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**Articles**

# The Aesthetic Relational Knowing of the therapist: factorial validation of the ARK-T scale adapted for the therapeutic situation

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## Abstract

*Background and aims:* The factorial validation study of a scale describing the therapist's intuitive knowing from a phenomenological, aesthetic, and field-oriented perspective, such as that of Gestalt therapy, is presented. The way in which the therapists use their senses to understand the patient's current experience, through embodied empathy and resonance, is termed Aesthetic Relational Knowing, and a special scale (ARK), described in its broader valence in a previous study, was constructed to assess it. The ARK-T version, validated in this study, is referred to the specific therapeutic situation, assessing the therapist's intuitive ability towards the patient, in the "here and now" of the session.

*Methods:* A sample composed of 209 psychotherapists (51 men, 157 women, 1 stated "other") aged 25-80 years old, 199 psychology graduates, 10 medical doctors, working in different regions of Italy, all holding a specialization in psychotherapy of different theoretical approaches, filled in the 46 items hypothesized for the composition of the ARK-T scale.

An Exploratory Factor Analysis was carried out preliminarily on the intercorrelation matrix of the items, then subsequently a Confirmatory Analysis was performed according to the Lisrel model. Item analysis was also performed and Cronbach's alpha was calculated for reliability analysis of the global score and of the factors included in the final version of the scale.

*Results:* Exploratory and confirmatory factor analyses allowed the selection of 21 items that make up the final version of the ARK-T Scale. The main factors validated in previous studies (Body awareness, Resonance, and Empathy), operationalized in the therapeutic situation, were redefined into: Body Awareness, Intuitive Resonance, and Affective Empathy. The reliability of the scale is good for both total score (alpha=0.841) and factorial subscales.

*Conclusions*: By enabling the assessment of body process awareness and aesthetic-relational skills in therapy, the ARK-T scale has significant implications for the training and supervision of psychotherapists, as well as for research on the therapeutic change process.

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## 1. Introduction

The therapist's intuitive knowing has been explored extensively in the literature about psychotherapy, from the Freudian description of counter-transference (Freud, 1910) to the role of psychotherapists in the process of managing the relational emotional field evoked in the "here and now" of the therapeutic relationship (Gabbard, 2014; Stern, 2004). With the emergence of phenomenology (Cargnello, 1961; Husserl, 1965; Jaspers, 2013; Lanzoni, 2001; Merleau-Ponty, 1965), counter-transference was no longer seen as an obstacle to "objective" knowledge of the patient's experience, but as one of the main means for therapeutic work. The feelings aroused by the patient in the therapist suggest something important for the therapeutic relationship and for the patient's inner world (Fromm-Reichmann, 1939; Greenberg & Geller, 2001; Heimann, 1950; Winnicott, 1994). Moreover, more recent psychotherapeutic approaches have recognized the clinical relevance of the therapist's emotional reactions and have attributed the inter-subjective affective environment a major role in determining therapeutic outcome (Dahl et al., 2012; Elliott, 2010; Flückiger et al., 2018; Heinonen & Nissen-Lie, 2020; Lingiardi et al., 2018; McWilliams & Spagnuolo Lobb, 2017; Stern et al., 1998). The emotional aspects of therapists have been widely studied, in terms of therapeutic alliance (Ardito & Rabellino, 2011; Iwakabe et al., 2000), empathy (Gallagher, 2012; Ratcliffe, 2012; Zahavi, 2010), and intersubjective relationship (Dosamantes, 1992; Dosamantes-Beaudry, 2007). Recently, there is a developing literature on therapists' responsiveness, a research current initiated by Stiles et al. (1998) that studies how the personal response of the therapist influences the therapeutic relationship and outcome (Wu & Levitt, 2020). The present study con be considered as belonging to this current, since it regards the situated feelings and understanding of the therapist (Spagnuolo Lobb at al., 2022).

Empirical investigators have commonly used self-report instruments—such as the *State Anxiety Inventory* (Hayes & Gelso, 1991), the *Therapist Appraisal Questionnaire* (Fauth & Hayes, 2006), the *Feeling World Checklists* (Dahl et al., 2012; Røssberg et al., 2003), the *Therapist Response Questionnaire* (Tanzilli et al., 2016), the *Responsiveness Scale* (Snyder & Silberschatz, 2017), and others (see *Strengths and Limitations*). All this tools do not sufficiently consider the therapist's aesthetic feelings, especially within the framework of phenomenological field theory (Bloom, 2009; Macaluso, 2020a, 2020b; Parlett, 1991, 2003; Spagnuolo Lobb, 2018). The phenomenological, aesthetic and field-oriented perspective proper to Gestalt psychotherapy (Perls et al., 1951) allows the therapist's intuition to be explored in a new way, basing on three main epistemological assumptions: : *phenomenological*, i.e., concerned with experience as it evolves in the near future (Bloom, 2009; Polster, 1987; Spagnuolo Lobb, 2013); *aesthetic*, i.e., informed by the senses

(Frank, 2022; Robine, 2003); *field-oriented*, i.e., focused on the reciprocity between therapist and patient (Frank, 2001; Jacobs & Hycner, 2010; Macaluso, 2020a; Robine, 2015; Spagnuolo Lobb, 2017; Yontef, 2001). Including the therapist's aesthetic and field-oriented feelings in the description of his or her intuition allows for the integration of the therapist's body awareness with his or her understanding of the patient's bodily, emotional, and relational processes, forming a creative gestalt that is "tailored" specifically for that particular patient.

Following this line, Aesthetic Relational Knowing (ARK) has been emphasized. ARK is defined as "the ways in which the therapist uses his or her senses to understand the patient's current experience through embodied empathy (i.e., immersing oneself in the patient's experience) and resonance, i.e., the sensitive and personal reaction to the experiential field that is activated with the patient" (Spagnuolo Lobb, 2018).

This term is similar to the one used by Daniel Stern - Implicit Relational Knowledge - to define the specific non-verbal knowledge that plays a fundamental role in the caregiver-child dyad, and is truly responsible for much of the therapeutic change (Stern et al., 1998). In this study, the focus is not so much on the implicit level but on the aesthetic resonance.

The concepts that describe ARK regard the therapist's perception and involvement. Hence, the ability to immerse him/herself in the patient's emotions (affective empathy), the ability to intuit relational aspects beyond the patient's words simply by resonating in the "here and now" with the modes of contact he/she enacts (intuitive resonance), and the awareness of his/her own bodily sensations, which give him/her a measure of the patient's implicit experience (bodily awareness). These competences of the therapist make it possible to intuit the specific relational support a particular patient needs.

This article, specifically, presents the factorial validation of the *Aesthetic Relational Knowing* scale adapted for the therapeutic situation: the ARK-T scale. The aim of this study is to measure the aesthetic intuition of the therapist in the here and now of the session, and to validate a scale to measure the therapeutic competence of integrating his/her bodily feelings, empathic understanding and resonance in the field in a unique way tailored for that patient.

### 1.2 Aims of the study

The general aim of this study is to develop a useful tool for evaluating the therapeutic aesthetic intuition, regardless of the therapist's specific orientation.

Specifically, this study responds to the need, for the purposes of clinical evaluation and research on the therapeutic process, to apply the construct of ARK, and its measuring instrument, to what happens in the session within therapy. In fact, the items considered in previous studies

(Spagnuolo Lobb et al., 2022, 2023) do not account for the situation that we want to investigate, that is, the specific competence of the therapist, his or her intuition in the "here and now" of the session.

We have modified the scale, making the items suitable for measuring the therapist-in-session experience, and we made the hypothesis that the ARK-T scale (the scale that specifically refers to therapeutic situations) will describe factors of the therapist's intuition more in detail.

The final and very specific aim of this study is to evaluate the reliability and factorial validity characteristics of the scale, thus modified, by making use of a larger and more representative sample of the various psychotherapeutic approaches, with different levels of experience.

## 2. Methodology

### 2.1 Sample

Criteria for inclusion have been: being certificate and active psychotherapists according to the Italian law (56/89), that allows only psychologists and medical doctors to enter psychotherapy training. The sample consisted of 209 psychotherapists (51 men, 157 women, 1 stated "other"), aged 25-80 years old, and working in different regions of Italy. All psychotherapists in the sample were already specialized in various psychotherapeutic approaches, they were experienced practitioners in the profession, from different theoretical and methodological traditions and with different cultural backgrounds and professional experiences.

We have considered the numerical difference between male and female psychotherapists as representative of the real situation in this field. This consideration is supported by studies that show that psychological professions are pervasively female-prevalent: 80 per cent of Clinical Psychologists are women (Johnson et al., 2020; Yang, 2022).

As regards the basic formation, 199 participants were psychology graduates, 10 were medical doctors.

Participants were invited by e-mail through the presidents of the psychotherapy associations involved. The invitation to participate anonymously in the online completion of a questionnaire on the Google Forms platform, via the link sent to the e-mails, was preceded by the acceptance of informed consent.

The characteristics of the sample are summarized in Table 1.

**Table 1.** Characteristics of the sample.

| | Frequency | % |
|---|---|---|
| **Age ranges** | | |
| 25-35 | 27 | 12.9% |
| 36-45 | 83 | 39.7% |
| 46-55 | 64 | 30.6% |
| 56-65 | 20 | 9.6% |
| 66-75 | 9 | 4.3% |
| >76 | 6 | 2.9% |
| **Gender** | | |
| M | 51 | 24.4 % |
| F | 157 | 75.1% |
| Other | 1 | 0.5% |
| **Psychotherapeutic approach** | | |
| Psychodynamic/psychoanalytic | 31 | 14.8% |
| Cognitive-behavioral | 34 | 16.3% |
| Systemic-Relational | 31 | 14.8% |
| Gestaltic | 70 | 33.5% |
| Client Centered (Rogersian) | 2 | 1.0% |
| Functional - Bodily | 31 | 14.9% |
| Integrated | 4 | 1.9% |
| Transactional Analytic | 3 | 1.4% |
| Constructivist-intersubjective | 2 | 1.0% |
| EMDR | 1 | 0.5% |
| **Years of professional activity** | | |
| <5 | 50 | 23.9% |
| 5-10 | 62 | 29.7% |
| 10-20 | 47 | 22.5% |
| 20-30 | 28 | 13.4% |
| 30-40 | 10 | 4.8% |
| >40 | 12 | 5.7% |
| **% of online therapeutic work** | | |
| <50 % | 102 | 79.7% |
| 50%> | 26 | 20.3% |

### 2.2 Instruments and procedure

In a previous study (Spagnuolo Lobb et al., 2023), a scale was built to measure the construct of Aesthetic Relational Knowledge (ARK), derived from instruments already found in the literature: the Basic Empathy Scale (BES) (Jolliffe & Farrington, 2006), the Multidimensional Assessment of Interoceptive Awareness (MAIA) (Mehling et al., 2012), adding a series of questions created ad hoc to assess resonance. The resonance questions, in particular, investigate a few main aspects such as the therapist's ability to intuit what was going on in the patient's

relationships in which the suffering arose, to approach the patient's suffering by considering his or her own prior experiences and bodily processes, to distance himself or herself from his or her own personal experience when encountering the patient's suffering, to empathically understand what caregivers or significant others who come into relationship with the patient feel, and to understand what the patient has missed in the relationship with the significant other.

The version of that first ARK scale consisted of 58 items, each on a 5-point Likert scale. The reliability of the entire scale, based on Cronbach's alpha, was good (alpha=0.870), as was that of the sub-scales of body awareness (0.921), empathy (0.672), and resonance (0.730) (Spagnuolo Lobb et al, 2022). That first study described the construct of ARK in its broadest valence, not referring specifically to the therapeutic situation.

The initial ARK scale of 58 items was therefore revised for use of the instrument by therapists, belonging to various modalities, not just Gestalt therapy. The items were selected through the "judges' method" (i.e., using the advice of expert therapists of different orientations, who evaluated the items and proposed retention or elimination or modification of the wording to fit the therapeutic context). Thus 46 items were selected, of which 17 were referable to body awareness, 15 concerning the concept of resonance, 5 concerning cognitive empathy, and 9 concerning the concept of affective empathy.

Participants proceeded to complete the ARK-T questionnaire online, in the 46-item version specifically prepared for the therapeutic context. Along with the questionnaire, participants provided information on sociodemographic characteristics such as gender, age, education, region of origin, psychotherapeutic approach of practice, years of practice, and prevalent mode of conducting sessions (online/in-presence). This information was reported in the sample description and in the related table.

The research was approved by the Ethic Review Board of Psychology Research, University of Catania, Prot. Ierb-Edunict-2024/03.

**2.3 Data Analysis**

Descriptive analyses of the sample were carried out, and an Exploratory Factor Analysis (EFA) with the method of principal components, and Varimax orthogonal rotation of axes, was carried out preliminarily on the intercorrelation matrix of the items. EFA was used to identify the latent structures underlying the original set of 46 items. To determine the factors to be extracted, the method of Eigenvalues >1 and Cattel's Scree test was used. Next, we proceeded at interpreting the factors to which each item could be referred. We used the threshold value of >.30 for interpreting the correlations between the variables and the factors. This threshold value is largely accepted and used in the practice of factor analysis (Tavakol & Wetzel, 2020).

To evaluate the adequateness of the factors extracted a Confirmatory Analysis, according to the Lisrel model, was performed on the items selected as best representative of the factors through exploratory analysis. Fit indices, Comparative Fit Index (CFI), Tucker-Lewis Index (TLI), Root Mean Square Error of Approximation (RMSEA) were evaluated to assess the goodness of fit of the hypothesized model to the empirical data.

Item analysis on the final version of the scale was also performed, and Cronbach's alphas were calculated to assess the reliability of the final version of the scale, both for total and factorial scores.

In all the analyses the significant threshold adopted was $p<0.05$.

Data analyses were carried out through the use of the opensource software Jamovi, graphical interface of R (The Jamovi Project, 2024).

## 3. Results

### 3.1 Exploratory factor analysis

From the exploratory factorial analysis with the methods already described (Fig. 1) a four-factor scale was obtained, although the first factor has a much higher eigenvalue than the others, and absorbs greater share of the overall variance explained by the test.

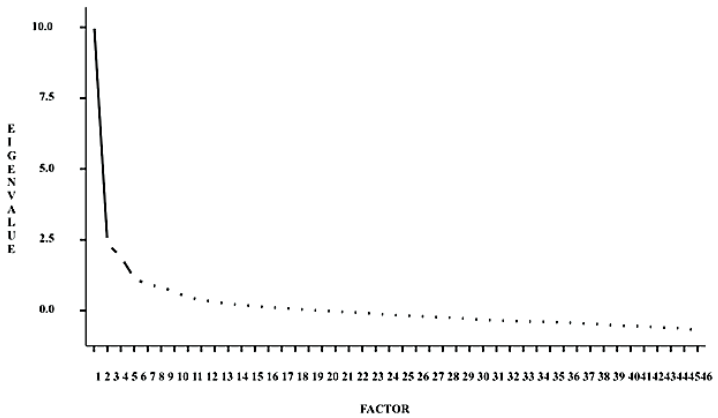


**Figure 1.** Exploratory Factor Analysis of the 46-item version of the scale. Cattell's scree test for Eigenvalues

The saturations of individual items are showed in Tab. 2.

**Table 2.** Exploratory Factor Analysis of the 46-item version of the scale, Factor loadings. Only loadings > .30 are reported

| Item | Factor 1 | Factor 2 | Factor 3 | Factor 4 |
|---|---|---|---|---|
| When I am with a patient, I pay attention to my body to know what to do | 0.641 | | | |
| When I feel overwhelmed in the relationship with the patient, I can find a quiet inner place | | | | |
| When something goes wrong in the relationship with the patient, I can sense it in my body | 0.657 | | | |
| When I am with a patient, I listen to information from my body regarding my emotional states | 0.616 | | | |
| When I'm with a patient, I can redirect attention from the act of thinking to the act of perceiving my body | 0.709 | | | |
| When I am with a patient, I do not notice the physical tension or discomfort until they become more serious | | | | |
| When I am in conversation with a patient, I don't pay attention to my posture | -0.439 | | | |
| When I get assailed by thoughts in the therapeutic situation, I can calm my mind by focusing on my body/breathing | 0.692 | | | |
| When I am with a patient, I can maintain awareness of my physical sensations even if distracting events occur around me | 0.513 | | | |
| I notice that my breathing becomes free and easy when I feel at ease with the patient | 0.568 | | | |
| When I am with a patient, I can use my breath to reduce tension | 0.736 | | | |
| When I feel tense with a patient, I notice where in my body the tension is located | 0.729 | | | |
| When I am with a patient, I tend not to trust my body sensations | -0.419 | | | |
| When I am with a patient, I notice changes in my breathing, for example, if it slows down or speeds up | 0.673 | | | |
| When I am with a patient, I am able to deliberately focus on my body as a whole | 0.714 | | | |
| When I am with a patient, I avoid being disturbed by feelings of discomfort | | | | |
| If I feel agitated when I am with a patient, I take the time to investigate how my body is | 0.624 | | | |
| I can empathize with the thoughts and intentions of people who enter into a meaningful relationship with the patient | | | | |
| I can hardly guess implicitly, without investigating directly, what was going on in the patient's relationships where the suffering arose | | | | |
| I have difficulty feeling empathy towards the patient's reference persons | | | | |
| When I listen to the patient, I find myself wondering what attitudes or behaviors of the significant other (including myself) contribute to his or her suffering | | | | |
| I always try to give the patient the support they need as a person, without involving myself | | | | |
| I generally focus on the patient's experience and try not to get involved so as not to interfere with the patient's experience | | | | |
| When I listen to a patient by focusing on my own bodily feeling, I can sense what experience or behavior he or she would like to receive support from me for | 0.628 | | | |
| By interacting with the patient and focusing on my own bodily experience, I can implicitly understand what relational support the patient has not received in meaningful relationships | 0.594 | | | 0.388 |

| | | | | |
|---|---|---|---|---|
| It is difficult for me to empathize with the patient's significant other | | | | |
| I generally cannot guess, without directly investigating, what happened in the patient's environment during significant episodes in his life | | -0.400 | | |
| When I listen to a patient by focusing on my own bodily feeling, I sense how together we co-construct a relational pattern | 0.694 | | | |
| I generally perceive what relational failure has generated suffering in the patient | | 0.472 | | |
| By focusing on my body-in-relationship with the patient, I am able to intuit, beyond a direct investigation, what was going on in my patient's relationships where suffering originated | 0.534 | | | 0.510 |
| When I listen to a patient I only focus on him/her and do not think that my feeling at that moment is important | -0.487 | | | |
| I am able to intuit the experiences of the people involved in the patient's primary relationships | | 0.458 | | |
| I also tend to feel fear when I am with a patient who is afraid | | | 0.464 | |
| When I stay with a patient who is sad about something, I usually feel sad too | | | 0.557 | |
| I find it difficult to empathize with my patients' fears | | -0.548 | | |
| I can identify with the happiness of my patients when they do something well | | 0.487 | | |
| I feel upset when patients expose distressing experiences | | | 0.531 | |
| I easily find myself involved in my patients' feelings, whatever they may be | | | 0.492 | |
| Seeing an angry patient has no effect on my feelings | | | -0.442 | |
| My patient's unhappiness does not particularly upset me | | | -0.453 | |
| I have difficulty empathizing with patients' happiness | | | | |
| I can usually intuit quite easily when a patient is angry | | 0.408 | | |
| I usually do not perceive whether a patient is afraid | | -0.400 | | |
| I often get a sense of how patients are feeling even before they tell me | | 0.462 | | |
| I usually cannot sense when a patient is cheerful | | -0.652 | | |
| I usually cannot instantly perceive my patients' feelings | | -0.463 | | |

Items created to investigate the cognitive empathy construct have loadings >0.30 in the second factor along with items referable to the resonance construct, understood as intuitive ability to understand the other. In addition, 5 items referring to resonance showed higher saturations in the first factor, hypothesized as body awareness.

Based on the results of the exploratory analysis, 25 items were eliminated because they were non-saturating in any factor or had ambiguous factorial placement, while only two had saturation >.30 in the fourth factor, but higher saturation in the first factor as well.

This selection achieved the goal of obtaining an overall slimmed-down and less redundant scale for easier clinical administration. The selected items are still representative, in a balanced way, of the main theoretical factors initially hypothesized, and to be confirmed by subsequent analyses.

### 3.2 Confirmatory factor analysis

For confirmatory factor analysis, based on the 21 items chosen as best representative of the factorial structure detected through exploratory analysis, three factors were hypothesized: "Body

Awareness," "Intuitive Resonance," and "Affective Empathy." Fit indicators such as chi-square (=302, d.o.f. 186, $p$ <.001), Comparative Fit Index (CFI=0.903), Tucker and Lewis Index (TLI=0.891), and Root Mean Square Error of Approximation (RMSEA=0.055), used to test the model, confirmed its goodness of fit. Tab. 3 shows the complete results of the analysis.

**Table 3.** Confirmatory Factor Analysis. Fit indices: chi-square =302 (d.o.f. 186, p<.001), CFI=0.903, TLI=0.891, RMSEA=0.055

| ITEM | Esteem | SE | Z | p |
|---|---|---|---|---|
| **Affective Empathy (AE)** | | | | |
| I tend to feel fear myself when I am with a patient who is afraid | 0.767 | 0.086 | 8.89 | <.001 |
| When I stay with a patient who is sad about something, I usually feel sad too | 0.724 | 0.078 | 9.23 | <.001 |
| I easily find myself involved in my patients' feelings, whatever they may be | 0.457 | 0.080 | 5.69 | <.001 |
| I feel upset when patients expose distressing experiences. | 0.638 | 0.091 | 7.00 | <.001 |
| My patient's unhappiness does not particularly upset me | -0.363 | 0.071 | -5.10 | <.001 |
| **Intuitive Resonance (IR)** | | | | |
| I am able to intuit the experiences of the people involved in the patient's primary relationships | 0.278 | 0.063 | 4.38 | <.001 |
| I generally perceive what relational failure has generated suffering in the patient | 0.363 | 0.056 | 6.41 | <.001 |
| I generally cannot guess, without directly investigating, what happened in the patient's environment during significant episodes in his life | -0.406 | 0.073 | -5.55 | <.001 |
| I can usually intuit quite easily when a patient is angry | 0.287 | 0.041 | 6.98 | <.001 |
| I usually do not perceive whether a patient is afraid | -0.357 | 0.045 | -7.92 | <.001 |
| I often get a sense of how patients are feeling even before they tell me | 0.607 | 0.061 | 9.93 | <.001 |
| I usually cannot sense when a patient is cheerful | -0.507 | 0.046 | -10.86 | <.001 |
| I usually cannot instantly perceive my patients' feelings | -0.367 | 0.069 | -5.32 | <.001 |
| **Body Awareness** | | | | |
| When I am with a patient, I pay attention to my body to know what to do | 0.615 | 0.055 | 11.09 | <.001 |
| When something goes wrong in the relationship with the patient, I can sense it in my body | 0.611 | 0.061 | 9.97 | <.001 |
| When I am with a patient, I listen to information from my body regarding my emotional states | 0.611 | 0.053 | 11.37 | <.001 |
| When I'm with a patient, I can redirect attention from the act of thinking to the act of perceiving my body. | 0.705 | 0.056 | 12.38 | <.001 |
| When I am in conversation with a patient, I don't pay attention to my posture | -0.511 | 0.067 | -7.52 | <.001 |
| When I get assailed by thoughts in the therapeutic situation, I can calm my mind by focusing on my body/breathing | 0.712 | 0.070 | 10.15 | <.001 |
| When I am with a patient, I notice changes in my breathing, for example, if it slows down or speeds up. | 0.724 | 0.069 | 10.38 | <.001 |
| When I am with a patient, I am able to deliberately focus on my body as a whole | 0.805 | 0.064 | 12.51 | <.001 |

The scale in the final version, consisting of 21 items, 5 of Affective Empathy, 8 of Intuitive Resonance, and 8 of Bodily Awareness, is shown in the annex. After the rotation of the scores for the inverted items (indicated in the annex), each factor allows the sum of sub-scale scores, to be used in addition to the total score.

### 3.3 Reliability and item-analysis

The coefficient Alpha for the total scale is 0.841, confirming the reliability of the global score of aesthetic knowledge ability in therapy.

The Alphas of individual factorial subscales are 0.870 for Body Awareness, 0.735 for Intuitive Resonance, 0.688 for Affective Empathy.

The good reliability of both the overall scale and the factorial subscales makes it possible to calculate scores both for the entire test and separately for the three factors, which is useful for clinical and research purposes.

To these aims, the standardization values obtained on the sample of psychotherapists in our study, for the total ARK-T scale score and factorial scores, are reported in Tab. 4.

**Table 4.** Standardization data for factor scores and total scale (n=209). Means and standard deviations, Average score for item, Skewness and Kurtosis and Quartiles of the distributions

| | *Factors* | | | |
|---|---|---|---|---|
| | *Body Awareness* | *Intuitive Resonance* | *Affective Empathy* | ***ARK total scale*** |
| | *n. of items: 8* | *n. of items: 8* | *n. of items: 5* | ***n. of items: 21*** |
| Mean | 30.50 | 33.58 | 16.25 | **80.33** |
| St.dev. | 5.67 | 3.77 | 3.57 | **9.66** |
| *Average* | *3.81* | *4.20* | *3.25* | **3.83** |
| Skewness | -0.51 | -0.41 | -0.01 | **-0.13** |
| Kurtosis | -0.21 | 0.66 | -0.35 | **-0.12** |
| **Percentiles:** | | | | |
| 25° | 26 | 31 | 14 | **73** |
| 50° | 31 | 33 | 16 | **81** |
| 75° | 35 | 37 | 19 | **87** |

## 4. Discussion

Aesthetic Relational Knowing (ARK) is a phenomenological and aesthetic construct that psychotherapists use during sessions with patients. This construct is based on the psychotherapist's awareness that allow them to experience their own feelings and bodily

sensations, to be attuned and understand the patient's situation using an *aesthetic lens* (Spagnuolo Lobb, 2016). ARK is the "sensory intelligence" of the phenomenological field.

The factorial validation of the ARK-T scale, a measure for the specific situation of the "here-and-now" of the therapeutic session has been conducted, drawing on an analysis of the more general construct, already carried out in a previous paper (Spagnuolo Lobb et al., 2023).

In the previous research the initial ARK scale did not refer specifically to the therapist-patient relationship. It was here redefined and operationalized in the therapeutic situation, measuring the degree by which the therapists can immerse themselves in the phenomenological field that is cocreated with the patient within the specific therapeutic model.

The previous scale was studied and adapted to the specific therapeutic context.

The three key factors hypothesized from the exploratory analyses and confirmed through the CFA are described as: Intuitive Resonance (IR), Body Awareness (BA) and Affective Empathy (AE).

*Intuitive Resonance* was defined as the ability to resonate in the patient's experiential field. *Body Awareness* is understood as the interceptive ability to recognize one's own emotional and physical activation. *Affective Empathy* includes the concepts of emotional contagion, emotional detachment, and affective involvement.

A distinction is made between cognitive empathy (Healey & Grossman, 2018), which refers to the ability to recognize and understand mental state, thoughts and intentions of others, and refers to theory of mind (Premack & Woodruff, 1978), and affective empathy, as the ability to understand feelings and emotions of others.

The analyses conducted confirmed the reliability of the global score and of the individual factorial subscales of the therapist's aesthetic knowledge in therapy.

The scale with the factorial breakdown is fully presented in the Annex, along with the Italian version.

**5. Strengths and Limitations**

The main strength of this study is the description of the aesthetic intuition of the therapists, a construct that is not sufficiently studied in literature. Other scales that measure the therapist's feelings or intuition, like the *Therapist Response Questionnaire* (Tanzilli et al., 2016), or *The patient's experience of attunement and responsiveness scale* (Snyder & Silberschatz, 2017), or the *Therapist Appraisal Questionnaire* (Fauth & Hayes, 2006), or the *Feeling World Checklists* (Dahl et al., 2012;

Røssberg et al., 2003) do not consider the phenomenological, aesthetic and field oriented perspective.

The ARK-T scale can give a contribution to qualitative research, adding meaningful variables to interviews, like Hayes et al. (1998), or Tishby and Wiseman (2014), and to open research projects on countertransference management (Pérez-Rojas et al., 2017).

The construct of the ARK-T is based on the perception that they have of the client's relational attitude, of their empathic feelings to the client, and on the understanding that they have of the relational "dance" where the sufferings originates and that the client brings into the therapeutic situation.

The ARK-T scale is able to measure a unique (and intuitive) competence of the therapists, that is the integrative capacity to create a therapeutic position from their feelings, their embodied empathy, their resonance to the client that allows them to contextualize these feelings in a field perspective.

The competence that the ARK-T measures refers to the *here and now* of what is co-created between therapist and client, and this is a new trend in psychotherapy research (Stiles et al., 1998; Lingiardi & De Bei, 2005; Gori et al., 2023).

The ARK-T scale can be used in supervision and training from any psychotherapeutic method.

Although the items of the scale are expressed in a very simple and immediate language, a limit of this study could be that therapists do not use categories of phenomenological and bodily process language in their understanding of the client's situation. A further study that includes more general categories, understandable by all psychotherapists, while keeping the aesthetic and field-oriented perspective, would be desirable.

## 6. Conclusions

The Aesthetic Relational Knowing is defined as the psychotherapist's ability to perceive the patient's situation (through *body awareness* and *affective empathy*) and to contextualize it in a relational field perspective (through *intuitive resonance*). It is a meta-competence of clinical practice that focuses on the bodily experience of therapist and patient and the phenomenological field experienced by both in the "here and now" of the session.

The aim of this paper was to create a scale to measure the presence of this construct in psychotherapists of various modalities and levels of professional experience.

The relevant contribution of the ARK-T scale is the possibility to describe an aspect of the therapist's intuition that is not sufficiently considered yet. This possibility can be used in the clinical field, as well as in training and research.

In clinical field, all psychotherapists can use this scale to reflect and improve their aesthetic and field intuition of their clients.

Considering psychotherapist training and supervision, the use of the ARK-T scale may have significant implications, highlighting the importance of body process work, situational contextualization and aesthetic relational skills in working with patients.

Finally, it seems particularly interesting to use this measure of the therapist's aesthetic and field intuition in various research on the psychotherapeutic process and to correlate it with the outcome of psychotherapy, or even with the measurement of relational factors such as the therapist's responsiveness (Watson & Wiseman, 2021), his or her self-compassion, and many other aspects developed within the various psychotherapeutic approaches. It will thus be possible to correlate this particular type of insight with the effectiveness of psychotherapy, as well as with other aspects of the therapist's training and personality, e.g., personal psychotherapy, caring attitude toward self, ethics of responsivity toward the patient.

It will be useful to develop further studies to compare the use of this competence among various theoretical models, and among therapists of the same model, but of different nationalities and cultures.

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**Ethic Statement**

The research was approved by the Ethic Review Board of Psychology Research, University of Catania, Prot. Ierb-Edunict-2024/03.

**Conflict of Interest Statement**

The authors declare that the research was conducted in the absence of any potential conflict of interest.

**Authors' Contribution**

*Spagnuolo Lobb M.:* theoretical project, data collection, revision of the whole article. *Riggio F.:* data collection, statistical analysis, and writing of the results. *Guerrera C.S.:* data collection, preliminary statistical analysis and references' editing. *Sciacca F.:* data collection and the initial drafting of the manuscript. *Di Nuovo S.:* Project and Supervision of statistical analysis, description of results and discussion, final check of the whole article.

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## Appendix

**ARK-T SCALE**

**English Version**

1. When I am with a patient, I pay attention to my body to know what to do. (BA)
2. I tend to feel fear myself when I am with a patient who is afraid. (AE)
3. I can usually intuit quite easily when a patient is angry. (IR)
4. When I stay with a patient who is sad about something, I usually feel sad too. (AE)
5. I usually do not perceive whether a patient is afraid. (IR)*
6. When something goes wrong in the relationship with the patient, I can sense it in my body. (BA)
7. When I am with a patient, I listen to information from my body regarding my emotional states. (BA)
8. When I'm with a patient, I can redirect attention from the act of thinking to the act of perceiving my body. (BA)
9. When I am in conversation with a patient, I don't pay attention to my posture. (BA)*
10. I generally cannot guess, without directly investigating, what happened in the patient's environment during significant episodes in his life. (IR)*
11. When I get assailed by thoughts in the therapeutic situation, I can calm my mind by focusing on my body/breathing. (BA)
12. I often get a sense of how patients are feeling even before they tell me. (IR)
13. I usually cannot sense when a patient is cheerful. (IR)*
14. I usually cannot instantly perceive my patients' feelings. (IR)*
15. I generally perceive what relational failure has generated suffering in the patient. (IR)
16. I feel upset when patients expose distressing experiences. (AE)
17. I easily find myself involved in my patients' feelings, whatever they may be. (AE)
18. When I am with a patient, I notice changes in my breathing, for example, if it slows down or speeds up. (BA)
19. My patient's unhappiness does not particularly upset me. (AE)*
20. When I am with a patient, I am able to deliberately focus on my body as a whole. (BA)
21. I am able to intuit the experiences of the people involved in the patient's primary relationships. (IR)

*21-Items ARK-T scale – in parenthesis the related factors:*

*AE: Affective Empathy – IR: Intuitive resonance – BA: Body Awareness*

** reversed items (score 6-x)*

## ARK-T SCALE

**Italian version**

1. Quando sono con un paziente, ascolto il mio corpo per sapere cosa fare (BA)
2. Tendo a sentire paura anch'io quando sono con un paziente che ha paura (AE)
3. Di solito riesco a intuire facilmente quando un paziente è arrabbiato (IR)
4. Quando sono con un paziente che è triste per qualcosa, di solito mi sento triste anch'io (AE)
5. Di solito non percepisco se un paziente ha paura (IR)*
6. Quando qualcosa va storto nella relazione con il paziente, riesco a percepirlo nel mio corpo (BA)
7. Quando sono con un paziente, ascolto le informazioni provenienti dal mio corpo riguardanti i miei stati emotivi (BA)
8. Quando sono con un paziente, riesco a ridirezionare l'attenzione dall'atto di pensare all'atto di percepire il mio corpo (BA)
9. Quando sto conversando con un paziente, non faccio caso alla mia postura (BA)*
10. In genere non riesco a intuire, senza indagare direttamente, cosa è successo intorno al paziente negli episodi significativi della sua vita. (IR)*
11. Quando mi assalgono i pensieri nella situazione terapeutica, posso calmare la mente concentrandomi sul mio corpo/respiro (BA)
12. Spesso mi capita di intuire come si sentono i pazienti ancor prima che me lo dicano (IR)
13. Di solito non riesco a percepire quando un paziente è allegro (IR)*
14. Di solito non percepisco i sentimenti dei miei pazienti (IR)*
15. In genere percepisco quale mancanza relazionale ha generato sofferenza nel paziente (IR)
16. Mi sento turbato quando i pazienti espongono esperienze angosciose (AE)
17. Mi ritrovo facilmente coinvolto nei sentimenti dei miei pazienti, qualsiasi essi siano (AE)
18. Quando sono con un paziente, mi accorgo dei cambiamenti nel mio respiro, per esempio se rallenta o accelera (BA)
19. L'infelicità del mio paziente non mi turba particolarmente (AE)*
20. Quando sono con un paziente, sono capace di focalizzarmi intenzionalmente sul mio corpo nella sua interezza (BA)
21. Sono capace di intuire i vissuti delle persone coinvolte nelle relazioni primarie del paziente (IR).

*21-Items ARK-T scale – in parentesi i fattori:*

*AE: Empatia affettiva – IR: risonanza intuitiva – BA: consapevolezza corporea*

** reversed items (score 6-x)*