

EMPATHY AS ONTOLOGICAL ORIENTATION: EMBODIMENT, THERAPEUTIC PRESENCE AND MIRROR-TOUCH SYNAESTHESIA

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Empathy is widely regarded as a foundational element of effective psychotherapy and is routinely framed as a core clinical skill within training and accreditation frameworks. Despite this consensus, persistent conceptual and experiential tensions remain regarding whether empathy can genuinely be taught or whether it reflects a deeper, dispositional mode of being that precedes formal instruction. This paper argues that empathy cannot be meaningfully taught as a technique because it is not fundamentally a skill but an ontological orientation towards others grounded in embodied, pre-reflective and relational processes. Drawing on humanistic psychotherapy, phenomenology, psychoanalytic theory and contemporary neuroscience, empathy is conceptualised as a way of being-with rather than a procedural competency. Particular attention is given to mirror-touch synaesthesia (MTS), a neurophenomenological condition in which observing touch to another evokes tactile sensation in the observer's own body. MTS is examined as an intensified manifestation of empathic embodiment that illuminates the involuntary and perceptual foundations of empathic resonance. The paper critiques skill-based pedagogies of empathy and proposes a shift in therapist education towards formation practices that cultivate reflexivity, affect tolerance and ethical presence. Implications for psychotherapy training, clinical practice and professional ethics are discussed.

KEYWORDS: EMBODIMENT, EMPATHY, MIRROR-TOUCH SYNAESTHESIA, ONTOLOGY, PSYCHOTHERAPY, THERAPEUTIC PRESENCE

INTRODUCTION

Empathy occupies a central position in psychotherapy theory, research and practice. Across therapeutic orientations, it is consistently associated with positive clinical

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outcomes, stronger therapeutic alliances and higher levels of client satisfaction (Elliott, Bohart, Watson, & Greenberg, 2011). Consequently, empathy has become institutionalised as a core professional competency within psychotherapy training, accreditation standards, and ethical frameworks. Trainees are expected to demonstrate empathy through observable behaviours such as reflective listening, emotional validation, perspective-taking and responsive communication.

Despite this centrality, empathy remains conceptually contested. Across psychotherapy, philosophy, counselling and neuroscience, empathy has been variously conceptualised as a clinical skill, interpersonal process, dispositional capacity, ethical stance, relational phenomenon and embodied mode of being (Levitt, Pomerville, Surace, & Greifenstern, 2022; Watson, 2016). This conceptual diversity reflects an ongoing lack of consensus regarding the nature of empathic understanding itself. More importantly, it raises questions about the assumptions underpinning contemporary psychotherapy education. While empathic behaviours can be observed, taught, and assessed, it remains unclear whether such behaviours adequately capture the phenomenon they are intended to represent.

Recent scholarship has increasingly questioned reductionistic accounts of empathy. Contemporary researchers argue that empathy is not a singular construct but a multidimensional phenomenon encompassing cognitive, affective, embodied, cultural and ethical processes that interact in complex ways (Levitt et al., 2022; Palumbo, Mucci, Arcangeli, & Giorgi, 2024). These developments have shifted the debate from whether empathy matters in psychotherapy to how empathy should be understood, cultivated and enacted within increasingly diverse therapeutic contexts. At the same time, multicultural and relational perspectives have highlighted the limitations of equating emotional resonance with genuine understanding, emphasising the importance of cultural humility, reflexivity and awareness of the limits of one's own perspective. Phenomenological and relational scholarship has increasingly located empathy within embodied intersubjective processes rather than communicative skills alone (Fuchs, 2017, 2024; Zahavi, 2021).

This paper argues that empathy is best understood as an ontological orientation rather than a teachable technique. While aspects of empathic communication can undoubtedly be developed through education and training, the deeper foundations of empathic understanding arise from embodied, relational and ethical forms of engagement that resist proceduralisation. Drawing upon phenomenology, psychoanalysis, neuroscience and contemporary multicultural scholarship, this paper examines empathy as a pre-reflective mode of being with others. Mirror-touch synaesthesia (MTS) is explored as a particularly vivid illustration of involuntary embodied resonance, highlighting the extent to which empathic responsiveness may be rooted in perceptual and affective processes that precede conscious intention. This paper concludes by arguing that psychotherapy education should move beyond competency-based models towards approaches that prioritise therapist formation, reflective practice, embodied awareness and cultural humility as foundations for empathic development.

COGNITIVE AND AFFECTIVE EMPATHY

Any discussion concerning the teachability of empathy requires clarification of what is meant by empathy itself. Although often treated as a singular construct within psychotherapy training and professional discourse, empathy is increasingly recognised as a multidimensional phenomenon comprising distinct but interrelated processes. One of the most influential frameworks is the distinction between cognitive and affective empathy proposed by Decety and Jackson (2004), which has informed research across psychology, psychotherapy and neuroscience.

Cognitive empathy refers to the capacity to understand another person's perspective, beliefs, intentions and emotional states. It involves perspective-taking, mentalisation and reflective understanding while maintaining awareness of the distinction between self and other. Within psychotherapy, cognitive empathy enables therapists to formulate clinical hypotheses, appreciate alternative perspectives and understand the contextual meanings underlying clients' experiences. Importantly, cognitive empathy appears relatively amenable to educational interventions, supervision and reflective training practices.

Affective empathy, by contrast, refers to the capacity to resonate emotionally with another person's experience. Rather than relying primarily on deliberate perspective-taking, affective empathy involves spontaneous emotional responsiveness and embodied attunement. Decety and Jackson (2004) suggest that such resonance is rooted in neural and bodily processes that often operate outside conscious awareness. Within psychotherapy, affective empathy is closely associated with clients' experiences of feeling emotionally recognised, understood, and accompanied in their distress.

Contemporary scholarship has highlighted the limitations of reducing empathy to either cognitive understanding or emotional resonance alone. Cuff, Brown, Taylor, and Howat (2016) conclude that empathy encompasses emotional, cognitive, behavioural and relational dimensions that resist simple categorisation. More recent psychotherapy literature has further expanded this understanding by emphasising the cultural, ethical and interpersonal contexts within which empathy occurs. Levitt et al. (2022) argue that effective empathy extends beyond interpersonal skill acquisition and requires reflexivity, cultural awareness, emotional openness and relational presence. Empathic understanding therefore emerges through the interaction of cognitive insight, affective responsiveness, embodied awareness and sensitivity to social and cultural contexts.

This distinction is central to the present argument. While aspects of cognitive empathy can be enhanced through education, supervision and reflective practice, affective empathy appears more deeply rooted in embodied and relational processes. The ability to understand another person's perspective differs from the capacity to be emotionally affected by their experience. Although these dimensions frequently interact, they are not identical, nor do they appear equally amenable to technical instruction.

Empathy therefore appears to exceed the status of a discrete professional competency. Particularly in its affective and embodied forms, it may be better understood as an ontological orientation: a way of being with others grounded in openness, responsiveness and participation in shared human experience. From this perspective, empathy is not simply something therapists do but a relational stance that underpins and gives meaning to therapeutic technique.

EMPATHY IN PSYCHOTHERAPY THEORY

Having distinguished between cognitive and affective dimensions of empathy, it is important to examine how empathy has been conceptualised within psychotherapy theory itself. Empathy has long occupied a central place within psychotherapy theory. Rogers (1957) identified empathy as one of the necessary and sufficient conditions for therapeutic change, describing it as the therapist's capacity to enter the client's perceptual world 'as if' it were their own while maintaining awareness of the distinction between self and other. In this formulation, empathy is not merely an intellectual understanding of another person's experience but a relational and experiential form of engagement.

Although contemporary psychotherapy training increasingly includes reflective and relational dimensions, empathy is frequently operationalised through observable behaviours such as paraphrasing, emotional reflection, validation and summarising (Watson, 2016). Such practices undoubtedly support therapeutic communication and may facilitate clients' experiences of being understood. However, they also risk reducing a complex relational phenomenon to a series of measurable competencies. As Mearns and Cooper (2018) argue, empathic techniques are not synonymous with empathy itself. Therapists may demonstrate the outward markers of empathy while remaining emotionally disconnected from the client's lived experience.

This distinction reflects a broader tension within psychotherapy education between relational depth and professional standardisation. In efforts to improve accountability and assessment, complex interpersonal processes are frequently translated into competencies that can be taught, practised and evaluated. While such developments have clear educational advantages, they may also obscure aspects of empathy that resist proceduralisation. Empathy becomes understood primarily as something therapists do rather than as a way of being with another person.

The present paper builds upon this tension by examining whether empathy is best conceptualised as a teachable clinical skill or as a more fundamental ontological orientation grounded in embodied and relational experience.

EMPATHY AS A WAY OF BEING: PHENOMENOLOGICAL PERSPECTIVES

Phenomenology offers a significant challenge to skills-based models of empathy by relocating empathic understanding from the level of technique to that of lived experience. Whereas competency frameworks typically conceptualise empathy as a set of observable behaviours that can be taught, practised and assessed, phenomenology understands empathy as emerging within the immediacy of human encounter.

Rather than asking how empathy is performed, phenomenology asks how another person's experience becomes meaningful in the first place. From this perspective, empathy is not primarily a cognitive achievement but an intersubjective process grounded in perception, embodiment and relational openness.

Early phenomenological accounts conceptualised empathy (*Einfühlung*) as a direct encounter with another person's subjectivity (Husserl, 1973). The other is not first experienced as an object requiring explanation but as a subject whose emotions, intentions and meanings are disclosed through bodily expression. When encountering someone in distress, one does not typically infer pain from neutral data and then construct an interpretation. Rather, suffering is perceived through gesture, posture, facial expression and tone of voice. Empathy therefore emerges not through detached analysis but through participation in a shared world of meaning.

This account contrasts with models that conceptualise empathy primarily as perspective-taking or imaginative simulation. While reflective understanding may contribute to empathic engagement, phenomenology argues that interpersonal understanding begins at a more immediate level of embodied perception. Human beings are already oriented towards one another as expressive subjects, and empathic contact is rooted in this pre-reflective responsiveness.

Contemporary phenomenological scholarship has extended these insights. Zahavi (2021) argues that empathy should not be understood as a process of reconstructing another person's inner world through inference. Instead, social understanding arises through direct engagement with the embodied presence of others. Emotions, intentions and meanings are not hidden behind behaviour but revealed through it. The other's subjectivity is encountered through participation in a shared social world rather than through detached observation.

These ideas have important implications for psychotherapy training. Competency-based approaches frequently assume that empathy can be broken down into discrete skills that can subsequently be taught and assessed. Reflective listening, emotional validation and perspective-taking become indicators of empathic competence. While such practices may communicate empathy, phenomenological perspectives caution against conflating the expression of empathy with empathy itself. Therapists may competently perform empathic behaviours while remaining emotionally detached from the client's experience. Conversely, moments of profound empathic connection may occur in the absence of elaborate technique.

A similar critique emerges in the work of Fuchs (2017, 2024), who conceptualises empathy as an expression of embodied intersubjectivity. Human understanding does not occur solely within individual minds but emerges through participation in a shared relational field. Meaning is co-created through affective resonance, mutual responsiveness and bodily engagement. Empathy is therefore not simply a competency possessed by the therapist but a relational event unfolding between therapist and client. Emotional understanding emerges through participatory sense-making rather than detached observation.

Merleau-Ponty (1962) further deepened this account by situating empathy within the lived body. For him, perception is always embodied; human beings encounter

the world through bodies already oriented toward others. Other people are not perceived as inert objects but as expressive beings whose emotions are communicated through movement, gesture and presence. The significance of another person's sadness, fear or joy is often apprehended directly through embodied encounter rather than deliberate reasoning.

Importantly, embodied responsiveness is not equivalent to emotional merging. Empathy depends upon maintaining a distinction between self and other while remaining open to being affected by the other's experience. The therapist may be moved or unsettled by a client's suffering without becoming overwhelmed by it. Such responsiveness requires the capacity to tolerate ambiguity, emotional intensity and uncertainty while remaining relationally present.

Collectively, phenomenological accounts suggest that empathy cannot be reduced to behavioural competence. While empathic skills may communicate understanding, the embodied openness and receptivity that make understanding possible are less amenable to standardisation and assessment. Empathy is therefore best understood not as a technique that therapists perform, but as a way of being with others grounded in embodied participation and relational openness.

EMPATHY ACROSS DIFFERENCE: MULTICULTURAL CONSIDERATIONS

While phenomenological accounts of empathy offer a compelling challenge to procedural and skills-based understandings of therapeutic encounter, they have also been criticised for assuming a degree of universality in human experience. Contemporary multicultural scholarship has questioned whether emotional resonance alone is sufficient for understanding experiences shaped by culture, race, ethnicity, religion, sexuality, gender, disability, migration and socioeconomic position. Such critiques are particularly relevant within psychotherapy, where therapists and clients frequently occupy different social and cultural worlds.

At the centre of this debate is the distinction between emotional resonance and cultural understanding. A therapist may feel deeply moved by a client's account of discrimination, migration, family conflict or identity struggle and yet misunderstand the cultural meanings through which that experience is organised. Emotional responsiveness does not necessarily guarantee interpretive accuracy. Indeed, overconfidence in one's empathic capacities may sometimes obscure important differences between therapist and client. The experience of feeling connected can create an illusion of understanding that reduces curiosity and limits exploration of the client's unique social and cultural context.

Recent psychotherapy scholarship has increasingly highlighted this concern. Levitt et al. (2022) argue that effective clinical empathy requires more than emotional attunement or interpersonal skill. Empathy also involves cultural awareness, reflexivity, openness to difference and recognition of the broader social contexts shaping experience. From this perspective, empathy is not merely an interpersonal process but also a cultural and ethical practice.

This challenge becomes particularly apparent when working across significant differences in race, ethnicity, religion, sexuality, gender identity, disability or social class. Experiences that appear familiar to the therapist may carry meanings that differ substantially from those generated within the therapist's own cultural framework. Concepts such as family obligation, spirituality, autonomy, shame, emotional expression and relational dependency are often understood differently across cultural contexts. Empathic resonance may therefore provide only partial access to the client's lived world unless accompanied by awareness of the assumptions through which understanding is constructed.

The concept of cultural humility offers an important response to this challenge. Hook, Davis, Owen, Worthington Jr., and Utsey (2017) argue that culturally responsive practice requires more than multicultural competence or the acquisition of knowledge about particular groups. Cultural humility involves an ongoing commitment to self-reflection, openness and recognition of the limits of one's own understanding. Rather than approaching the client as someone who can be fully known through professional expertise, the therapist remains curious about aspects of experience that may challenge existing assumptions and frameworks.

Contemporary intercultural research supports this position. Zhang and Noels (2024) argue that intercultural empathy involves both affective responsiveness and reflexive awareness of the cultural lenses through which understanding is shaped. Empathy therefore requires not only sensitivity to another person's emotional experience but also recognition that one's interpretations may be partial, incomplete, or influenced by unexamined assumptions. Intercultural understanding emerges not through certainty but through dialogue, negotiation of meaning and willingness to revise one's perspective.

Importantly, these multicultural critiques do not undermine the ontological account of empathy developed throughout this paper. Rather, they deepen it. If empathy is understood as openness to the other, then such openness must include openness to difference, ambiguity and the possibility of misunderstanding. The therapist's task is not to achieve perfect empathic accuracy but to remain receptive to experiences that exceed familiar categories and challenge existing assumptions. Empathy therefore involves not only recognising similarity but also encountering alterity.

This perspective carries important implications for psychotherapy training and practice. Therapists require opportunities to develop cultural reflexivity, examine implicit biases, engage critically with questions of power and privilege, and cultivate comfort with uncertainty. Such capacities cannot be reduced to behavioural competencies, yet they are essential for ethical therapeutic practice in increasingly diverse societies.

Ultimately, multicultural scholarship reinforces rather than weakens the central argument of this article. Emotional resonance remains an important dimension of empathy, but it is not sufficient in itself. Genuine empathic engagement requires humility, reflexivity and recognition of the limits of one's understanding. Empathy is therefore best understood not as a state of complete knowledge but as an ongoing

ethical and relational orientation characterised by openness to both connection and difference.

PSYCHOANALYTIC PERSPECTIVES: EMPATHY, RECOGNITION AND THE UNCONSCIOUS BODY

Within psychoanalysis, empathy occupies a complex and evolving position. Unlike approaches that conceptualise empathy as a discrete clinical skill, psychoanalytic traditions have tended to locate empathic understanding within broader questions of receptivity, unconscious communication and relational depth. This orientation reflects a longstanding tension between technique and presence: between what the therapist does and how the therapist is with the patient.

Freud's early writings already contained a scepticism towards excessive technique that remains relevant to contemporary debates regarding empathy training. In his recommendations to analysts, Freud (1912/Freud, 1958) advocated evenly suspended attention, a stance in which the analyst avoids imposing preconceived frameworks upon the patient's material and remains open to whatever may emerge. Although Freud did not explicitly theorise empathy, this position implies a receptive orientation that resists procedural control. Understanding arises not through the application of technique but through openness to the unfolding analytic encounter.

Bion (1962) extended this emphasis on receptivity through his injunction that analysts work without memory, desire or understanding. These terms refer not only to conscious intentions but also to the analyst's tendency to impose coherence prematurely upon emotional experience. Genuine analytic work requires tolerating uncertainty and remaining open to experiences that have not yet acquired meaning. From this perspective, empathy depends less on technical proficiency than on the therapist's capacity to remain present in the face of ambiguity, emotional intensity and not-knowing.

Kohut's self-psychology marked a significant shift by explicitly foregrounding empathy as the primary mode of psychoanalytic understanding. Kohut (1984) conceptualised empathy as vicarious introspection, an experiential immersion in the patient's subjective world that enables the therapist to understand experience from within. Importantly, empathy was not conceived as an intervention but as a mode of knowing. It was the means through which understanding became possible rather than a technique applied to produce therapeutic change. This distinction preserves empathy as a relational stance rather than a professional tool.

Relational and intersubjective psychoanalytic traditions further challenge individualistic conceptions of empathy. Stolorow, Atwood, and Orange (2002) argue that therapeutic understanding emerges within an intersubjective system shaped by the histories, expectations and affective worlds of both therapist and patient. Empathy is therefore not a stable property residing within the therapist but an emergent quality of the therapeutic relationship. It may deepen, falter or be transformed through moments of connection, rupture and repair. Such perspectives reinforce the view

that empathy cannot be fully standardised or reduced to a competency possessed by an individual practitioner.

A more extended clinical illustration may help clarify this process. A client entered therapy following the end of a long-term relationship. Across several sessions, he described the separation in a remarkably detached manner, focusing almost exclusively on practical concerns such as housing arrangements, finances and changes in daily routine. Although the material concerned a significant loss, little overt grief was expressed. The therapist repeatedly found themselves feeling unusually tired during sessions and struggled to maintain concentration despite otherwise feeling alert. Initially, these experiences were understood as personal fatigue. However, as the pattern persisted, curiosity emerged regarding whether the bodily response might reflect something occurring within the therapeutic relationship.

Over time, the therapist became aware of a subtle pressure to remain intellectually engaged while simultaneously feeling emotionally disconnected from the client. In supervision, this experience came to be understood as potentially reflecting an aspect of the client's internal world. Subsequent exploration revealed a longstanding history in which emotional needs had been minimised within the family and painful experiences managed through self-sufficiency and cognitive control. As the therapeutic relationship deepened, the client gradually described feeling 'numb' following the separation and acknowledged fears that emotional vulnerability would lead to humiliation or rejection.

What proved clinically significant was not that the therapist's fatigue provided direct access to the client's experience, but that it functioned as an embodied signal prompting further reflection. The countertransference experience became meaningful only through ongoing dialogue, supervision and collaborative exploration. Empathic understanding emerged neither through detached interpretation nor through emotional fusion but through sustained attention to what was occurring between therapist and client. Such examples illustrate how embodied responsiveness may contribute to clinical knowing while remaining open to multiple interpretations. The therapist's body becomes not a diagnostic instrument but a participant in an unfolding intersubjective process.

RECOGNITION BEYOND UNDERSTANDING

Contemporary relational theorists have increasingly argued that empathy alone may not adequately capture the ethical dimensions of therapeutic encounter. Rather than focusing exclusively on understanding another person's experience, they emphasise the importance of recognition. This shift is significant because it moves psychotherapy away from the ideal of complete understanding and towards an appreciation of the other's irreducible subjectivity.

Benjamin (2018) argues that recognition involves acknowledging the other as a separate subject with their own desires, meanings and forms of experience. Whereas empathy is often described as entering another person's world, recognition requires preserving awareness that aspects of that world will always remain beyond complete

understanding. Genuine therapeutic encounter therefore involves both connection and difference, both resonance and separateness. The therapist seeks understanding while simultaneously recognising that the client's subjectivity can never be fully assimilated into their own interpretive framework.

Contemporary relational and post-Bionian writers have further developed these themes. Ogden (2019) argues that analytic understanding frequently emerges through experiences that are initially felt before they can be thought, highlighting the importance of reverie, emotional participation and the analyst's capacity to dream the patient's experience. Similarly, Aron (2020) emphasises mutual influence within the analytic relationship, suggesting that therapeutic understanding arises through reciprocal processes of recognition rather than unilateral observation. Contemporary field theorists such as Civitarese and Ferro (2022) describe analytic work as a jointly created emotional field in which meanings emerge through shared affective experience rather than individual cognition alone. These perspectives reinforce the proposition that empathy is not primarily a technical accomplishment but a relational achievement grounded in embodied participation and openness to uncertainty.

Orange (2016) develops this argument through her emphasis on hermeneutic humility. All acts of understanding occur within particular cultural, historical and personal horizons. Consequently, therapists must remain open to the possibility that their interpretations are partial, incomplete or shaped by assumptions that have yet to be recognised. Clinical practice therefore requires humility, reflexivity and a willingness to be corrected. Such a stance is particularly important when working across cultural, racial, religious, gendered or socioeconomic differences where assumptions about understanding may easily obscure the client's unique experience.

THE UNCONSCIOUS BODY AND EMBODIED COUNTERTRANSFERENCE

Psychoanalytic theory has also long recognised that empathic understanding frequently emerges through bodily experience. Countertransference is often encountered not as a fully articulated thought but as a somatic response: tension, heaviness, fatigue, agitation, anxiety or inexplicable emotional shifts. Increasingly, such experiences are understood not as obstacles to therapeutic work but as potential sources of clinical knowledge.

Contemporary relational writers have conceptualised countertransference as an embodied form of participation within the therapeutic field (Benjamin, 2018; Orange, 2016). The therapist's body becomes a site through which aspects of the patient's emotional world may be registered before they can be consciously articulated. A sudden feeling of constriction, exhaustion or unease may signal dimensions of experience that remain unsymbolised within the patient's narrative. While such experiences require careful reflection rather than immediate acceptance, they highlight the extent to which empathic understanding is grounded in bodily and affective responsiveness.

From this perspective, empathy involves allowing oneself to be affected while maintaining sufficient reflective capacity to think about those experiences rather than

act them out. The therapist's body becomes not merely an instrument of observation but a participant in the relational process. Empathy therefore emerges through a complex interplay of unconscious communication, bodily attunement and reflective awareness.

Taken together, psychoanalytic perspectives challenge the assumption that empathy can be straightforwardly taught as a skill. Training and supervision may help therapists recognise, tolerate and reflect upon empathic experience, but empathy itself emerges through receptivity, recognition and embodied participation in the therapeutic relationship. Within psychoanalysis, empathy is best understood not as a competency to be mastered but as an ongoing ethical and relational mode of being with the other.

NEUROSCIENTIFIC FOUNDATIONS OF EMBODIED EMPATHY

Although psychoanalytic accounts emerged largely from clinical observation rather than experimental investigation, contemporary neuroscience has increasingly provided empirical support for the proposition that empathic understanding is rooted in embodied responsiveness. Over the past three decades, social neuroscience has increasingly challenged models that locate empathy primarily in deliberate reasoning, perspective-taking or learned communicative techniques. Instead, empathic responsiveness appears to arise from automatic perceptual and affective processes that precede conscious reflection.

Central to this development is research on mirror neuron systems. Originally identified in the premotor cortex of macaque monkeys, mirror neurons fire both when an individual performs an action and when they observe another performing the same action. Subsequent human research suggests that analogous neural systems are involved in the perception of actions, emotions and bodily states (Rizzolatti & Sinigaglia, 2016). Observing another person's pain, distress or emotional expression activates neural networks associated with similar experiences in the observer. Importantly, such activation occurs rapidly and often outside conscious awareness.

These findings align closely with phenomenological accounts of empathy as immediate and embodied. From a neuroscientific perspective, empathic understanding begins not with reflective judgement but with resonance. The observer's nervous system partially re-enacts aspects of another person's experience, creating a foundation for interpersonal understanding. However, contemporary scholars caution against reducing empathy to neural resonance alone.

DEBATES REGARDING NEURAL RESONANCE

Early enthusiasm surrounding mirror neuron research sometimes encouraged the view that empathy could be fully explained through neural simulation. More recent phenomenological and enactive scholars have challenged this assumption. More recent phenomenological and enactive scholars have challenged this assumption. Zahavi (2021) argues that while neural resonance contributes to empathic responsiveness, it cannot by itself explain meaning, intention, or subjectivity. Human

beings do not encounter isolated behaviours but meaningful persons situated within relational and social contexts. Similarly, Fuchs (2024) emphasises participatory sense-making, arguing that empathy unfolds within interpersonal encounters rather than solely within individual brains. Contemporary scholarship increasingly suggests that neural resonance is necessary but insufficient for empathic understanding.

Neuroscientific findings broadly support the distinction between cognitive and affective empathy proposed by Decety and Jackson (2004). Cognitive empathy involves perspective-taking and reflective understanding, whereas affective empathy concerns embodied emotional resonance. Although distinct, both contribute to therapeutic understanding, with research suggesting that clients often experience empathy through the integration of emotional presence and reflective comprehension (Cuff et al., 2016; Levitt et al., 2022).

THE EMOTIONAL COSTS OF EMPATHY

Neuroscientific research also highlights the ethical complexity of empathic engagement. Automatic resonance with another person's distress can be emotionally demanding and may expose therapists to significant psychological burden when adequate reflective supports are unavailable. Figley (2002) argued that repeated exposure to suffering can contribute to compassion fatigue, empathic distress and secondary traumatic stress, particularly when clinicians are unable to process the emotional impact of their work effectively.

More recently, Palumbo et al. (2024) found that counsellors and psychotherapists working with trauma frequently described empathy as simultaneously enriching and burdensome. Deep emotional attunement enhanced therapeutic connection while also increasing vulnerability to exhaustion, emotional depletion and vicarious suffering. These findings highlight the distinction between empathic openness and emotional overwhelm. The therapeutic task is not to eliminate resonance but to develop the reflective capacities necessary to remain emotionally available without becoming consumed by another person's experience.

Consequently, supervision, personal therapy, mindfulness and reflective practice should be understood not as protections against empathy but as conditions that enable empathic engagement to remain sustainable. Empathy is neither a simple skill nor an uncomplicated virtue. Rather, it is a complex relational capacity that requires ongoing containment, reflexivity and support.

Taken together, contemporary neuroscience supports the view that empathy is fundamentally embodied and relational. While aspects of empathy, particularly its cognitive dimension, can be refined through education, its affective foundations arise from perceptual and bodily processes that precede deliberate instruction. Neuroscience therefore reinforces the argument advanced throughout this article: empathy is less a transferable skill than an emergent property of embodied openness to the experience of another. One phenomenon that illustrates these embodied processes in particularly striking form is MTS.

MTS AS EMBODIED EMPATHY

MTS offers a vivid illustration of empathy as an embodied and perceptual phenomenon rather than a purely cognitive achievement. Before considering its implications for psychotherapy, it is important to situate MTS within the broader category of synaesthesia. Synaesthesia refers to a group of neuropsychological conditions in which stimulation in one sensory domain automatically evokes experiences in another. Individuals may, for example, perceive colours when hearing sounds or associate numbers with particular visual or spatial experiences. These responses are involuntary and experienced as genuine perceptual events rather than metaphorical associations.

MTS is one of the most socially significant forms of synaesthesia. In this condition, observing another person being touched evokes tactile sensations on the observer's own body, often corresponding to the location of the observed touch. Banissy, Kadosh, Maus, Walsh, and Ward (2009) estimate that MTS occurs in approximately 1.6% of the population. Although relatively uncommon, it has attracted considerable interest because it provides a unique window into the embodied foundations of interpersonal understanding.

MTS should not be understood as a direct analogue of ordinary empathy. Most individuals do not experience tactile sensations when observing another person being touched, and therapeutic empathy clearly does not depend upon synaesthetic perception. The significance of MTS lies elsewhere. As an extreme case, it makes visible processes that ordinarily remain implicit. Scientific understanding frequently relies upon atypical phenomena to illuminate more general mechanisms. Just as neurological lesions have contributed to understanding language and memory, MTS provides insight into the embodied foundations of social perception. The condition demonstrates that another person's experience can become registered within one's own bodily system prior to conscious reflection, supporting phenomenological and psychoanalytic accounts that conceptualise empathy as grounded in embodied responsiveness.

What distinguishes MTS is the apparent reduction of perceptual boundaries between self and other. Experiences that most individuals observe from a distance are partially experienced within the synaesthete's own body. Research suggests that individuals with MTS report heightened emotional sensitivity and elevated levels of affective empathy compared with non-synaesthetic populations (Banissy et al., 2009). While MTS should not be viewed as a direct model of ordinary empathy, it offers a particularly clear demonstration of how another person's experience can become registered within one's own perceptual and affective life.

From a theoretical perspective, MTS challenges models that conceptualise empathy primarily as perspective-taking or cognitive simulation. The synaesthete does not deliberately imagine another person's experience or consciously attempt to empathise. Rather, the experience of the other's touch is registered directly within their own somatosensory system. Empathy, in this context, appears less as a cognitive accomplishment and more as an event that happens to the observer. Its

involuntary nature highlights the extent to which empathic responsiveness may emerge prior to conscious intention or reflection.

Neuroimaging research supports this interpretation. Individuals with MTS show heightened activation in somatosensory cortices and mirror systems when observing touch to others (Blakemore, Bristow, Bird, Frith, & Ward, 2005). These findings suggest an unusually strong coupling between perception and bodily experience. Whereas most individuals maintain neural mechanisms that distinguish observed touch from personal sensation, synaesthetes appear to experience a reduced perceptual boundary between self and other. Importantly, this does not imply confusion of identity but rather an intensified form of embodied resonance. MTS therefore provides compelling support for the broader argument advanced throughout this paper: that empathy is rooted not only in cognition but also in embodied forms of perception and relational responsiveness that precede conscious reflection.

MTS AND CLINICAL INTERSUBJECTIVITY

The significance of MTS extends beyond neuroscience and raises important questions regarding the nature of therapeutic understanding. Although most therapists do not experience synaesthetic touch, MTS may be understood as an intensified manifestation of embodied processes that are present, albeit less explicitly, within ordinary interpersonal relationships. In this respect, MTS provides a useful lens through which to reconsider psychoanalytic and phenomenological accounts of empathy, countertransference and embodied participation.

Psychoanalytic theory has long recognised that therapists encounter aspects of their clients' emotional worlds through bodily sensations, affective shifts and seemingly inexplicable emotional responses. Contemporary relational approaches increasingly conceptualise such experiences not as obstacles to understanding but as potential sources of clinical knowledge. MTS makes visible a possibility that psychoanalytic clinicians have often described implicitly: that another person's experience may be communicated and apprehended through bodily channels that precede conscious reflection.

Consider a therapist listening to a client describe a recent assault. Although the client focuses primarily on the practical consequences of the event, the therapist becomes unexpectedly aware of tension in their shoulders and chest. The sensation is fleeting and open to multiple interpretations, yet it draws attention to dimensions of fear and vulnerability that remain largely absent from the client's narrative. Most therapists would not experience the tactile immediacy characteristic of MTS. Nevertheless, such moments illustrate how bodily resonance may contribute to empathic understanding. MTS can therefore be viewed as an intensified manifestation of processes that appear more subtly within ordinary therapeutic encounters.

This perspective resonates with Fuchs's (2017) account of embodied intersubjectivity. Human understanding emerges not solely through cognition but through participation in a shared affective and bodily field. Meaning is co-created through resonance, responsiveness and mutual regulation. Within psychotherapy, the

therapist's bodily responses may therefore constitute an important dimension of empathic understanding rather than a secondary accompaniment to it. What is often described clinically as intuition or felt sense may, in part, reflect embodied forms of participation that precede conscious conceptualisation.

Benjamin's (2018) theory of recognition offers a complementary perspective. Therapeutic encounter involves more than observing and interpreting another person's experience; it involves participation in an intersubjective process through which both therapist and client influence one another. Recognition requires acknowledging the other as a separate subject while remaining open to mutual impact. MTS illustrates the extent to which interpersonal experience may be embodied and relational rather than exclusively cognitive. Although therapeutic empathy is not identical to synaesthesia, the phenomenon highlights how understanding can emerge through participation rather than detached observation.

These considerations invite a reconsideration of the therapist's body as a source of clinical knowing. Psychotherapists frequently report experiences of heaviness, tension, sadness, fatigue or agitation that arise within sessions without obvious explanation. Within relational and phenomenological frameworks, such experiences may be understood as manifestations of embodied attunement. The therapist's body becomes a site where aspects of the therapeutic relationship are registered, processed and potentially understood. MTS provides an extreme but illuminating example of this process.

Importantly, recognising the body as a source of clinical knowledge does not imply abandoning reflection or treating bodily responses as inherently accurate. Such experiences remain open to multiple interpretations and require careful consideration within supervision and practice. Nevertheless, MTS highlights the limitations of models that conceptualise empathy primarily as a cognitive skill. If interpersonal understanding is partly grounded in embodied participation, therapeutic knowledge cannot be reduced to technical competence alone.

MTS also highlights the ethical complexity of empathic openness. Heightened resonance may facilitate connection while simultaneously increasing vulnerability to emotional overwhelm. This has clear parallels within psychotherapy, where deeply attuned clinicians may be susceptible to exhaustion, vicarious trauma, or compassion fatigue. Consequently, supervision, reflective practice and emotional regulation become essential not because they reduce empathy but because they help contain and sustain it.

CONTEMPORARY CHALLENGES TO COMPETENCY-BASED TRAINING

The argument advanced in this article should not be interpreted as a rejection of psychotherapy training or as a denial that empathic capacities can develop through professional education. There is substantial evidence that therapists can become more emotionally aware, culturally responsive, reflective and relationally attuned through supervision, personal therapy, clinical experience and structured educational

programmes. The central issue is therefore not whether empathy can be cultivated, but how empathy is conceptualised within contemporary training frameworks.

Over recent decades, psychotherapy education has increasingly adopted competency-based approaches that emphasise measurable learning outcomes, observable behaviours and standardised assessment procedures. Such developments have emerged in response to legitimate concerns regarding professional accountability and quality assurance. Within these models, empathy is often operationalised through behaviours such as reflective listening, emotional validation, accurate responding and perspective-taking. While these practices undoubtedly support therapeutic communication, contemporary scholars have questioned whether observable behaviours adequately capture the complexity of empathic understanding.

Levitt et al. (2022) argue that prevailing models of empathy training risk reducing empathy to an interpersonal technique rather than recognising its multidimensional nature. Empathic practice encompasses not only behavioural skills but also emotional openness, cultural responsiveness, reflexivity, ethical sensitivity and relational presence. These dimensions are difficult to operationalise because they concern qualities of being rather than discrete actions. A trainee may learn how to formulate an empathic reflection while still struggling to remain emotionally available in the presence of suffering, uncertainty or difference.

Such approaches risk conflating the behavioural expression of empathy with empathy itself. Therapists may competently reproduce the language of empathy while remaining preoccupied with technique, performance, or anxiety about doing therapy correctly. In such circumstances, interventions may appear empathic from an external perspective while failing to communicate genuine emotional contact. The issue is not that empathic skills are inherently inauthentic, but that behavioural competence alone cannot guarantee relational engagement.

A CLINICAL ILLUSTRATION OF PERFORMATIVE EMPATHY

Consider a trainee therapist working with a client who has recently experienced the death of a parent. The client describes feeling abandoned by family members who appear to have resumed their lives while their own grief remains overwhelming. The therapist responds with a technically accurate reflection: 'It sounds as though you are feeling very alone and abandoned in your grief.' Although clinically appropriate, the client subsequently remarks: 'I know you're saying the right things, but I don't feel like you're really with me.' In supervision, the trainee later recognises that much of their attention during the session had been directed towards formulating an appropriate response rather than remaining emotionally present with the client's grief. The issue was not a lack of empathic intention, nor an absence of technical competence, but a subtle preoccupation with performing therapy correctly. As the trainee becomes more comfortable tolerating silence, uncertainty and emotional intensity, their interventions become less scripted and more responsive to the unfolding encounter. What develops is not simply greater technical proficiency but a different relational stance.

This brief vignette illustrates the distinction between empathic performance and empathic presence. The therapist has correctly identified the emotional content of the client's experience, yet the intervention fails to generate a sense of emotional contact. The problem lies not in the wording itself but in the relational process from which it emerges. The therapist may be focused on formulating an accurate response or demonstrating competence, leaving limited space for genuine emotional engagement. Empathy becomes something delivered rather than something lived.

From a phenomenological perspective, clients respond not only to what therapists say but to how they are present. Feeling understood involves more than hearing an accurate reflection; it involves sensing that another person has been affected by one's experience and remains emotionally available in relation to it. Such moments highlight the limitations of equating empathic competence with empathic understanding.

Recent empirical findings support this distinction. Palumbo et al. (2024), examining psychotherapists working with trauma, found that clinicians frequently described empathy not as a technique they applied but as an emotionally lived process involving vulnerability, exposure and ongoing relational negotiation. Empathy was experienced as something that affected the therapist personally rather than simply a skill deployed during sessions. These findings challenge educational models that conceptualise empathy primarily as a competency to be acquired.

Importantly, recognising these limitations does not invalidate competency-based education. Therapists benefit from learning how to communicate understanding, respond sensitively to distress and avoid harmful interpersonal behaviours. The problem arises when competencies become mistaken for the phenomena they are intended to represent.

DEVELOPING EMPATHY: FORMATION, REFLECTION AND ETHICAL PRACTICE

Personal psychotherapy occupies a central place in empathic development. Across psychodynamic, humanistic, existential and relational traditions, personal therapy has long been regarded as a cornerstone of therapist formation. Its value lies not simply in increasing self-awareness but in expanding the therapist's capacity to tolerate emotional experience without excessive defensiveness. Through engagement with their own vulnerabilities, conflicts and relational patterns, therapists may become less reliant on intellectualisation, premature interpretation, or professional performance as defences against emotional contact. Empathy develops not because therapists learn particular techniques but because they become more emotionally available to the experiences of others.

Reflective practice and supervision similarly contribute to empathic growth. Empathy involves more than emotional responsiveness; it requires the capacity to think about one's own reactions, assumptions and participation within therapeutic encounters. Reflective writing, process notes and supervision create opportunities to explore how personal history, cultural identity, values and emotional responses

shape clinical understanding. Contemporary relational approaches emphasise that empathic understanding often emerges through attention to countertransference, bodily sensations, uncertainty and moments of rupture or disconnection. Supervision provides a space in which such experiences can be explored rather than dismissed, helping therapists remain emotionally present without becoming overwhelmed.

Recent scholarship supports this broader conception of empathic development. Levitt et al. (2022) argue that empathy-focused training should move beyond narrow behavioural models and incorporate cultural responsiveness, reflexivity, emotional openness and relational depth. Similarly, Garrote-Caparrós, Nieto-Ruiz, García-Gracia, and Pérez-Marfil (2022) found that mindfulness-based practices enhance emotional awareness, attentional regulation and tolerance of difficult affective states. Such capacities support empathy indirectly by strengthening the therapist's ability to remain receptive to emotional experiences that are painful, uncertain or difficult to understand.

Encounters with difference represent another important source of empathic development. Empathy is often associated with similarity, yet meaningful understanding frequently emerges through engagement with experiences that challenge familiar assumptions. Exposure to diverse perspectives on identity, suffering, relationships, spirituality and social life can expand the therapist's capacity for responsiveness while reducing tendencies towards projection and premature certainty. Empathy therefore develops not only through resonance but also through engagement with difference and alterity.

Viewing empathy as a way of being rather than a technique carries important ethical implications. Levinas (1969) argued that ethical responsibility arises through encounter with the Other, whose experience can never be fully known or possessed. From this perspective, empathy is not a matter of achieving perfect understanding but of remaining open to another person's vulnerability while recognising the limits of one's own perspective. Ethical empathy therefore requires humility rather than certainty.

The concept of cultural humility extends this ethical stance. Hook et al. (2017) argue that culturally responsive practice depends not upon mastery of cultural knowledge but upon ongoing self-reflection and recognition of the limits of understanding. Similarly, Zhang and Noels (2024) suggest that intercultural empathy requires both emotional responsiveness and awareness of the interpretive frameworks through which understanding is constructed. Orange (2016) describes this position as epistemological humility: a willingness to acknowledge that all understanding is partial, situated and open to revision.

These perspectives highlight an important tension within empathic practice. Deep empathic openness can facilitate connection; however, it may also expose therapists to emotional exhaustion, vicarious trauma or blurred boundaries. As illustrated by MTS, heightened resonance can become overwhelming when not accompanied by sufficient containment. Ethical empathy therefore requires the capacity to be affected without becoming engulfed, to resonate without collapsing the distinction

between self and other. Openness must be balanced by reflexivity, emotional regulation and respect for difference.

Taken together, these considerations suggest that empathy is best understood as a process of formation rather than instruction. Personal therapy, supervision, mindfulness, reflective practice and encounters with difference do not teach empathy directly. Rather, they cultivate the emotional, relational and ethical conditions through which empathic understanding can emerge. Empathy is therefore not a competency to be mastered but an evolving way of being with others that requires continual development throughout professional life.

TEACHABILITY, DEVELOPMENT AND FORMATION

Debates about empathy often become polarised around whether empathy is teachable or unteachable. Such a binary framing obscures important distinctions between competencies that can be taught, capacities that can be cultivated and orientations that emerge through broader processes of personal and professional formation.

At the level of teachability, many aspects of empathic communication can be learned. Trainees can acquire skills such as reflective listening, emotional validation and perspective-taking. These competencies provide important means through which understanding may be communicated and are legitimate targets of psychotherapy education. Development refers to the gradual expansion of therapists' capacity to tolerate uncertainty, reflect upon emotional experience and remain open to perspectives that challenge established assumptions. Such capacities emerge through sustained clinical practice, reflection and relational experience rather than through instruction alone.

Formation concerns a deeper transformation. Rather than focusing on what therapists do, formation concerns who therapists become. It involves the cultivation of ethical sensibilities, emotional receptivity, relational openness and ways of being that shape how therapists encounter others. In this sense, empathy is not reducible to the skills through which it is expressed. While its behavioural manifestations may be taught and its capacities developed, its deepest foundations emerge through ongoing processes of personal, relational and ethical formation.

Empathy is therefore neither wholly teachable nor wholly unteachable. Its communicative expressions can be learned, its relational capacities can be cultivated, but its ontological foundations arise through the gradual formation of the therapist as a person. Psychotherapy education is most effective when it attends to all three dimensions.

IMPLICATIONS FOR PSYCHOTHERAPY EDUCATION AND PRACTICE

If empathy is understood as an ontological orientation rather than a discrete competency, important implications follow for psychotherapy education. The theoretical traditions examined throughout this article converge on a common challenge to skills-based models of training. Phenomenological writers, such as Zahavi (2021) and Fuchs (2024), locate empathy within embodied participation and intersubjective

encounter rather than technical performance. Psychoanalytic thinkers, including Bion (1962), Ogden (2019), Aron (2020) and Civitarese and Ferro (2022), similarly emphasise receptivity, emotional participation, uncertainty and the co-created nature of understanding. Multicultural scholars, such as Levitt et al. (2022), Hook et al. (2017) and Orange (2016), further argue that empathic engagement requires reflexivity, humility and awareness of the limits of one's own perspective. Despite their theoretical differences, these traditions share the view that empathy emerges through the development of relational, emotional and ethical capacities that exceed technical competence alone.

The implications of this position extend beyond individual clinicians to the institutions responsible for training and professional regulation. Contemporary competency frameworks have undoubtedly strengthened accountability and consistency within psychotherapy education. However, an exclusive emphasis on observable skills risks privileging aspects of practice that are readily measurable while marginalising dimensions of therapeutic work that are less easily assessed but equally central to effective practice.

Psychotherapy education may therefore benefit from a broader developmental framework in which competencies are situated within processes of professional formation. Assessment would continue to address communicative skills and clinical knowledge while also creating space for the evaluation of reflexivity, ethical awareness, openness to feedback, tolerance of uncertainty and responsiveness to difference. Such capacities are more difficult to quantify; however, they may be closer to the qualities that enable therapists to sustain meaningful therapeutic relationships.

A further implication concerns embodied awareness. Throughout this paper, phenomenological, psychoanalytic and neuroscientific perspectives have converged around the proposition that empathy involves bodily participation in interpersonal experience. Therapists therefore benefit from developing sensitivity to bodily responses arising within therapeutic encounters. Feelings of tension, heaviness, constriction, agitation or warmth may provide valuable information about affective and relational processes. The task is neither to dismiss such experiences nor to treat them as inherently accurate, but to reflect upon them as potential sources of clinical understanding.

These considerations also have implications for clinical practice. Traditional models of listening often privilege verbal content and explicit meaning. While these remain essential, contemporary relational and phenomenological perspectives suggest that therapists continuously receive information through affective and bodily channels. Listening therefore involves attending not only to what clients say but also to how therapists are affected by the encounter. Empathic understanding emerges through engagement with both spoken and unspoken dimensions of experience.

CONCLUSION

This paper has argued that empathy is best understood not as a discrete clinical skill but as an ontological orientation grounded in embodied, relational and ethical forms

of engagement. Drawing upon phenomenology, psychoanalysis, neuroscience, multicultural scholarship and the phenomenon of MTS, it has challenged assumptions that empathy can be adequately reduced to observable competencies or taught through technique alone. While empathic behaviours, such as reflective listening, validation and perspective-taking, may communicate understanding, they do not fully account for the embodied and relational processes through which therapeutic connection emerges. Recognising the limits of competency-based models does not imply abandoning psychotherapy training. Rather, it suggests that therapist education must attend not only to technical competence but also to the relational, embodied and ethical dimensions of professional formation.

Ultimately, empathy is not something therapists simply perform but a relational and ethical mode of participation in another person's experience. MTS does not explain empathy in its entirety, nor does therapeutic practice require synaesthetic perception. Rather, MTS functions as a neurophenomenological illustration of the embodied responsiveness that underlies empathic encounter more generally. By making visible processes that ordinarily remain implicit, it highlights how understanding emerges not solely through cognition or technique but through embodied participation in a shared interpersonal world. Empathy is therefore best understood not as a competency to be mastered but as an ongoing capacity to remain open to the presence of another person while recognising the limits of one's own understanding. Psychotherapy education may consequently benefit from shifting its emphasis from the acquisition of empathic skills alone towards the cultivation of the relational, embodied and ethical capacities that make empathy possible.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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