



Integrating Reperceptive Body Psychotherapy Within Multiple Code Theory

A Single Case Study

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Abstract: *Background:* Reperceptive body psychotherapy (RBP) is a body-oriented cognitive-behavioral modality. *Aim:* This study explores an integrative approach to psychotherapy by applying multiple code theory (MCT) to RBP. *Method:* We examined a single clinical case longitudinally from April 2018 to December 2020. We assessed the therapeutic outcomes using psychopathological questionnaires by conducting process evaluation using linguistic measures based on MCT. *Results:* The results suggest that the treatment, including RBP group-based sessions, may be useful in enhancing psychological functioning. The intervention was associated with activation of the referential process (RP), reflected in changes in emotional processing and symbolization over the course of therapy. Comparisons between in-person and online therapy seem to reveal no significant differences in process indicators. Qualitative analyses seem to support a temporary shift during the initial transition to online sessions: increased emotional and sensory engagement alongside reduced reflectiveness, which normalized after a few sessions. *Conclusions:* These findings suggest that therapeutic continuity, rather than the treatment setting, is a key factor in supporting therapeutic change. Across modalities, RP seems to remain active with fluctuations consistent with psychotherapeutic engagement. Therefore, linguistic measures may usefully capture aspects of symbolization in body psychotherapy, which are underexplored within the framework of MCT.

Keywords: reperceptive body psychotherapy, multiple code theory, body image, obesity, eating disorders

Introduction

The evolution of psychotherapy in recent decades has led to a progressive reconceptualization of the mind-body relationship, promoting integrative clinical models that move beyond the Cartesian-derived dualistic approach historically dominant in psychopathology (Dennett, 1995). This dualistic perspective conceptualizes mind and body as fundamentally separate and independent entities, often privileging cognitive and verbal processes over bodily experience in both theory and clinical practice. In contrast, contemporary approaches increasingly emphasize the intrinsic integration of bodily and mental processes. Within this framework, body-oriented psychotherapies encompass therapeutic approaches that explicitly employ body-based techniques to facilitate the dialogue between patient and therapist regarding lived experiences and perceptions, including approaches such as Bioenergetic Analysis, Somatic Experiencing, and Sensorimotor Psychotherapy.

These modalities are grounded in the premise that the body is not merely a passive container of psychic content but an active participant in the construction, expression, and transformation of emotional, relational, and traumatic experiences. By attending to posture, movement, breath, and interoceptive awareness, these approaches enable access to embodied memories and implicit emotional processes, fostering insight, regulation, and therapeutic change (Bloch-Atefi, 2015). This perspective is also consistent with the theoretical framework of embodied cognition, which conceptualizes cognitive processes as inherently grounded in bodily states, sensorimotor activity, and interactions with the environment (Kiverstein & Miller, 2021; Shapiro, 2019). From this viewpoint, meaning making emerges from the continuous interplay between bodily experience and symbolic processes, supporting the integration of affective and cognitive dimensions within psychotherapy.

These approaches draw on affective neuroscience, attachment theory, developmental psychology and psycho-

traumatology, emphasizing the body's central role in affect regulation and implicit memory, particularly in the context of early trauma. Today, bodily dimensions are incorporated into many psychotherapeutic models – both as a source of information (e.g., nonverbal cues) and as a therapeutic tool. Techniques such as mindfulness, biofeedback, and eye movement desensitization and reprocessing (EMDR) illustrate the growing integration of body and mind in contemporary psychotherapy. However, bodily expressiveness and movement remain underutilized, particularly within third-wave cognitive-behavioral therapies. While some psychotherapeutic approaches incorporate these elements, they often struggle to gain scientific recognition due to methodological heterogeneity and limited empirical validation (Johanson, 2014). Indeed, although body-oriented psychotherapies show promising clinical outcomes, their scientific validation is still constrained by the lack of standardized randomized controlled trial (RCT) protocols and consistent methodologies (Van de Kamp et al., 2019, 2023). This stands in contrast to more extensively researched approaches such as mindfulness-based interventions and EMDR, which benefit from a stronger empirical ground (Linardon et al., 2017).

Among body-oriented psychotherapies, reperceptive body psychotherapy (RBP) is a recent and emerging integrative approach that focuses on the reorganization of bodily perception as a pathway for emotional and trauma-related change (Persichetti Auteri, 2019). The RBP emphasizes the role of interoceptive and proprioceptive awareness in accessing implicit memory and maladaptive patterns, with the aim of promoting the regulation, integration, and transformation of emotional and relational experiences through embodied processes. RBP enables individuals to explore their personal meanings and patterns of functioning through structured bodily experiences. RBP is characterized by its purposeful and strategic use of body experiences, not as ancillary elements but as therapeutic tools aligned with specific treatment goals. Body techniques are employed to foster emotional regulation, enhance interoceptive awareness, and, most notably, access implicit mental states, where bodily engagement supports processes of individuation and symbolic elaboration. These body experiences, offered in both individual and group settings, are conceptualized as embodied metaphors: the human conceptual system is inherently metaphorical, and many abstract cognitive structures are grounded in concrete bodily experience (Lakoff & Johnson, 1980, 2008). The body dimension plays a central role in the therapeutic process, facilitating both recognition and active modification of dysfunctional patterns. The RBP bases its practice on mind-body integration and places great emphasis on the search for metaphors between different processing systems, drawing on the principles of contemporary cognitive sciences, particularly the

perspective of embodied cognition. From this perspective, embodied cognition posits that cognitive and emotional processes are grounded in bodily experience and sensorimotor activity, highlighting how meaning-making emerges through the continuous interaction between the body and the environment (Shapiro, 2019). Although controlled studies on RBP in clinical populations are currently lacking, evidence from broader body-oriented approaches suggests that interventions focusing on embodied processes may contribute to emotional regulation and therapeutic change in different clinical conditions (Rosendahl et al., 2021).

The structured use of bodily experience as a metaphor for functioning proposed by RBP resonates also with the principles of multiple code theory (MCT; Bucci, 1997), which emphasizes the integration of levels of processing and elaborating information including (1) the subsymbolic system, handling nonverbal communication and affective core organization; (2) the nonverbal symbolic system, processing discrete images and representations derived from subsymbolic inputs; and (3) the verbal symbolic system, translating representations into language (Bucci, 2001, 2021; Bucci & Maskit, 2007). In the evolution of MCT (Bucci, 2001), three functions link experience to language: Arousal, the activation of an emotion schema; Symbolizing, when an image aligns with this arousal; and Reflection/Reorganizing, restructuring meanings of images and events to create new significance. These sequential phases form the referential process (RP) representing the process of connecting nonverbal material with material that can be communicated to others using language (Bucci, 2001). MCT posits that analyzing the language used, both in spoken and in written narratives, can provide insight into the interplay between different modes and levels of information processing. By examining individuals' speech patterns and the language they employ to recount their experiences, it is possible to observe how effectively they link emotions with verbal expression and cognitive processes (Bucci, 1997; Renzi et al., 2023, 2025). All of this is particularly relevant in the field of research in psychotherapy, especially as regards the area of research on process, since through MCT and the derived computerized measures of RP, it is possible to explore changes in the way people construct and organize their experience (Renzi et al., 2020). At present, RBP does not yet have an established scientific literature, so MCT can provide a meta-theoretical basis for RBP that is useful in creating a basis for a rigorous study of the therapeutic process. Within this framework, MCT provides a process-oriented lens for comparing psychotherapy modalities, as it allows the analysis of how different settings may influence the activation and integration of subsymbolic, nonverbal, and verbal symbolic processes. The use of MCT as a metatheoretical key to RBP is particularly useful for examining differences between psychotherapy modalities.

This perspective is especially relevant in situations where the therapeutic setting undergoes significant changes, such as the transition from in-person to online psychotherapy during the COVID-19 pandemic. A single-case study conducted in the context of verbal psychotherapy reported increased communication effort by both therapist and patient, alongside a reduction in emotional engagement and relational connection (Negri & Christian, 2022). This study can be interpreted within an MCT framework, as the observed changes in communication patterns may reflect variations in the functioning of the RP across different therapeutic modalities. Such a perspective may contribute to a deeper understanding of the mechanisms underlying RBP and help clarify whether the impact of body-based techniques on emotional-symbolic integration is influenced by the treatment setting. MCT is usually able to capture phase differences by working with transcripts of entire sessions; however, this is not feasible in an intervention such as RBP, where patient sharing mainly occurs through homework rather than during sessions. However, recently therapists' clinical notes have also been studied as a potential expression of internal referral processes (Fortunato et al., 2023; Mariani et al., 2025), and this opens research to the possibility of using MCT on patients' homework.

Aims

This work presents a clinical case treated with group-based RBP, individual psychotherapy, and psychoeducational interventions on nutrition, aiming to explore its clinical effectiveness and underlying therapeutic mechanisms through both outcome and process evaluation. The study is structured around three primary objectives:

- a) To evaluate the impact of treatment on psychological functioning by comparing a patient's scores on standardized clinical measures from baseline to a 2-year follow-up. The core hypothesis is that the patient's symptomatology will significantly decrease over the course of the treatment, with improvement in the general psychological functioning.
- b) To examine changes in emotional processing and symbolization throughout the therapeutic process using longitudinal linguistic analysis based on MCT of patient-written session narratives. Specifically, changes in emotional elaboration, symbolization, and reflection/reorganization will be evaluated across different stages of therapy. It is hypothesized that the bodily focus of RBP will facilitate the activation of the referential cycle, thereby increasing the integration of emotional and verbal symbolic content.
- c) To investigate potential differences between in-person and online therapy settings, particularly in terms of

emotional engagement and linguistic markers of referential activity. Given the transition from in-person to online therapy during the COVID-19 pandemic, the study explores how different modalities (in-person vs online) may influence the depth and quality of emotional-symbolic processing. This analysis aims to assess whether the therapeutic use of bodily experience in RBP remains effective across settings, and whether and how the presence or absence of physical co-regulation affects the RP. It is hypothesized that different settings will influence the linguistic measures of the RP.

Methods

Single Case Description

Aurora, the patient described in this case study, first accessed the clinical service in April 2018 at the age of 41. She was referred by the ward physician of the Obesity Medical Unit, following a series of objective and laboratory tests that led to a diagnosis of first-degree obesity. Subsequently, Aurora underwent three individual psychological assessment sessions, during which she completed a battery of standardized self-report questionnaires routinely employed by the clinical service. Indeed, all the questionnaires were administered within the clinical service in which the patient was treated, under the responsibility of a qualified professional.

The clinical picture that emerged from this assessment was consistent with a diagnosis of binge eating disorder (BED), which informed her inclusion in a multidisciplinary treatment protocol. The treatment included participation in RBP group sessions, individual psychotherapy, and psychoeducational interventions on nutrition. Group-based RBP was conducted in spacious settings, accommodating between five and twelve patients per group. Each group was led by a psychotherapist, supported by a psychologist and at least two movement practitioners trained in both bodywork and the fundamentals of psychotherapy. Following the outbreak of the COVID-19 pandemic, from April 2020 onward, therapy was adapted to an online format, taking place in the patients' homes. Sessions alternated between seated moments in front of the camera and standing moments involving embodied exploration. In line with the structure of the multidisciplinary protocol, patients completed standardized clinical questionnaires at both the beginning and end of the therapeutic process, allowing for quantitative monitoring of psychological functioning over time. Aurora completed her baseline assessment in 2018 and follow-up in September 2020, providing data for longitudinal outcome analysis. In addition to the quantitative measures, a corpus of qualitative data was collected

through narrative material. Specifically, Aurora produced written session-by-session reports from April 2018 to December 2020. From April 2020 onward, due to the COVID-19 pandemic, the psychotherapy sessions transitioned to an online format. A total of 38 session reports were collected during in-person therapy, and 25 during online sessions. Although these texts were not standardized in content or format, they offered rich material for examining the evolution of emotional and symbolic processing throughout therapy. The integration of quantitative and qualitative data was aimed at offering a comprehensive view of both outcome and process dimensions of change.

Measures

The questionnaires used for the study were as follows.

The Symptom Checklist-90 Revised (SCL-90 R; Derogatis & Savitz, 1999)

It is a self-report questionnaire developed to assess psychological distress in both clinical and nonclinical populations. The questionnaire evaluates nine psychopathological dimensions: Somatization (SOM, physical symptoms caused by psychological factors); Obsessive-Compulsive Disorder (OC, repetitive, intrusive thoughts and behaviors); Interpersonal Sensitivity (IS, enhanced sensitivity in interpersonal interactions); Depression (DEP, persistent feelings of sadness and loss of interest); Anxiety (ANX, excessive worry and fear); Hostility (HOS, aggressive and angry feelings); Phobic Anxiety (PHO, irrational fears and avoidance behaviors); Paranoid Ideation (PAR, suspiciousness and belief that others intend harm); and Psychoticism (PSY, symptoms such as delusions and hallucinations). Raw scores were transformed into standardized *T*-scores according to the norms reported in the Italian validation manual (Sarno et al., 2011). Accordingly, a clinical cut-off of ≥ 63 , ensuring high sensitivity in identifying symptomatic severity, was applied in line with these normative data.

Binge Eating Questionnaire (BES; Ricca et al., 2000)

This is a unifactorial instrument used to assess binge eating disorder (BED). Its psychometric properties indicate high sensitivity and low specificity. A clinical cut-off of ≥ 17 (raw score) has been proposed for use in rapid screening.

Body Uneasiness Test (BUT; Cuzzolaro et al., 1999, 2006)

This is an instrument for the evaluation of body image distortions, a psychopathological construct deeply related to eating behavior and eating disorders. The instrument consists of five factors: Weight Phobia (WP, fear of being or becoming fat), Body Image Concerns (BIC, worries related

to physical appearance), Avoidance (A, body image-related avoidance behavior), Compulsive Self-Monitoring (CSM, compulsive checking of physical appearance) and Depersonalization (D, feelings of detachment and estrangement toward one's body).

Computerized linguistic measures of the RP were applied to Aurora's diary (Cornell & Bucci, 2020; Mariani et al., 2013). The unit of analysis for linguistic measures was defined as each individual session report written by the patient. A total of 63 reports were collected and analyzed longitudinally across the treatment period. Given the variability in length and structure of the reports, no further internal segmentation into smaller units (e.g., paragraphs or thematic segments) was applied to preserve the narrative coherence of each entry. To address variability in text length, all linguistic indices were computed as proportional measures relative to the total number of words in each report. This approach minimizes potential biases related to differences in text length and ensures comparability across sessions. This procedure enhances the transparency and replicability of linguistic analyses.

Based on the assumption of referential cycle activation during RBP, the linguistic measures most representative of each stage were selected:

- The Italian Sensory Somatic Dictionary (ISenS): A list of Italian words associated with the body, bodily activities, sensory processes, and symptom descriptions was used, as defined by the ISenS dictionary (Bucci, 2021). The frequency of ISenS words in a speech sample serves as an indicator of the activation of subsymbolic components within emotion schemas. According to Bucci's multiple code theory, this corresponds to the arousal phase of the RP.
- Italian Weighted Referential Activity Dictionary (IWRAD) (Mariani et al., 2013): The dictionary comprises 9,596 commonly used linguistic elements. Includes words with high-frequency functions, such as articles, pronouns, and prepositions, which are integral to the generative function of language. IWRAD focuses on evaluating language style rather than content, capturing unintended aspects of emotional expression. It also enables microanalytic tracking and corresponds to the Symbolizing phase of RP (Mariani et al., 2013).
- The Italian Weighted Reflection and Reorganization List (IWRRL) (Negri et al., 2018): A weighted dictionary comprising 1,633 linguistic items offers a measure of the extent to which the speaker is restructuring and reorganizing the meanings within their narrative. This process of elaboration at a meta level facilitates reflection on emotional experiences in retrospect. The IWRRL captures the Reflection/Reorganization (R/R) phase of the RP.

In addition, measures derived from the above-mentioned measures were used:

- Number of words (words): number of words per unit of text.
- Italian Mean High WRAD (MHIWRAD) and Italian Mean High WRRL (MHIWRRL; Mariani et al., 2013): These two metrics quantify the concentrated intensity of referential activity (MHIWRAD) and the reorganization-reflection phase (MHIWRRL), respectively. Their calculation involves a common approach: For each metric (IWRAD or IWRRL), only words within the discourse whose individual score surpasses a threshold of 0.5 are identified. Subsequently, the average score is computed for this subset of “high” words. MHIWRAD quantifies the *magnitude* of referential peaks, indicating the intensity with which language conveys vivid information or emotional content. Similarly, MHIWRRL captures the *strength* of reorganization and reflection expressions, offering insights into the depth of cognitive processes when language deviates from a neutral state.
- High Proportion Italian WRAD (HPIWRAD) and High Proportion Italian WRRL (HPIWRRL; Negri et al., 2020): These metrics assess the proportion of analyzed words that demonstrate an overall elevated level of either referential activity (HPIWRAD) or reorganization-reflection (HPIWRRL), respectively symbolizing and reflection/reorganizing phases. Their calculation involves identifying words whose score in the IWRAD or IWRRL dictionaries, respectively, exceeds the average score established for the entire text segments. HPIWRAD indicates the percentage of words with weight above-average that show the symbolizing process. Similarly, HPIWRRL indicates the percentage of words with weight above-average in cognitive reorganization and reflective processes.

Data Analysis

The questionnaires were normalized and compared across the years 2018 to 2020 to support the clinical report provided in the results section on the Aurora patient. The normalization of the data was performed using validated reference values for each instrument: the BUT (Cuzzolaro et al., 2006b) and the BES (Imperatori et al., 2016). With specific regard to the SCL-90-R, raw scores were converted into *T*-scores according to the Italian validation manual (Sarno et al., 2011). Regarding the evaluation of RP, the data extracted from the software were observed qualitatively in relation to temporal progression to explore potential correlations between body language expressions and levels of symbolic processing at various stages of therapy.

Lastly, the *C* statistics (Leelarungrayub et al., 2020) were used to examine trends in the time-series data and to assess changes across online and in-person settings in the ISenS, IWRAD, IWRRL, MHIWRAD, MHIWRRL, HPIWRRL, HPIWRAD, and Words measures. Baseline data were first analyzed using the *C* statistics to assess the presence of trends and confirm the stability of the indices over time. Once baseline stability had been established, we examined whether introducing a second phase, namely, the transition to the online modality, produced upward or downward trends in the indices across sessions. In sum, these analyses aimed to determine whether significant shifts in linguistic indices occurred as therapy progressed from face-to-face to the online format.

Results

Figure 1 summarizes the results of the three self-report questionnaires (SCL-90-R, BUT, and BES) administered in 2018 and 2020, suggesting improvements across the assessed symptom dimensions. However, these findings should be interpreted with caution given the single-case design.

With specific regard to the SCL-90-R, *T*-scores were used. In 2018, Aurora exhibited clinically significant psychological distress across multiple dimensions, with *T*-scores exceeding the clinical cut-off (≥ 63) in several dimensions including Depression (DEP; $T = 72$), Psychoticism (PSY; $T = 73$), and Interpersonal Sensitivity (IS; $T = 66$), therefore indicating the presence of marked internal distress and possible impairments in psychological functioning. In the 2020 assessment, all *T*-scores fell within the normative range, with no dimension exceeding the clinical threshold. Indeed, several scales showed substantial reductions, including the Global Severity Index (GSI; $T = 43$), Depression (DEP; $T = 47$), Psychoticism (PSY; $T = 48$), and Interpersonal Sensitivity (IS; $T = 40$), suggesting potential improvements in symptomatology.

Regarding the Body Uneasiness Test, the results from 2018 highlighted significant body image disturbances, especially in Body Image Concern (BIC, $Z = 3.17$) and Weight Phobia (WP, $Z = 2.91$). Two years later, these scores were reduced, with *Z*-scores near or within the normative range, suggesting possible progress in body image-related issues. The Binge Eating Scale confirmed severe binge eating symptoms in 2018 (raw score = 46; $Z = 3.08$), far exceeding the clinical cut-off (28). By 2020, the patient's score decreased to 21 ($Z = -0.14$), falling within the “moderate” range, reflecting possible improvement in eating behaviors. These findings align with the psychotherapist's assessments. At baseline, the patient exhibited significant guilt,

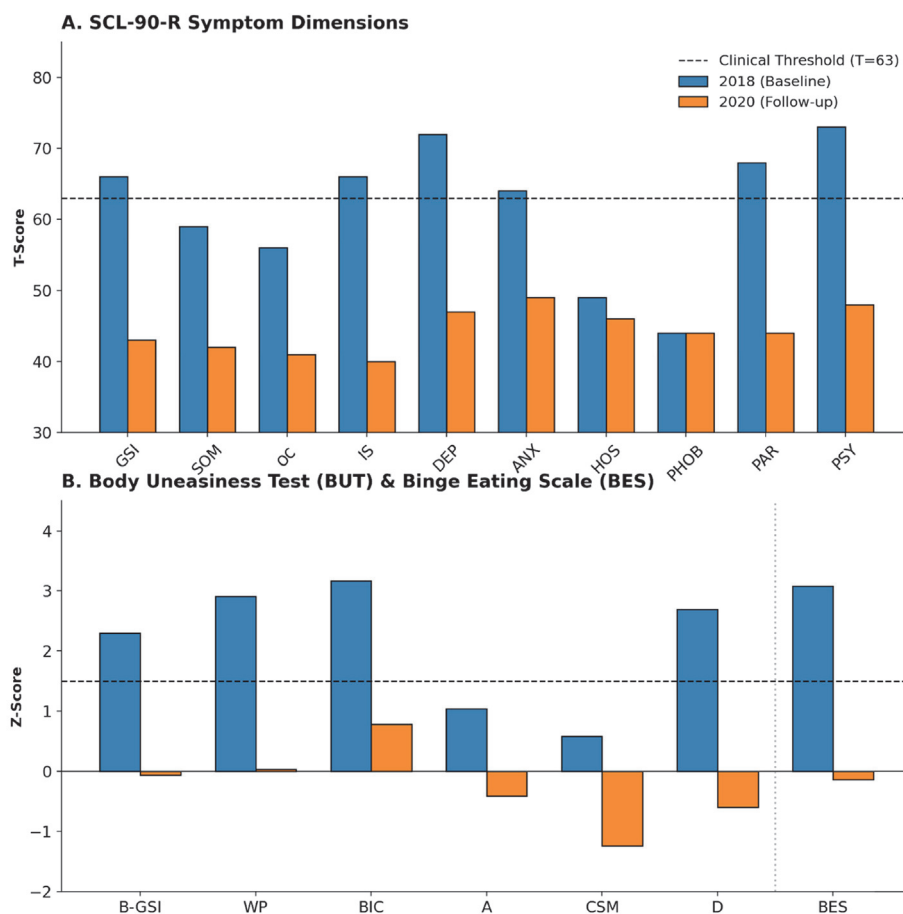


Figure 1. Psychometric profiles comparison (2018 vs. 2020). Blue bars represent baseline (2018) and orange bars represent follow-up (2020). Panel A displays *T*-scores for the SCL-90-R (dashed line = clinical threshold $T \geq 63$). Panel B displays *Z*-scores for BUT and BES (dashed line = clinical cut-off $Z = 1.5$). Abbreviations: GSI: Global Severity Index; SOM: Somatization; OC: Obsessive-Compulsive; IS: Interpersonal Sensitivity; DEP: Depression; ANX: Anxiety; HOS: Hostility; PHOB: Phobic Anxiety; PAR: Paranoid Ideation; PSY: Psychoticism; WP: Weight Phobia; BIC: Body Image Concern; A: Avoidance; CSM: Compulsive Self-Monitoring; D: Depersonalization; BES: Binge Eating Scale.

a passive communication style, persistent rumination, and a tendency toward procrastination, accompanied by an avoidant coping strategy. After two years of treatment, Aurora appeared to have achieved a range of personal, interpersonal, and therapeutic goals, while her BMI showed a reduction from 30 to 28.

Regarding the RP metrics, 38 session reports were collected during in-person therapy and 25 during online sessions. As shown in Figure 2, several indices displayed fluctuations across Aurora's reports. However, when applying *C* statistics to check if these fluctuations are significant the data do not show statistically significant variations – neither positive nor negative – between the online phase and the in-person setting in IWRAD ($C = -0.0991$, $p = .4273$), ISenS ($C = 0.0806$, $p = .5185$), IWRRL ($C = -0.0246$, $p = .8435$), MHIWRAD ($C = -0.427$, $p = .7325$), MHIWRRL ($C = -0.0257$, $p = .8370$), HPIWRRL ($C = -0.452$, $p = .6412$), and HPIWRAD ($C = 0.0630$, $p = .641$). The only significant variation in trends was observed in the number of

words ($C = 0.4297$, $p = .0005$), which increased from an average of 244.9 words during the in-person phase to nearly double that amount (442.1) during the online phase. Although no statistically significant changes in trends were observed between the online and in-person modes, a qualitative change can be noted immediately after the transition to the online format. Specifically, ISenS and IWRAD values increased in the first online session (ISenS from 0.0590 to 0.1221; IWRAD from 0.5059 to 0.5116), decreased markedly in the following two sessions (ISenS = 0.0618 and 0.0000; IWRAD = 0.4960 and 0.4972), and then returned to the average values recorded in in-person sessions.

Similar trends were observed in the derived measures. HPIWRAD increased from 0.0568 in the last in-person session to 0.5147 and 0.6832 in the first two online sessions, before dropping back to 0.1374. In other words, while only 5% of words exceeded the neutral referential activity value in the last in-person session, 51% and 68% of words did so in the first online sessions, before returning to 13%.

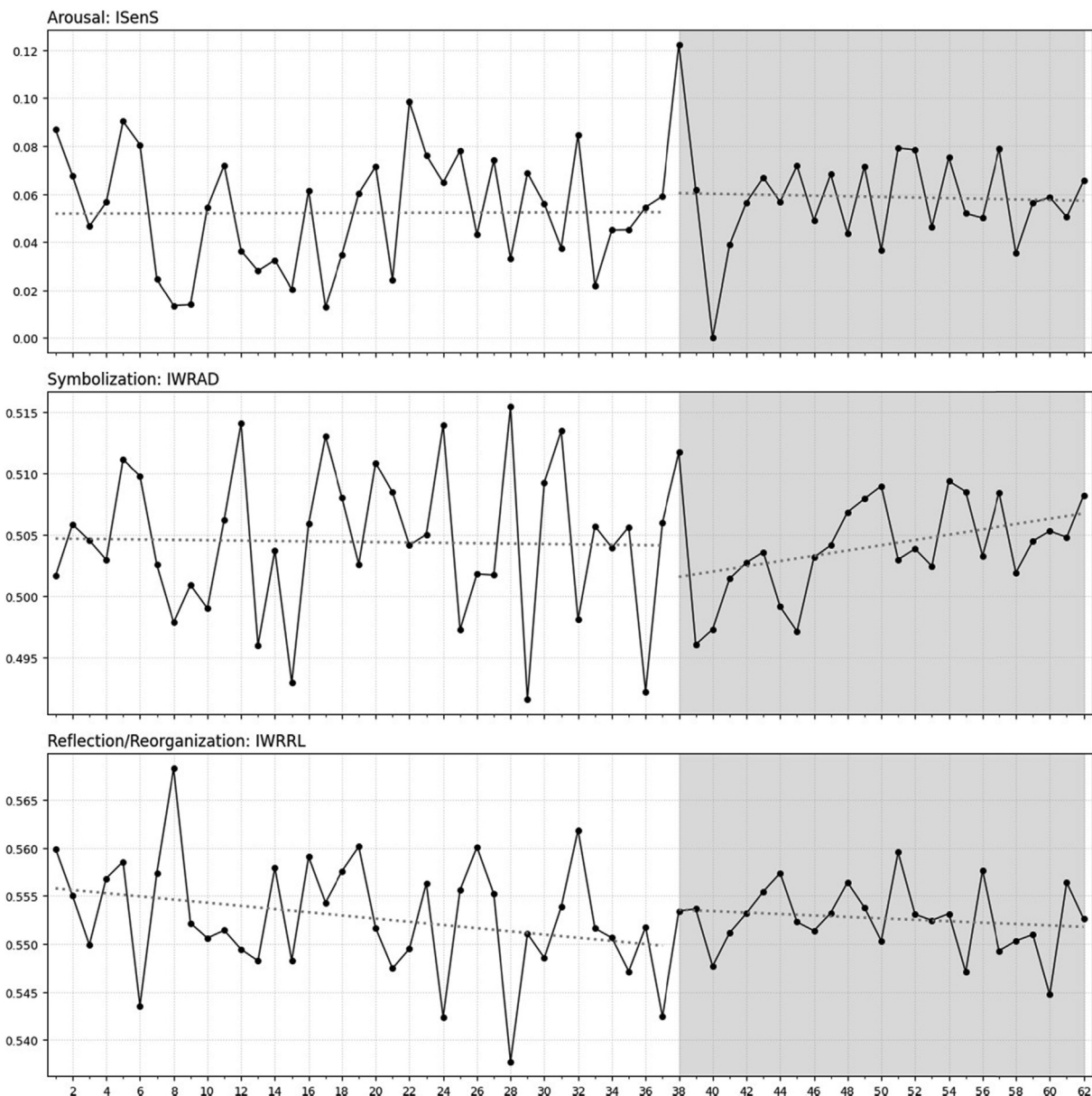


Figure 2. This graph displays the longitudinal trend of the patient's average session report scores, broken down by three psychometric scales: Arousal (ISenS), Symbolization (IWRAD), and Reflection/Reorganization (IWRRL). Each point on the x-axis represents the average score of a single session report. The gray shaded area (from session 38 onwards) indicates sessions conducted in remote (online) mode, while the white area represents in-person therapy. For each graph, there are two separate trend lines: one for the in-person therapy period and one for the online period.

Similarly, MHIWRAD rose from 0.0024 to 0.0191 and 0.0186 in the first online sessions, then fell to 0.0017, indicating higher referential activity during the patient's emotional storytelling at the beginning of the online phase. In contrast, IWRRL values, which indicate the degree of reflective style in the speaker's words, decreased slightly in the first online sessions (from 0.5517 to 0.5424) before returning to previous levels. Similarly, the patient's word count decreased from 422 in the last in-person session to lower levels in the first four online sessions (with session

40 reaching 114 words) and then returned to levels like those of the earlier sessions.

Discussion

The data collected between 2018 and 2020 through the measures employed appear to indicate a potentially meaningful improvement in Aurora's psychological functioning.

Elevated levels of general distress, body image disturbance, and binge eating symptoms observed at baseline seem to have gradually decreased, approaching values within or near the normative range at follow-up. This pattern of change appears to be consistent with the psychotherapist's clinical evaluations, suggesting a possible consolidation of therapeutic gains; however, the single-case nature of these findings requires cautious interpretation. Beyond outcome measures, the analysis of the therapeutic process through RP indices may offer some preliminary insight into the mechanisms underlying this change. Contrary to expectations of differential effectiveness between settings, in the present investigation, the quantitative analyses did not reveal statistically significant differences in the overall trends of RP measures between in-person and online modalities. These findings seem to suggest that the shift to the online setting did not interrupt or weaken the core process of emotional elaboration and symbolization. From a process-oriented perspective, continuity rather than modality may represent a key factor supporting therapeutic change in this single case study. Across both settings, the RP seems to remain active, fluctuating in a manner consistent with effective psychotherapeutic work. According to MCT, such fluctuations are thought to reflect ongoing oscillations between subsymbolic experience, nonverbal symbolic representation, and verbal symbolic elaboration. The apparent maintenance of this oscillatory pattern across settings could suggest that the symbolic work initiated in face-to-face sessions may have continued in the online context without a clear qualitative rupture.

A closer qualitative examination of the early transition to online therapy may suggest a brief reorganization of expressive modalities rather than a clear disruption of the therapeutic process. In the initial online sessions, indices associated with emotional and sensory engagement appear to increase, while reflective language and verbal output seem to temporarily decrease. Importantly, these changes appeared to be transient, returning to levels comparable to those observed during in-person sessions after a brief adjustment period. This pattern may suggest that the therapeutic system gradually adapted to the new setting while maintaining its underlying symbolic function.

The clinical vignettes may offer exploratory insight into the ways in which this continuity of symbolization might be maintained across modalities. In the in-person modality, Aurora's diary entries primarily focused on the immediate lived experience of bodily exercises, emphasizing sensorimotor awareness and procedural engagement. For example, in describing a group exercise involving changes in speed and direction, Aurora reflects on the discrepancy between her subjective perception and the therapist's exter-

nal observation: "Last session, (xxx) asked us to perform the three modules in space, changing the mode of execution. After the exercise, she asked us if we had effectively changed speed and directions ... I believe that, from an external observation, this way I performed the exercise would have been noticeable." This vignette seems to illustrate an early form of symbolization rooted in bodily action, in which awareness of automatized patterns begins to emerge through reflective observation.

In contrast, diary entries from online modality seem to show a more explicitly narrative and reflective use of language. In a later vignette, Aurora articulates changes in her relationship with food and actively reformulates her emotional needs and expectations in interpersonal relationships: "Where do I stand with the symptom? It has been a long time since I have had any episodes of binge eating ... I repeat this phrase to myself whenever I feel rejected and ignored ... Let me try to rephrase it: I express my need for love and understanding to people close to me, and if I do not receive any, it legitimizes me to feel anger and sadness." In this vignette, symbolic work appears to be expressed through verbal differentiation, cognitive reformulation, and emotional legitimization, suggesting a more advanced phase of narrative integration.

Crucially, the two settings did not appear to activate entirely separate or competing meaning-making processes. Rather, they may have supported different phases of a shared symbolic cycle. Face-to-face work may have facilitated the emergence of subsymbolic and bodily experiences, whereas online sessions – particularly through written narratives – may have offered opportunities for reflective reorganization and verbal integration. In the literature, a previous study reported a different pattern of symbolization and interaction between in-person and online treatment modalities (Negri & Christian, 2022). This pattern was not observed in the present study; rather, the findings appear to suggest that the therapeutic process continued with a generally adequate level of symbolization across settings in this single case, although these observations should be interpreted cautiously. This apparent absence of significant quantitative differences between modalities may support the view that neither setting is inherently more conducive to symbolization. Instead, symbolic continuity seems to be preserved when the therapeutic frame remains stable, and the therapeutic work is maintained over time. The discrepancy with previous findings may reflect methodological differences, as the present study relied on patient diary data rather than direct analysis of in-session interactions. In sum, from a qualitative perspective, it can be suggested that the patient's emotional processing may have shifted during the initial transition

from in-person to online therapy, with increased emotional and sensory engagement accompanied by a reduction in reflective style and speech length. However, after a few sessions, these aspects of the therapeutic process appeared to return to levels comparable to those observed during in-person sessions. In this sense, aside from a brief transitional phase, the internal process of emotional integration seems to continue steadily rather than being disrupted. This continuity is further illustrated by the longitudinal transformation in Aurora's representation of her body. Early descriptions tended to depict the body as inert and burdensome and closely associated with depressive withdrawal: "I used to spend whole days lying on my bed, doing nothing; it weighed on me to perform the simplest tasks ...". Later accounts, emerging after ongoing therapeutic work across both modalities, appear to depict the body as more responsive, grounded, and emotionally informative: "In the exercise, at the body level, I knew that I could do whatever I wanted ... I felt my body steady, safe, strong."

This shift may reflect not only symptomatic improvement but a qualitative change in the capacity to symbolize bodily experience and integrate it into a coherent self-narrative. In conclusion, this single-case study seems to suggest that effective therapeutic change is less dependent on the physical setting than on the continuity of the symbolic process, underscoring the clinical importance of maintaining continuity in therapeutic meaning-making processes.

Limitations

The limitations of this study primarily relate to its reliance on a single clinical case, which restricts the generalizability of the findings. The case was not selected randomly but based on specific clinical characteristics, introducing potential selection bias. Additionally, the study heavily relied on qualitative tools such as the clinical reports, which, while rich in clinical insight, are subjective and may affect the reliability and replicability of the observations. The use of self-report questionnaires as primary instruments for outcome evaluation presents further limitations, as these measures are susceptible to response biases, limited introspective accuracy, and may not fully capture unconscious or nonverbal dimensions of the therapeutic change. The absence of a control group and the lack of quantitative validation further limit the ability to draw definitive conclusions. Moreover, due to the multicomponent and multidisciplinary nature of the intervention, the observed clinical improvements cannot be specifically attributed to any single treatment component, including RBP, as the effects likely emerged from the integrated action of the overall therapeutic program.

Conclusions

In conclusion, MCT appears to be compatible as a metatheoretical basis for RBP. This possible integration has been examined both conceptually and in practical psychotherapeutic application. The use of these measures may offer some potentially relevant insights, and, despite the inherent limitations of the present study, this approach may contribute to reinterpreting RBP within a framework oriented toward greater integration with the broader field of psychological science. In this context, such integration may be considered not only feasible but also potentially beneficial for both areas, insofar as it could promote a broader and more nuanced understanding of their respective perspectives. Microanalysis of the therapeutic process, supported by MCT methodology, appears to offer a potentially deeper understanding of emotional regulation and symbolization mechanisms, which may go beyond the mere assessment of symptomatic improvement. Overall, the findings of this single-case study do not appear to indicate substantial differences between in-person and online modalities regarding the activation and development of the RP. Rather than functioning as qualitatively distinct therapeutic contexts, the two modalities seem to support a continuous and coherent process of emotional elaboration and symbolization over time. The transition from face-to-face to online therapy does not appear to have disrupted the therapeutic process but rather suggests its stability and adaptability across settings.

From a clinical perspective, the results seem to suggest that therapeutic effectiveness may be less dependent on the specific modality and more related to the continuity of the symbolic work and the maintenance of a stable therapeutic frame. In this single case, in-person and online sessions seem to have supported different moments within the same integrative process, allowing bodily experience and verbal narration to remain dynamically interconnected. When sustained within an ongoing therapeutic relationship, both modalities can contribute to the elaboration and integration of emotional experience. From a methodological and theoretical standpoint, this study may potentially extend the application of MCT measures to a novel clinical context, namely a body-oriented psychotherapy that underwent an unplanned transition to online delivery. The findings appear to indicate that RP indices may be sensitive not only to therapeutic change but also to shifts in expressive modalities, while still capturing the underlying continuity of meaning-making processes. In this sense, the present work may lay the groundwork for further research on the applicability and robustness of MCT-based measures across different therapeutic settings, including hybrid and flexible clinical formats. However, given the exploratory nature and

methodological limitations inherent in a single-case design, the present findings should be interpreted with caution and considered preliminary rather than conclusive.

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The authors declare no potential conflicts of interest.

Publication Ethics

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