suggested that a discursive approach to empathy encourages clients to resist those who are oppressive constricting and constraining discourses.

Sheila Redfern, Christine P. Dancey & Windy Dryden (1993) *Empathy: Its effect on how counsellors are perceived:* The findings of this study back up the central concept that empathic counsellors are more attractive and knowledgeable than nonempathic counsellors. On the CRF, empathetic counsellors were evaluated higher than non-empathic counsellors, whether black or white,

male or female. Regardless of empathic or non-empathic style or sex, ethnicity had a substantial effect on ratings on all three scales on the counsellor rating scales, with black counsellors rated higher than white counsellors. This study, as well as prior research (e.g., Bryson and Cody, 1973), suggests that ethnicity is a significant element that influences both the level of knowledge in the counselling process and the clients' perspectives. Generalizations about ethnicity and the ability of counsellors and clients to comprehend each other, on the other hand, should be avoided. It should also be highlighted that the goal of this study is not to create new stereotypes, and it is hesitant to apply the findings to the entire community.

Susy Churchill & Rowan Bayne (01 Jul 2010) *Psychological type and conceptions of empathy in experienced counsellors*: This research project clearly demonstrates the complex nature of empathy, as predicted by type theory, with different psychological types emphasizing particular aspects while giving less or no attention to others. Assuming the outcomes are favorable the consequences for practitioners, researchers, and theorists are evident because the research is well-founded. However, type theory implies that actual understanding and long-term application will be a difficult task.

REYNOLDS W.J., SCOTT B. & JESSIMAN W.C. (1999) *Empathy has not been measured in clients' terms or effectively taught:* It is proven in this research that traditional models of empathy do not effectively respond to clients' perceptions of their ability to offer empathy. Clients' perspectives of the helping connection may enable them to advise nurses and other professional experts about the degree of empathy present in a relationship, according to one theory. This guidance is expected to clarify the nature of empathy in clinical nursing and define the goals of empathy courses for nurses. The low levels of empathy in nursing and the limits of existing empathy courses point to the need for new strategies to assist nurses in providing clinical empathy.

BEE TENG LIM, HELEN MORIARTY, MARK HUTHWAITE, LESLEY GRAY, SUE PULLON & PETER GALLAGHER. *How well do medical students rate and communicate clinical empathy?* This study confirmed that, as elsewhere in the globe, self-reported empathy abilities deteriorate after undergraduate medical training in New Zealand. They discovered a moderate connection between peer assessments and tutor assessments of interaction competence, implying that peer assessments give unique and valuable data in the assessment of interns' MI/BI skills and should be employed in the future if moderated by tutor assessments. The discovery that senior medical students may be unaware of others' perspectives on their empathy communication skills suggests that this is another area that needs to be investigated further.

CHARLES B. TRUAX (1996) *Reinforcement and no reinforcement in Rogerian psychotherapy*: More specific knowledge of how positive human qualities like empathy and warmth operate to create personality or behavioral change in the patient would come from research designed to determine which patient behaviors, when reinforced at what intensity levels, etc., lead to positive therapeutic outcomes. More particular knowledge is the goal of this technique, but not more mechanical therapy. Because the communication of any "reinforcing machine" quality implies a low level of empathy and warmth.

BRUNERO S, LAMONT S and COATES.M (2010) *A review of empathy education in nursing*: it is proven in this research although using a variety of evaluation methodologies, efforts to determine the impact of empathy-based education have yielded encouraging findings in various populations of nurses. Empathy education must evolve in order to be effective must be seen in well-designed trials that show not just its efficacy but also the practical challenges of delivering education at both the undergraduate and postgraduate levels populations of nurses The results are difficult to generalize because of the various measurement tools and styles used in education.

Karen E. Gerdes*, Elizabeth A. Segal, and Cynthia A. Lietz 2010 *conceptualising and measuring empathy:* This paper suggests that empathy definitions have proven semantically ambiguous or unclear. As a result, conceptualizations and measuring procedures for empathy differ widely from study to study, making meaningful comparisons and drawing substantial conclusions about how we define and analyze empathy challenging. Social cognitive neuroscientists have now observed the brain networks that make empathy possible. Social work can and should be in the forefront of developing a standard definition of empathy and measuring all four components, as well as empathic accuracy.

Mohammadreza Hojat, Joseph S. Gonnella, Thomas J. Nasca, Salvatore Mangione, Michael Vergara, Michael Magee *Physician empathy: definition, components, measurement, and relationship to gender and specialty:* This research contributes to the understanding and measurement of physician empathy. Because this vital humanistic feature of medicine eludes the performance measures usually used in medical education, the definition and measurement of empathy demand special consideration. Such research could have significant ramifications for medical student and resident selection and education, as well as career advice. The Jefferson Scale of Physician Empathy utilized in this study is a psychometrically sound tool for future research on physician empathy, including construct validity, test-retest, and internal consistency reliabilities.

Richard Thwaites and James Bennett-Levy 2007 *conceptualising empathy in cognitive behaviour therapy: making the implicit explicit:* The goal of this study was to bring together a heterogeneous body of empathy literature into a coherent theoretical framework that clinicians, supervisors, and trainers can use to think critically about their clinical practice. The role of empathy in CBT has been discussed. Empathy was mostly defined in terms of psychotherapy. Our conceptualization, however, although empathy shares ideas with other therapeutic schools, it has its own set of ramifications for CBT, which can help with clinical practice refinement, supervision, training, and research. The emphasis on the empathetic process in CBT literature and many training courses gives the impression that CBT therapists only pay attention to it when the client gives negative feedback. This new model gives a framework for CBT therapists to think about therapeutic empathy, and it raises crucial concerns about how it might be investigated, trained, and cultivated in clinicians.

Vincent Price and John Archbold *(what it is all about empathy):* This paper suggests that empathy is a concept that is widely used yet poorly understood. It's tough to define or quantify because it appears to be a multidimensional phenomenon an idea that has yet to be completely defined It appears that the true measure of empathy is understanding means appreciating the hopes and dreams of others fears of those who are different from us. Empathy has been advocated as appropriate, desirable, therapeutic, and the key component of the nurse-patient connection for the past three decades. Although no other communication strategies have been presented or studied, the sole use and therapeutic efficacy of empathy has been called into question.

III Research methodology

In examining the processes of empathy in counselling qualitative method of research was used in this paper. Qualitative content analyses of the related research materials theories, and empirical studies was done to determine the overall impact of empathy in field of counselling, Carl Rogers theory of person centered therapy was the underlining base of the study.

OBJECTIVE

1. The aim of this paper is to study empathy.
2. This paper also aims to check the importance of empathy in counselling.
3. How carl roger has defined empathy
4. How empathy helps in counselling and psychotherapy

IV Discussion

Empathy is the ability to comprehend the feelings of a client. This refers to the therapist's capacity to understand the client's current experience and feelings sensitively and accurately [but not compassionately]. Empathy is the ability to enter another person's world without passing judgement through the use of willed imagination. In a previous post on the philosophical dimensions of empathy, empathy as a broad way of experiencing the world, and the interconnectedness of all living things. It's vital to remember that empathy does not imply agreement in this situation. A person-centered counsellor places such a high value on authenticity and following the client's lead, they do not place the same focus on time and technique as a psychodynamic therapist. A person-centered counsellor may deviate significantly from traditional counselling procedures if they believe it is acceptable. We can't understand person-centered therapy just on the basis of its procedures, as **Mearns and Thorne (1988)** point out. The person-centered counsellor has a very happy and upbeat attitude toward people. The belief that people are fundamentally good and that, in the end, each person knows what is best for them is a crucial component of a successful person-centered therapy that is "all about love."

The first aim of this paper is study empathy, which is the ability to truly understand what others are going through, to see things from their point of view, and to put yourself in their shoes. It's essentially imagining another person's point of

view and feeling how they should feel. When you observe someone else suffering, you may automatically put yourself in their shoes and feel compassion for what they are going through. While most people are extremely sensitive to their own emotions and sensations, getting into another person's thoughts can be a little more difficult.

Secondly, this paper aims the importance of empathy in counselling. Client-centered and existential theories (Hartley, 1995) both place a strong emphasis on counsellor empathy and psychoanalytic theory (Bohart & Greenberg, 1997); Duan & Numerous studies on empathy and related topics have also been conducted associated constructs in psychodynamic therapy Gestalt therapy (Pearson, 1999), and behaviour therapy. Warmth, accurate empathy, and authenticity, are contributors to counsellor efficacy in cognitive therapy. These constructs, according to Beck et al., are necessary but not sufficient for optimal therapeutic impact. They claim that "accurate empathy improves therapeutic partnership" by assisting the therapist in "making sense of the patient's unproductive actions and being less judgemental about them". Empathy, according to Beck et al., has both an intellectual and an emotional component.

Third we see, how carl roger has defined empathy? **Rogers in 1998** defined empathy as "Empathy, in my opinion, is a therapeutic agent in and of itself. It is one of the most powerful components of therapy since it liberates, verifies, and reintegrates even the most terrified client into society. A person belongs if he or she is understood." Also he emphasized, Empathy to the ability to perceive the client's private world as if it were your own, but without losing the "as if" quality—and it appears to be vital to therapy. The situation we're attempting to express is the ability to perceive the client's rage, fear, or perplexity as if it were your own, but without becoming entangled in it. When the client's environment is like this, If the therapist's environment is clear to him and he is free to move around in it, he can both express his comprehension of what the client knows and speak meanings in the client's experience that the client isn't aware of.

Lastly we discussed, how empathy helps in counselling and psychotherapy? The current study trend is to identify empathy as a component of the therapeutic bond, which is thus recognised as a common characteristic among counselling modalities. Duncan and Moynihan's (1994) essay on the deliberate use of the client's frame of reference to achieve good outcomes is another current understanding of empathy. Despite the difficulties in defining and measuring empathy, our examination of the literature shows that empathy or a related interpersonal element is included in all counselling theories to some level. Many of the hypotheses discussed earlier in this page rely on it. Despite the fact that the majority of the evidence supported the necessity of empathy as a component, Rogers' key requirements of authenticity, empathy, and unconditional positive regard as adequate for therapeutic change have not been widely recognised, despite their success (Bohart & Greenberg, 1997). Empathy, on the other hand, remains a crucial term in therapy. Empathy is as relevant in the twenty-first century as it was in the 1950s when Rogers first defined the value of empathy in the therapeutic interaction, with origins in psychoanalytic thought and constructivist theory.

Gerald A. Gladstein in his paper *Understanding Empathy: Integrating Counseling, Developmental, and Social Psychology Perspectives* says Empathy has been established as critical to optimal outcomes in counselling and psychotherapy. Rogers' (1957) description of empathy as a source of inspiration one of the "conditions required and adequate for therapeutic personality transformation," There have been several publications on theory, research, and application. Simultaneously, psychoanalysts like Stewart (1956), Greenson (1967, 1978), & Kohut (1977, 1978) had written on empathy, building on Preud's (1921/1923) brief remarks on identification and empathy. Traux and Carkhufr appear to have established the importance of therapeutic outcomes (1967). Others, though, have questioned this finding in recent years. In their evaluation of the research, Bergin and Suinn (1975) concluded that empathy and many other facilitative factors are likely insufficient "unless in highly particular, client-centered type conditions."

Lambert, DeJulio, and Stein (1978) and Parloff, Waskow, and Wolfe (1978) questioned the role of empathy in psychotherapy in other reviews. Gladstein (1970, 1977) found inconsistent evidence after separating counselling and psychotherapy research. "In fact, the empirical data remains inconclusive despite the enormous number of theory, debate, case, and process papers indicating the beneficial association between empathy and counselling outcome" (1977).

V CONCLUSION

This basis of findings clearly demonstrates the multifaceted nature of empathy, Rogers and his associates' work in the 1950s and 1960s elevated empathy to significance in counselling and psychotherapy philosophy. The core conditions of genuineness, empathy, and unconditional positive regard proposed by Rogers (1957) as sufficient for therapeutic change have not been widely recognised (Bohart & Greenberg, 1997). Empathy, on the other hand, remains a crucial term in therapy. Empathy is as relevant in the twenty-first century as it was in the 1950s, when Rogers first defined the value of empathy in the therapeutic interaction. It has roots in psychoanalytic thought and has since evolved into constructivist theory. Also this research suggests that empathy is important in clients' and potential clients' opinions of a therapist. It can also be argued that information about the counsellors' ethnicity has a significant impact on their perceptions.

Empathy is seen to be vital in therapy for establishing and maintaining a counselling connection. Client preferences can lead to different expectations. Some clients desire a strong emotional bond with their therapist (Of course, this might be a good thing or a bad thing.) If that's the case, both affective and cognitive empathy would likely be beneficial it is state that, too much emotional contagion at this moment can result in countertransference and counsellor withdrawal. As I believe that role playing would be extremely useful in this situation. Clients who desire a neutral emotional interaction, on the other hand, may find therapist emotional contagion to be too dangerous. Even role-playing might cause problems because the therapist is clarifying or reflecting the client's feelings and views.

I hope that in the future, the researcher would distinguish between dispositional and state empathy, intellectual empathy and empathetic feeling, and whether they are looking at the therapist's or the client's experience of empathy. In order to comprehend the therapeutic empathic experience, various situational elements and cultural differences must be examined, and the importance of such empathic experiences must be recognised through research into the settings in which empathy is beneficial.

VI REFERENCES

1. Gladstein, G. A. (1983). Understanding empathy: Integrating counseling, developmental, and social psychology perspectives. *Journal of counseling psychology*, *30*(4), 467.
2. Jani, B. D., Blane, D. N., & Mercer, S. W. (2012). The role of empathy in therapy and the physician-patient relationship. *Complementary Medicine Research*, *19*(5), 252-257.
3. Jani, B. D., Blane, D. N., & Mercer, S. W. (2012). The role of empathy in therapy and the physician-patient relationship. *Complementary Medicine Research*, *19*(5), 252-257.
4. Price, V., & Archbold, J. (1997). What's it all about, empathy? *Nurse education today*, *17*(2), 106-110.
5. Duan, C., & Hill, C. E. (1996). The current state of empathy research. *Journal of counseling psychology*, *43*(3), 261.
6. Bohart, A. C., & Greenberg, L. S. (1997). Empathy and psychotherapy: An introductory overview.
7. Sinclair, S. L., & Monk, G. (2005). Discursive empathy: A new foundation for therapeutic practice. *British Journal of Guidance & Counselling*, *33*(3), 333-349.
8. Gould, D. (1990). Empathy: a review of the literature with suggestions for an alternative research strategy. *Journal of Advanced Nursing*, *15*(10), 1167-1174.
9. Squier, R. W. (1990). A model of empathic understanding and adherence to treatment regimens in practitioner-patient relationships. *Social science & medicine*, *30*(3), 325-339.
10. Rogers, C. R. (1975). Empathic: An unappreciated way of being. *The counseling psychologist*, *5*(2), 2-10.
11. Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy*, *48*(1), 43.
12. Greenberg, L. S., Elliott, R., Watson, J. C., & Bohart, A. C. (2001). Empathy. *Psychotherapy: Theory, research, practice, training*, *38*(4), 380.
13. Kahn, E., & Rachman, A. W. (2000). Carl Rogers and Heinz Kohut: A historical perspective. *Psychoanalytic Psychology*, *17*(2), 294.
14. Redfern, S., Dancey, C. P., & Dryden, W. (1993). Empathy: Its effect on how counsellors are perceived. *British Journal*

of Guidance & Counselling, *21*(3), 300-309.

15. Churchill, S., & Bayne, R. (2001). Psychological type and conceptions of empathy in experienced counsellors: Qualitative results. *Counselling Psychology Quarterly*, *14*(3), 203-217.
16. Reynolds, W. J., Scott, B., & Jessiman, W. C. (1999). Empathy has not been measured in clients' terms or effectively taught: a review of the literature. *Journal of advanced nursing*, *30*(5), 1177-1185.
17. Lim, B. T., Moriarty, H., Huthwaite, M., Gray, L., Pullon, S., & Gallagher, P. (2013 *Medical teacher*, *35*(2), e946-e951.
18. Truax, C. B. (1966). Reinforcement and no reinforcement in Rogerian psychotherapy. *Journal of abnormal psychology*, *71*(1), 1.
19. Gerdes, K. E., Segal, E. A., & Lietz, C. A. (2010). Conceptualising and measuring empathy. *British Journal of Social Work*, *40*(7), 2326-2343.
20. Brunero, S., Lamont, S., & Coates, M. (2010). A review of empathy education in nursing. *Nursing inquiry*, *17*(1), 65-74.
21. Bambling, M., King, R., Reid, W., & Wegner, K. (2008). Online counselling: The experience of counsellors providing synchronous single-session counselling to young people. *Counselling and Psychotherapy Research*, *8*(2), 110-116.
22. Hojat, M., Gonnella, J. S., Nasca, T. J., Mangione, S., Vergare, M., & Magee, M. (2002). y. *American Journal of Psychiatry*, *159*(9), 1563-1569.
23. Thwaites, R., & Bennett-Levy, J. (2007). Conceptualizing empathy in cognitive behaviour therapy: Making the implicit explicit. *Behavioural and Cognitive Psychotherapy*, *35*(5), 591-612.