The American Journal of Medical Sciences and Pharmaceutical Research
ISSN 2689-1026 | Open Access

TYPE Original Research
PAGE NO. 28-34
DOI 10.37547/tajmspr/Volume07Issue08-05

Check for updates

The Role of Empathy and the Therapeutic Information Field in Contemporary Psychosomatic Practice

Korobeinikova Olga Ivanovna
Director General Autonomous non-profit organization of additional professional education "Academy of Conscious Thinking" (ANO DPO "AOM") Madrid, Spain

OPEN ACCESS

SUBMITTED 15 July 2025
ACCEPTED 05 August 2025
PUBLISHED 21 August 2025
VOLUME Vol.07 Issue 08 2025

CITATION
Korobeinikova Olga Ivanovna. (2025). The Role of Empathy and the Therapeutic Information Field in Contemporary Psychosomatic Practice. The American Journal of Medical Sciences and Pharmaceutical Research, 7(8), 28–34. https://doi.org/10.37547/tajmspr/Volume07Issue08-05

Abstract

This article presents a theoretical and analytical review of the mechanisms underlying the formation and maintenance of therapeutic interaction in the context of home-based palliative care, with a focus on the role of empathy, emotional intelligence, and the practitioner's sensitivity to meaning. The study is based on an interdisciplinary approach that integrates clinical phenomenology, empathic diagnostics, and practices of humanistically oriented care. Special attention is given to the analysis of validated empathy and compassion scales as sensitive indicators of emotional distress and vulnerability — both on the part of the patient and the accompanying professional. Three key categories of risks characteristic of the home-based palliative context are identified: clinical, communicative, and emotional-semantic. For each, empathy-oriented support strategies are proposed, including compassionate observation, trust-based confirmation of understanding, and telemedical empathy. The importance of differentiating between cognitive and affective empathy is emphasized in the interpretation of therapeutic risks, the development of a stable therapeutic alliance, and the preservation of the patient's subjective sense of safety. The central concept proposed is that of the therapeutic information field, understood as a dynamic structure responsive to the patient's physical, emotional, and spiritual condition. Its significance is substantiated as a foundation for adaptive and ethically attuned support, capable of integrating narrative, existential, and clinical-social dimensions of care. The

article will be of interest to professionals in palliative medicine, psychosomatic therapy, ethics of care, clinical psychology, and interdisciplinary support for vulnerable patient populations.

Keywords: empathy, palliative care, emotional intelligence, psychosomatics, therapeutic field, phenomenology, compassion, home care, clinical risks, narrative approach.

Introduction

In recent years, there has been a steady rise in the proportion of patients receiving palliative care outside hospital settings, predominantly at home. This shift is driven by demographic and economic factors and by patients' growing preference for care that prioritizes the quality of remaining life, meaningful experiences, and emotional connectedness rather than the invasive prolongation of biological processes. Yet home-based palliative care entails a number of systemic and communicative risks. The most salient include fragmented collaboration among professionals, delayed recognition of clinical deterioration, diminished sensitivity to the patient's inner life, and pronounced cognitive and emotional destabilization of both the patient and the surrounding social network [2].

Patients with progressive chronic and terminal illnesses—already burdened by physical exhaustion, social isolation, and existential disorientation—are particularly vulnerable. In such cases, traditional biomedical models for assessing and monitoring care quality prove insufficient because they fail to encompass the depth of subjective suffering and the crises of meaning that patients face. There is a growing need to rethink the very foundations of quality assurance in palliative support in favor of models capable of addressing both the bodily and the emotional-spiritual dynamics of dying.

Foremost among emerging requirements is the integration of formal care instruments with approaches grounded in empathy, emotional intelligence, and the practitioner's spiritual sensitivity. Within this context, empathy acquires clinical and existential significance: it underpins supportive presence, therapeutic trust, and the capacity to perceive intangible signals of distress that elude standard classification. A practitioner's emotional intelligence, in turn, makes it possible to maintain inner equilibrium, exercise subtle self-regulation in emotionally charged interactions, and remain present without sacrificing professional stability [1].

Meditation and mindfulness practices offer an additional resource. They deepen contact with the patient, strengthen empathic responsiveness, and provide the therapist with an inner anchor. Such practices allow the practitioner to be both observer and co-participant, prepared to accompany the patient at the boundaries of pain, uncertainty, and transcendent experience.

The study seeks to analyze the role of emotional intelligence, empathic sensitivity, and spiritual connectedness as key factors in ensuring the quality of home-based palliative care under conditions of the patient's psychosomatic vulnerability. Particular emphasis is placed on understanding empathy not as a personality trait but as a regulator of the therapeutic space and a moderator of clinical, communicative, and existential risks.

Materials and Methods

This study employs a theoretical-analytical approach involving a multi-level reconstruction of the conceptual, empirical, and existential foundations of palliative care quality in the home-care setting. The primary strategy combined comparative analysis, thematic synthesis, and narrative analytics. This approach enabled identification of key interdisciplinary contexts that elucidate the role of emotional intelligence, empathy, and spiritual sensitivity in maintaining a sustainable therapeutic space. The analysis drew on peer-reviewed scientific publications spanning several areas:

- clinical and relational empathy;
- therapeutic alliance and the phenomenology of interaction;
- psychosomatic vulnerability and bodily self-experience;
- emotional intelligence and practitioners' self-regulation;
- mindfulness and compassion practices in care;
- spiritual and existential aspects of palliative support.

Howick [1] conducted a conceptual analysis of therapeutic empathy as a relational process critically important for establishing trust and sustaining contact. Irarrázaval [2] examines empathy as a phenomenologically rich experience capable of

mediating the meaning of suffering in the home context. Palumbo [3] highlights empathy as a resource for preventing professional burnout within trauma-centered therapy, a finding directly relevant to multidisciplinary palliative care teams.

Contributions to understanding spiritual sensitivity and the practitioner's existential readiness to accompany patients in extreme states come from Watson [10], who formulates compassion as an operationalizable ethical category essential for quality care of the dying, and von Boetticher [9], who emphasizes the need to develop practitioners' conceptual and philosophical competence to overcome a reductionist clinical-technical care model.

Additional studies on meditative and self-regulatory practices were reviewed, interpreting mindfulness as a method of psycho-emotional stabilization that deepens empathic engagement and reinforces the practitioner's inner resilience.

Thus, the present study views the therapeutic informational field as an integral interactional space shaped by empathic, emotionally intelligent, and spiritual signals. These parameters are not derived from administrative or protocol-driven procedures but are understood as key quality indicators mediating care dynamics under conditions of high psychosomatic and existential vulnerability.

Results

In the context of home-based palliative care, the challenge of risk management gains particular significance due to patients' high degree of bodily, psycho-emotional, and existential vulnerability, limited clinical oversight, and critical dependence on the quality of interpersonal interactions among professionals, family members, and the patient. The theoretical-analytical synthesis of source materials identified three key risk categories characteristic of palliative support at home:

- clinical risks;
- communication risks;
- emotional-existential risks.

Clinical risks encompass threats related to improper medication use, lack of timely monitoring, and overload of informal caregivers. Ruffalo [5] emphasizes that when caring for mentally vulnerable patients (including individuals with schizophrenia, dementia, and pronounced anxiety disorders), the likelihood of analgesic dosing errors, delayed responses to adverse effects, and insufficient coordination among care providers is especially high.

Communication risks cover situations of information distortion or loss arising from emotional overwhelm, misinterpretation of medical instructions, and absence of a trusting space for clarification. As Von Boetticher [9] notes, even terminological discrepancies between practitioner and patient (for example, differing understandings of "support," "deterioration," or "hope") can provoke anxiety, alienation, and frustration. Watson [10] further points out that a deficit of compassionate communication can exacerbate feelings of isolation and existential loneliness.

Emotional-existential risks manifest as a sense of abandonment, loss of meaningful orientation, disruption of the "self" narrative, and internal disorganization. Howick [1] demonstrates that deep empathic engagement by the practitioner can create a stabilizing therapeutic field in which such states may be partially processed through support, joint narration, and sustained presence.

A consolidated overview of these risk categories and their corresponding empathy-oriented support strategies is presented in Table 1.

Table 1 – Main categories of risk in palliative care and corresponding empathy-oriented support strategies (Compiled by the author based on sources: [5], [9], [10])

Risk category	Manifestations in practice	Empathy-oriented strategy
Medication-related risk	Overdose, missed doses, patient anxiety about treatment	Compassionate monitoring, gentle clarification, emotional attunement to the patient's rhythm
Communication	Misunderstanding instructions,	Verification of understanding through trust,

Risk category	Manifestations in practice	Empathy-oriented strategy
breakdown	shifts in meaning, withholding of concerns	slowing the pace of communication, clarifying without pressure
Emotional-existential destabilization	Feelings of abandonment, alienation, existential anxiety	Telemedicine empathy, narrative listening, symbolization of feelings and meanings

In the context of home-based palliative care, where formal clinical and logistical procedures inevitably intertwine with deeply personal, emotionally intense, and often existential interactions, intangible quality indicators assume particular importance. Among these parameters is empathy — both as subjectively experienced by the patient and professionally enacted by practitioners. It is empathy that sustains a stable field of trust, reduces internal destabilization, and fosters a sense of shared presence in extreme life situations.

In recent years, standardized instruments for assessing empathic states have been developed, capable of serving as sensitive indicators of the emotional climate within the care system. Their implementation enables detection of communication breakdowns and emotional exhaustion risks, as well as monitoring the evolution of care quality at the level of interpersonal experience. For example, Vieten [8] provides a comprehensive review of scales suitable for analyzing practitioners' empathic engagement. One of the most valid is the Interpersonal Reactivity Index (IRI), designed to measure cognitive and affective empathy in medical staff and caregivers. Scores on this scale capture practitioners' emotional responsiveness, the subtlety of perceiving others' suffering, and the presence of supportive compassionate responses, while also revealing tendencies toward emotional overload and reduced sensitivity over long-term interactions.

Subjective perception of empathy by the patient can be reliably measured using the CARE measure — a tool aimed at evaluating the quality of interpersonal interaction. As Watson et al. [10] note, this scale provides direct feedback on the patient's experience of the professional relationship and indirectly gauges the depth and stability of the therapeutic alliance, the degree of co-presence, and attention to the meaningful aspects of the patient's concerns.

The internal state of both practitioners and patients can be partly assessed with the Self-Compassion Scale (SCS), which focuses on levels of self-empathy and the capacity for compassionate acceptance of one's own limitations, pain, and frustration. Despite its limited use in clinical management, this instrument can serve as an internal indicator of professional resilience, especially when working with emotionally intense cases, extreme requests, and existentially challenging patient groups. A summary of the discussed scales, along with their functional applicability in the context of home-based palliative care, is presented in Table 2.

Table 2 – Approaches to Measuring Empathy and Compassion in Home-Based Palliative Care (Compiled by the author based on sources: [6], [8], [10])

Scale	Target Population	Measured Components	Practical Applicability
Interpersonal Reactivity Index	Medical staff, caregivers	Affective and cognitive empathy	Monitoring empathic responsiveness; preventing burnout
CARE measure	Patients	Relational empathy	Feedback on interaction quality; therapeutic alliance adjustment

Scale	Target Population	Measured Components	Practical Applicability
Self-Compassion Scale	Patients and practitioners	Self-empathy; emotional regulation	Internal self-monitoring; resource support for professionals

As shown in Table 2, each of these scales allows assessment of different facets of empathic interaction in palliative care — from professional resilience to the subjective validity of relationships. Their adoption significantly broadens the understanding of care quality beyond protocol-driven and biomedical criteria, drawing on the deeper structure of human contact, co-presence, and meaningful responsiveness.

Discussion

Despite the institutionalized importance of risk-management strategies in healthcare, their classic configuration reveals significant limitations when applied to home-based palliative care. Standardized control models—relying predominantly on clinical-administrative indicators—are unable to capture the nuanced emotional-existential, interpersonal, and existential parameters that prove critical for patients in terminal stages.

As Von Boetticher [9] emphasizes, the traditional medical model overlooks the deeper facets of clinical competence: the practitioner's capacity to recognize the internal context of suffering, interpret behavioural and symbolic signals of disorganization, and create a therapeutic field that transcends biomedical reduction. In the home-care environment—where rigid institutional protocols are absent and relational dependencies are intensified—these shortcomings become especially pronounced: many key processes unfold in the non-verbalizable spaces of proximity, co-presence, and trust, eluding conventional quantification. Watson's research [10] underscores that much palliative suffering carries a transcendent and existential dimension, irreducible to symptom checklists or logistical metrics. Evaluating care quality solely by formal measures risks devaluing patient experience, fracturing the therapeutic alliance, and causing secondary trauma. Moreover, Rodríguez-Nogueira et al. [4] demonstrate that, without empathic exchange between practitioner and patient, the therapeutic alliance becomes fragmented and unstable, so that even technically correct interventions fail to stabilize suffering. Rubin [6] further notes that, even in a high-tech setting saturated with algorithms and artificial intelligence, nothing can replace affective responsiveness, motivational rapport, and empathic intuition—elements that constitute genuine therapeutic support. It becomes evident that care quality hinges not only on protocol but on human availability at moments of utmost vulnerability.

Another key limitation of traditional approaches lies in the undervaluation of intangible indicators—such as empathy, compassion, subtle responsiveness, and emotional presence. Although validated scales exist [8], they are seldom integrated into routine practice as monitoring tools. This omission forfeits the opportunity to detect empathic breakdowns in time—breakdowns that, as Ruffalo's data reveal, can trigger a cascade of serious clinical-communicative consequences [7].

One of the most promising directions for advancing home-based palliative care lies in conceptualizing the therapeutic informational field as a space where empathic resonance, semantic responsiveness, and relational dynamics among patient, family, and practitioners converge. Such a model overcomes the classic "procedure–outcome" dichotomy by incorporating subtle intersubjective and emotional-semantic parameters into quality assessment—parameters that cannot be formalized yet exert a direct influence on the stability of care.

A key distinction in this context is between cognitive and affective empathy, as proposed by Irarrázaval [2]. Cognitive empathy involves mentalizing and accurately interpreting another's internal state, whereas affective empathy entails emotional attunement and shared experience. In palliative practice, these two forms of empathy function synergistically: cognitive empathy enables practitioners to detect early signals of distress, while affective empathy fosters an atmosphere of trust, loyalty, and existential engagement.

Rubin's study [6] underscores that even within

automated decision-making systems, empathy remains an unreplicable factor in sustaining therapeutic impact—especially when patients experience fragmented consciousness or confront the irreversibility of their condition, making decisions less algorithmic and more rooted in interpretation of deep personal experience. The concept of compassion also offers additional heuristic value as a regulatory mechanism in practitioner practice. Watson [10] notes that compassion serves as a form of calibration: it helps maintain the boundary between engagement and burnout, mobilizes attention, shapes communication, and minimizes emotional exhaustion. Table 3 systematizes the core elements of the therapeutic informational field and their functional effects in palliative support.

Table 3 – Elements of the therapeutic informational field and their functional significance in palliative care (Compiled by the author based on sources: [1], [3], [10])

Field element	Function and effect	Context of application
Empathic resonance	Increases trust, reduces sense of abandonment	Contact with patient and family, feedback
Semantic awareness	Facilitates cognitive integration of diagnosis, reduces anxiety	Discussing prognosis, supporting difficult decisions
Dialogicality	Reveals non-medical dimensions of suffering, enhances subjective control	Joint planning, narrative communication

These elements are not reducible to external administrative structures. They form the internal fabric of palliative interaction, shaping trust, retention, and profound connectedness. The therapeutic informational field functions not as a mere tool or methodology but as an ontological reality of interaction—within which the meanings of care unfold, acute forms of suffering are alleviated, and the grounds for a dignified presence in extreme states are established.

Conclusion

The conducted study synthesized and conceptually structured contemporary approaches to understanding risks in home-based palliative care through the prism of empathic sensitivity, phenomenological receptivity, and the practitioner's existential openness. It demonstrated that embedding both cognitive and affective empathy within the architecture of clinical reasoning opens fundamentally new horizons for designing personalized and sustainable care, especially in contexts of high psychosomatic and existential vulnerability.

The necessity of incorporating intangible quality indicators—such as levels of empathic responsiveness, depth of co-presence, semantic integration of diagnosis, and subjective sense of safety—has been substantiated. The relevance of applying validated scales for empathy, compassion, and self-compassion as tools to monitor the emotional states of patients and practitioners has been illustrated; these instruments can serve as early markers of distress and professional burnout.

The proposed concept of the therapeutic informational field is presented as an intrinsic, dynamic structure formed through relational contact, which determines both intervention effectiveness and the depth of human presence. This field unites empathic resonance, semantic awareness, and dialogicality as key quality parameters that transcend formalized metrics.

Thus, the presented model highlights the need to move from reductionist approaches to an empathic-humanistic paradigm of support, in which patient suffering is understood not as a biomedical failure but as an experience warranting respect, responsiveness, and shared presence. The theoretical outcomes lay the groundwork for further empirical research, clinical validation, and interdisciplinary integration into palliative care practice at both the individual and systemic levels.

References

1. Howick J., Bennett-Weston A., Dudko M., Eva K. Uncovering the components of therapeutic

empathy through thematic analysis of existing definitions [Electronic resource] // Patient Education and Counseling. 2025. Vol. 131. P. 108596. URL: https://doi.org/10.1016/j.pec.2024.108596 (accessed: 09.07.2025).

2. Irarrázaval L., Kalawski J.P. Phenomenological considerations on empathy and emotions in psychotherapy [Electronic resource] // Frontiers in Psychology. 2022. T. 13. P. 1000059. URL: https://doi.org/10.3389/fpsyg.2022.1000059 (access date: 07/10/2025).

3. Palumbo A., Wezyk A., Woodward A., Panourgia C. The empathetic landscape: Examining the role of empathy in the well-being of counselors and psychotherapists working with trauma [Electronic resource] // Counseling and Psychotherapy Research. 2024. URL: https://doi.org/10.1002/capr.12778 (access date: 07/11/2025).

4. Rodríguez-Nogueira O., Leirós-Rodríguez R., Pinto-Carral A., et al. The association between empathy and the physiotherapy–patient therapeutic alliance: A cross-sectional study [Electronic resource] // Musculoskeletal Science and Practice. 2022. Vol. 59. P. 102557. URL: https://doi.org/10.1016/j.msksp.2022.102557 (accessed: 12.07.2025).

5. Ruffalo M.L., Kottapalli M., Anbukkarasu P. Empathy in the Care of Individuals With Schizophrenia: A Vital Element of Treatment [Electronic resource] // American Journal of Psychotherapy. 2023. Vol. 77, No. 1. URL: https://doi.org/10.1176/appi.psychotherapy.20230022 (accessed: 13.07.2025).

6. Rubin M., Arnon H., Huppert J.D., Perry A. Considering the Role of Human Empathy in AI-Driven Therapy [Electronic resource] // JMIR Mental Health. 2024. Vol. 11. P. e56529. URL: https://doi.org/10.2196/56529 (accessed: 14.07.2025).

7. Stefanello E. Intuition, empathy, and intellectual humility in psychotherapy. A philosophical perspective [Electronic resource] // Frontiers in Psychology. 2025. Vol. 16. URL: https://doi.org/10.3389/fpsyg.2025.1590481 (accessed: 15.07.2025).

8. Vieten C., Rubanovich C.K., Khatib L., et al. Measures of empathy and compassion: A scoping review [Electronic resource] // PLOS ONE. 2024. URL: https://doi.org/10.1371/journal.pone.0297099 (date of access: 15.07.2025).

9. Von Boetticher D. Conceptual competence in medicine: promoting psychosomatic awareness in clinics, research and education [Electronic resource] // Frontiers in Psychiatry. 2025. Vol. 16. URL: https://doi.org/10.3389/fpsyt.2025.1500638 (date of access: 15.07.2025).

10. Watson T., Waters R., Watts L., Hodgson D. Exploring the Challenges of Empathy in a Therapeutic Context: An Interpretative Phenomenological Analysis [Electronic resource] // Qualitative Health Research. 2025. Vol. 0, No. 0. URL: https://doi.org/10.1177/10497323251331460 (accessed: 16.07.2025).