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Impaired ability to feel in cases of pelvic floor issues: two case descriptions of haptotherapy treatment

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Abstract

The objective of this article is to provide insight into the therapeutic possibilities of haptotherapy in case of pelvic floor problems. Haptotherapy and the concept of 'an impaired ability to feel' are explained, followed by two case descriptions. The authors conclude that haptotherapy can be a valuable additional therapy for patients with an impaired ability to feel in case of pelvic floor problems and that further research is desirable to scientifically confirm its positive effect.

Keywords: Haptotherapy, impaired ability to feel, pelvic floor.

Introduction

Pelvic floor issues

The Foundation Pelvic Floor Patients (2023) lists more than thirty different types of pelvic floor problems. According to the authors, all of these problems may involve an impaired ability to feel, which could be an indication for haptotherapy.

The number of Dutch people with pelvic floor issues is not precisely known. The Foundation Pelvic Floor Patients (2023) estimate the number at around one million. Since people with pelvic floor issues may not all report this to their family doctor or specialist, the numbers could be even higher (Foundation Pelvic Floor Patients, 2023). Medical and psychological problems may also play a role as the cause and the effect in pelvic floor problems (Dutch Society for Obstetrics and Gynaecology, 2023).

The pelvic floor is an area that can be examined and treated by many different specialists: the gynaecologist, urologist, urogynaecologist, colorectal surgeon and the pelvic physiotherapist, but also the sexologist, gastroenterologist, incontinence nurse, psychologist and psychiatrist can play an important role in examination and treatment (Dutch Society for Obstetrics and Gynaecology, 2023; Foundation Pelvic Floor Patients, 2023).

The haptotherapy professional branch is not yet listed as involved in caring for pelvic floor problems, although healthcare haptotherapists with a healthcare registration do collaborate with all relevant disciplines, such as: pelvic physiotherapy, psychiatry, sexology, psychotherapy, obstetrics and gynaecology. Two such examples are found, i.e., at the Amsterdam University Medical Centre, where for twenty years a secondary healthcare haptotherapist has been participating every six weeks in a multidisciplinary consultation with representatives of the aforementioned disciplines (Amsterdam UMC, 2023). Secondly, healthcare haptotherapists in Apeldoorn have been active within an integrated multidisciplinary cooperation since 2003, collaborating with the disciplines of obstetrics, gynaecology and psychotherapy to help pregnant women with extreme fear of childbirth (CARE Pathway for Pregnant Women with Fear of Childbirth, 2023). In both cases, the multidisciplinary collaboration is organized at the local level and dependent on some personal networks of individual therapists and has not yet been implemented nationwide. However, an informal study of the patient records by the authors participating in this article shows that healthcare haptotherapists throughout the Netherlands are regularly consulted by patients with pelvic floor problems.

This primarily applies to patients who present with psychological trauma, stress and the aftermath of sexual abuse, whereby also an impaired ability to feel usually occurs (among other things).

Impaired ability to feel

Such an impaired ability to feel can be illustrated by the example of shaking someone's hand without any emotional involvement, which is also a metaphor

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for many other situations in human contact. For example, one might shake or squeeze someone else's hand, without feeling the other's hand or them as a person. One doesn't allow themselves to be emotionally felt by the other person, neither does one perceive oneself to be felt. The issue in the preceding example is the lack of emotional involvement. If this phenomenon occurs unintentionally and undesirably, and in more situations than just handshaking, there may be from the haptotherapeutic perspective a so-called 'impaired ability to feel', which can be examined and treated by a healthcare haptotherapist. According to the authors, the lack of said emotional involvement can be interpreted as a form of dissociation (Mental Healthcare standards, 2022).

Restrain Internal Sensitive Participation (RISP)

Klabbers (2014) described a specific example of such an impaired ability to feel regarding vaginal examination and labelled it 'Restrain Internal Sensitive Participation' (RISP). He described it as follows. "A pregnant woman who receives a vaginal examination by her family doctor, midwife or gynaecologist may feel somewhat uncomfortable, even though she recognizes the need for such a physical examination. The pregnant woman will allow her body (the object) to be examined, but will instinctively try to be as emotionally uninvolved as possible. She does this by pulling back emotionally while being examined internally." This may be an adequate response during a vaginal examination, because women naturally consider this area to be private. However, if it is a question of permanent RISP causing an impediment to normal functioning, then one can speak of an impaired ability to feel, which may be an indication for haptotherapy (Klabbers, 2020).

The objective of this article is to provide more clarity to therapists, trainers, patients and referrers about the possibilities of haptotherapy in pelvic floor problems involving an impaired ability to feel.

The authors of this article are unaware of any publications that mention the treatment of an impaired ability to feel, as it is addressed in haptotherapy and described in this article.

Haptotherapy

The healthcare haptotherapist uses insightful conversation, skills training, and affective touch to help the patient become aware of their ability to feel and to experience it personally (Plooij, 2005; Association of Haptotherapists, 2023). If, for example, a patient with burnout symptoms has little feeling for the signals from their own body, then body-focused mindfulness exercises can be used as a first step in becoming more engaged with their own body. Haptotherapeutic touch can be a next step in the path to a better perception of their corporality.

In her article 'When Touch is Required' ('Als aanraken nodig is') Plooij (2014) offers an overview of the various forms of affective touch: for encouragement and support during a difficult period, which include the handshake, an arm around a shoulder and the awareness of 'self-touch' by the patient (Leijssen, 2006); as support when expressing feelings and for protection against decompensation or disintegration (Leijssen, 2006); to release the emotions, while touch continues to offer containment (Leijssen, 2006); as a safety net, for relaxation and to prevent being overwhelmed by emotions (Goodman, & Teicher, 1988); to access new material, that cannot be reached in another way (Goodman & Teicher, 1988); to experience safety (Main & Solomon, 1990); and, for reassurance (Gray, Watt & Blass, 2000).

Klabbers (2021) added as a possible form of affective touch the following to the above list: "To impart experiential knowledge (hapto-education), i.e.: to help the patient methodically familiarise themselves with opening and closing themselves to sensory impressions; and to introduce the patient to the awareness of their emotional, 'feeling' self and to being palpably present, to sense the space around them and the other people in the space around them."

Affective touch in haptotherapy: Haptotherapeutic touch is not the same as touching in general everyday life; it distinguishes itself from medical palpation and the objectified sensing of tension or distension. It is characterised by sensing and perceiving whether the patient consciously perceives themself, physically and emotionally, and it aims to bring the patient more in touch with their physical and intrinsic feeling, with affectivity and affective touch being central (Klabbers, 2018, 2020; Plooij, 2007, 2010, 2017; Veldman, 2007).

Haptotherapy for pelvic floor issues: Hapto-education is not so simple in pelvic floor problems, because body-focused mindfulness exercises are often emotionally-charged and touching patients' pelvic floor by the therapist is never acceptable. If you have trouble being emotionally connected to your right knee, because you banged it against something, then a healthcare haptotherapist can touch and/or hold the knee and ask the patient to feel from inside themselves what they can feel, i.e., you can call on someone's emotional involvement. If there's a problem with the right knee, people sometimes talk about their bad leg and their other good leg. Haptotherapeutic touch can often recover that difference. However, you can't treat the pelvic floor in the same way, because if you were to touch that area as a therapist, then there is a good chance that

someone will withdraw emotionally in that area, as in the example of the pregnant woman who receives a vaginal examination, or perhaps cause a new trauma. Nonetheless, it may be desirable from a therapeutic perspective for a patient to rediscover their pelvic area emotionally, as a normal tactile part of their body, without the connotation of sexuality and/or eroticism.

Basic presence: People can perceive themselves sensorily, have feeling for the space around them and they can have feeling for others; they can empathise, sense, intuit, be intensely sensitive, sympathise, and they can perceive and be conscious of their inner experiences in themselves, and also in others (Plooij, 2005: Klabbers, 2020). Haptotherapy has specified definitions for these inner experiences, one of which, the concept known in haptotherapy as 'basic presence', will be explained as an introduction to the cases described in this article.

Anatomically and physiologically, the perineal zone is the base of the body, surrounded by the pelvic plate that forms the pelvis, the pubic bone and the sacrum from which the spinal column rises, supported by the legs on which we stand. Being present means being there, being in the world, being present within the expression of being oneself in connection with the world and with life. People who are instinctively present in their basis, feel an inner security, a stability that gives them the courage to be themselves even in the presence of others, and they can express their boundaries and desires in a natural way (Veldman, 2007).

Case descriptions

The patients and their partners of both cases gave their consent to anonymously describe their cases and have approved their case description. The case histories that follow have in common that each involves the development of basic presence. They are intended to provide insight into the haptotherapeutic method in pelvic floor issues, whereby it is not necessary to touch the pelvic floor area in order to effect change and development in that area. The assumption is that basic presence reduces RISP and increases emotional involvement.

Case 1

A 26-year-old woman suffering from headaches was referred for haptotherapy by her family doctor, with the indication of 'stress-related tension headaches'. *Somatic*: The patient complained of headaches and felt perfectly healthy otherwise. *Cognitive*: Initially, the patient felt that exclusively contextual factors played an important role. In the course of the intake interview, personal factors also emerged, such as a lack of self-confidence. *Emotional*: The patient appeared outwardly quite impassive. *Behaviour*: The patient had become a pleaser both at work and in relationships. She always did her best to keep everyone happy and found it difficult to set boundaries. *Social*: The patient needed warmheartedness, but she could no longer tolerate the attention and support of her partner and her friends very well. *Affective*: Further questioning revealed a childhood with little affective affirmation.

The patient wanted fewer headaches after conflict situations, and she also wanted to be able to set boundaries, stand up for herself and learn to talk about this. After explaining the learning plan and how haptotherapy works, treatment was agreed upon to build a basic sense of safety and self-confidence. One of the experiential exercises used was that of sitting on a chair. The exercise was conducted as follows: 'Place your hand under your buttock so that you feel the knob (tubercle) of the sit bone (ischium) pressing into your hand. Feel your buttock with your hand; does it feel warm or cold, hard or soft?; does the knob feel large or small? Then feel the seat of the chair with the back of your hand. Does the seat feel warm or cold, hard or soft? Then feel your hand with your buttock. Does your hand feel warm or cold, hard or soft, large or small? Can you also feel the chair through your hand? How much space does your hand take up between the buttock and the chair? Then remove your hand and experience if there is any difference in how you're sitting. What differences can you name? Then repeat the exercise on the other side with the other hand.'

Gradually, the patient became aware of physical tension and relaxation and the healthcare haptotherapist was able to guide her in experiencing the distinction between body-object and body-subject.*

*The term `body-object` refers to the body as an object that, for example, can be examined for medical purposes. The term `body-subject` refers to the way the body is subjectively experienced (Merleau-Ponty, 1945; Ter Meulen & Van Woerkom, 2009).

After four treatments, it had become clear that there were complex and interfering factors that impeded recovery, including various informal care responsibilities and demanding familial behaviour.

During the fifth treatment, the topic came up that, according to the patient, she experienced vaginistic reactions when she and her husband tried to have intercourse, which then effectively failed. Her husband, however, was patient and kind. They made love without intercourse and they each individually had a perception of sexuality, but always without penetration. The turning point in therapy came when the patient said that she did not want children, but

felt sad for her husband, who did want a child, and that she would want to do it for him. However, he only wanted it if she really wanted it. At this point, it was suggested that she and her partner come into the practice together once, provided that he was somewhat supportive of the idea.

The sixth treatment proved to be the beginning of a new trajectory. Specifically, the patient herself actually had a desire for children after all, but because of her alleged vaginismus*, she was so afraid of giving birth that she did not want to become pregnant. She also could not imagine how a delivery would go, because sex was not really going well either.

*Vaginismus is the involuntary contraction of the pelvic floor muscles, which makes sexual intercourse very painful or even impossible (Banaei, Kariman, Ozgoli, Nasiri, Roozbeh, & Zare, 2023).

Her husband, tired of all the rejections at the beginning of the relationship and seemingly resigned to his fate, gave her all the space she needed without really addressing her anymore. So, they had fallen into a vicious circle of tolerating each other, like being in a lift, very close, but without any real contact. Over a period of about six months, through experiential exercises the partner increasingly came out of his shell in his contact with his wife, including expressing his anger. Step by step, they learned to enjoy loving contact without the extra strain of sexuality and the possibility of pregnancy. After the patient's revelation of her (hidden) desire for children, during which she and her partner both spontaneously burst into tears, their desire for children ceased to be a topic of conversation for them for a while.

After a few months, the desire for children did gradually come up again in passing, but at the same time, there always seemed to be some kind of unspoken agreement that the time for discussion was not yet ripe. Throughout the process, the partner's body became more supple and he said: 'I feel that I move more easily'. And the woman began to feel and smell herself more, the latter of which she didn't like at first, but became used to it in time. She said about this: 'I am becoming more aware of my body'.

At a certain point, their lovemaking began to develop spontaneously and it appeared that the patient was actually not vaginistic at all, but that the approach hadn't been right. For a while however, intercourse could not be completed. They both felt the urge halfway to fall back into old patterns, which they did from time to time. In retrospect, they were then dissatisfied with the ending, but over time they gained the courage to stop doing that.

After a year and a half, it turned out that the patient was pregnant. There was not an immediate affective father-mother-child unity, because the rather unexpected pregnancy seemed to set them back slightly in their development and made them a bit cautious. Then the problem arose that the woman wanted to continue the haptotherapy biweekly and her partner thought it was enough for now and wanted to wait until the 30th week of pregnancy to start preparing for the birth, because he found it all to be rather stressful. As a compromise, the haptotherapy was continued on a monthly basis.

Reflection on the therapeutic treatment (Case 1)

When one is ill or something isn't working, the natural reaction generally is to get rid of the problem as soon as possible. Illness, however, can also be a signal to do something about oneself. For instance, a symptom can provide someone with an opportunity for growth. Acceptance of or learning to deal with a symptom or illness precedes possible growth. For example, an imbalance between one's feelings and intellect cause stress, between what one should do or wants to do, and what one is able to do. Symptoms of a physical and/or psychological nature may arise. How one responds to this is unique to each person (Association of Haptotherapists, 2023).

At the start of therapy in case 1, the healthcare haptotherapist initially focused on building a basic sense of safety and self-confidence. The healthcare haptotherapist provided contact in which the patient felt safe and secure and in which an encounter could take place. Gradually, the focus could shift from the physical pain symptoms and the problem, to the person. Experiential situations were presented, in which the patient could (re)discover her own capacity of touch and her ability to connect with someone, allowing her to manage herself and her symptoms differently.

It may be assumed that within the safety of the therapeutic relationship that was created, the patient was afforded the opportunity to allow the 'symptom behind the symptom' to appear. If this therapist had restricted herself to a massage of the neck and shoulder muscles and relaxation exercises, for example, the actual underlying issue might never have come to light. After her partner became involved, the patient could then work with him on both their sensitivity and responsiveness, i.e., under the guidance of their therapist, they could develop their own ability to feel and make contact.

Guided by the healthcare haptotherapist in this case 1, the patient, together with her husband (re)discovered her pelvic floor, even though the therapy was not specifically focused on that.

If a specific examination of the pelvic floor for only muscle tension is desired, then the healthcare haptotherapist may work together with a pelvic floor physiotherapist for this purpose. This was not relevant in this case 1, because the issue was not just about tension/distension but more about learning to consciously discern oneself, emotionally and physically.

This case 1 started with the chair exercise. For a child's natural development, this exercise is obviously unnecessary as they will simply sit on your lap. In the haptotherapy, the chair exercise is a good alternative to sitting on your lap. During the development phase of haptotherapy in the 1980s, a patient was also invited to literally sit on the therapist's lap, as a child would sit on the lap of its parents. That was very common at the time, as were other things. However, times change and that is also true for haptotherapy. Anno 2023, we no longer have a patient just sit on our lap. If it happens at all, it will be theoretically substantiated and methodically applied as part of the treatment plan, which is discussed and approved by the patient in advance. This is informed consent.

With the influence of the Me-Too movement (2017-2023) and the Covid-19 pandemic (2019-2023) 'distance and proximity' are sometimes experienced differently these days, which is why prudence is more essential than ever. Exercising caution has always been very important, but even more so today.

Case 2

A 28-year-old woman with a 7-year-old child was referred by her obstetrician in the 20th week of her second pregnancy for haptotherapy regarding her fear of giving birth. She had a score 107 on the Wijma Delivery Expectancy/ Experience Questionnaire (Wijma, Wijma & Zar, 1998), meaning she was extremely anxious about giving birth. Physically, there were no concerns and she felt perfectly healthy. However, the Four-Dimensional Symptom Questionnaire (Tebbe, Terluin, & Koelewijn, 2014), showed elevated scores in all four dimensions: distress-25 (strongly elevated); depression-5 (moderately elevated); anxiety-11 (moderately elevated); somatisation-13 (moderately elevated). Her response to this result was, "I was sometimes in a panic during my first delivery. I expect this second delivery will be even more difficult". During the intake, the woman looked at her pregnant belly, but she did not seem emotionally involved. She said she couldn't stand for her baby bump to be touched.

At the patient's request, a treatment programme of eight sessions was agreed, of which the last four were together with her husband. The aim was to become familiar with experiencing her own physicality, which was necessary for learning the correct use of abdominal pressure during pushing, dealing with contractions and managing pain during labour. Note that this case history description is not a full account of all sessions and is limited to some specific aspects related to pregnancy and birth.

Opening and closing: Patient: "After the first pregnancy, I felt an emptiness within me, and although my belly is now full with a new pregnancy, I still feel an emptiness in my abdomen". When she was taught to feel the difference between affective turning towards and turning away from the contact with her husband and his hand, she said: "When I feel the contact of his hand on my belly, I also feel a softness in my belly again. This is surprisingly pleasant to learn and I'm glad that I feel like this now". It was emphasised that this ability to make contact with her husband and his hand is her own ability, and that she has a choice to open and close herself to sensory impressions. Having become more comfortable with interacting with her baby after several sessions, she became more aware of the space around her which, as she recounted, also resulted in a more relaxed contact with her husband at home.

Directed pushing: The first time that pushing was practised, the patient's face became red and full and she pushed in every direction, except towards her pelvic floor. This technique was improved, so that pushing would be more effective during the expulsion. This gave her self-confidence. She subsequently learned to be emotionally involved during the pushing.

Dealing with contractions and managing pain: To express her feelings about the upcoming birth of her baby, the patient said after several sessions, "I don't know how yet, but when I think about the upcoming birth, I'm getting the feeling that there is hope". Her husband learned that he was able to evoke her emotional involvement with his affective attention. This helped her to cope better with the exercise of managing pain. In the end it became clear that what she feared was not the pain, but loss of control during labour. Her husband learned to support his wife, which made him feel like he could contribute something. She said, "During the first delivery, I tensed up during the contractions and desperately tried to relax in between them. Now I realise I can also relax during contractions and actively help them along. I feel less emptiness in my abdomen and I now understand how important emotional involvement is during labour." An additional result was that the parents themselves appeared to have developed a more harmonious relationship together and with their child.

Delivery: In the phase leading up to the birth, only the stress score remained slightly elevated; all the other scores had decreased too normal. An uncomplicated vaginal delivery followed at home, which was assisted by a primary healthcare midwife.

After forty minutes of pushing, a healthy baby was born. A day after the delivery, the patient sent a message to her therapist. "Hello, just a little note to say that I gave birth at home yesterday. I had strong contractions from 6 pm onwards, at 7 pm I had three cm. dilation, at 9 pm, ten cm. dilation and the baby was born at 9.40 pm. Who would have thought it would go so fast? I'm still a bit confused, but our baby is doing well. I didn't know this midwife, so I had to tell her myself how I felt and what I wanted during labour. That went really well. It was really surprising and even liberating that I was able to stand up for myself."

After the postpartum review, the therapist was hugged by both the patient and her husband, and the patient told the therapist how happy she was that she and her husband had been able to stay connected to each other during the labour and delivery.

Reflection on the therapeutic treatment (Case 2)

The pregnant woman exhibiting fear of childbirth and her partner were treated by a healthcare haptotherapist who is also qualified as a haptonomic pregnancy therapist, so that the treatment was a compilation of haptotherapy and pregnancy haptonomy. The explanation and skills exercises in directed pushing and practicing dealing with (painful) contractions are a standard part of pregnancy haptonomy. Making tangible the difference between having emotional involvement or not is also part of this treatment. However, the pregnant woman's emotional involvement was seriously inhibited. Perhaps this was caused by the negative experiences during the first delivery, or it might have also predated that. In any case, this pregnant woman needed several haptotherapeutic interventions to realise the desired emotional involvement.

The healthcare haptotherapist in this Case 2 assessed the hug at the end of the session as appropriate. The parting hug or embrace has evolved within the therapist-patient relationship. It was very common forty years ago, but is not done automatically or out of habit anymore. If it does occur, it has a therapeutic function and happens in the middle of a session rather than at the end of the therapy (session), allowing for reflection after the experiential exercise.

Case 2 may not be immediately recognised as a pelvic floor issue, because there was no specific problem with the pelvic floor itself. In this case, it involved the entire abdominal area, of which the pelvic floor is a part. When discussing the abdomen, one often thinks only of the front of the abdomen, but our abdomen also has a rear (the back), an upper side (diaphragm), and a lower side (pelvic floor). Symptoms that patients generally mention in and around the abdominal area when they first come to the healthcare haptotherapist are (among others): back pain and a stiff spine and pelvis; increased diaphragmatic tension which can lead to hyperventilation; an empty abdomen feeling, a painful abdomen and nausea, feeling of tension in the abdomen; and insufficient emotional involvement with one's pelvic floor (RISP) (Klabbers, 2020). Further questioning often reveals that there are multiple symptoms and the authors have found in their practice that this frequently includes permanent RISP.

Discussion

Last but not least, we have to discuss the various shifts in the requests for help: from headaches, to the pelvic floor, to vaginismus and sexual problems, to whether or not a wish for children (case 1); and the shift from elevated scores in all four dimensions of the 4DSQ and fear of childbirth, to relaxing and be able to stand up for herself, to feel a softness in her belly and to stay connected to each other during the labour and delivery (case 2)? Why and how did these changes occur and what was the therapist's role in these developments?

In the cases described, the healthcare hapto-therapist created a safe therapeutic environment in which the patient could (re)discover their emotional involvement in themselves and with each other through self-exploration. The healthcare hapto-therapist provided for a contact, in which the patient felt safe and secure and in which the encounter could take place. In this contact, there was room for the patient to gain experience with the principles and methodology of haptotherapy, the therapist in question as a person, the patient's own capacities of touch and ability to connect with someone, the correlation between relating to herself and to others, and how that is experienced in her physicality, i.e., gradually, the focus on complaints and problems could shift to attention to the person.

In all this, the healthcare haptotherapist also played a role as a person, because not only are the experiential exercises important, but also how and by whom the patient is guided. For example, if therapeutic prompts are agitated, it is harder to create an atmosphere of quiet and relaxation than if the therapist works calmly. As such, it is also important for the healthcare haptotherapist to be present in their basis.

The cases discussed (n=2) represent successful haptotherapy treatments and the patients concerned were very satisfied with the treatment and the outcome afterwards.

The therapist-patient relationship was not explicitly mentioned in these case descriptions. The authors hope, however, that the healthcare haptotherapist's awareness factor (meaning to be consciously affectively present) is evident in the care taken to describe both cases.

A core value of haptotherapy is restoring the ability to feel and to connect. The treatment of the so-called impaired ability to feel may therefore be assumed to contribute to the added value of haptotherapy in pelvic floor problems. The authors of this article are not aware of any publications mentioning the treatment of an impaired ability to feel as is addressed in haptotherapy and described in this article.

Limitations

(1) Because only two cases have been discussed, the positive outcomes of haptotherapy described in this article cannot yet be generalised.

(2) No validated measuring instruments were used to confirm the positive effects of haptotherapy.

Strengths

(1) According to the authors, the representation of haptotherapy presented in this article corresponds to the everyday reality in haptotherapy practice, i.e., it has high ecological validity.

(2) While haptotherapy sometimes works with guidelines, such as for fear of childbirth and for chronic pain (Workgroup on Fear of Childbirth, 2021; Workgroup on Chronic Pain, 2021), haptotherapy is also pre-eminently a tailormade therapy and the authors hopes this article gives a good impression of that.

Recommendations for future scientific research

A larger group of patients is needed to scientifically corroborate the positive effect of haptotherapy in pelvic floor issues.

We recommend further research into identifying which pelvic floor problems can benefit from haptotherapy and which not, as well as the specific therapy factors that play a role.

Conclusion

In clinical practice, haptotherapy appears to be a valuable complementary therapy for people with pelvic floor issues. More clinical research is needed to scientifically corroborate the positive effect of haptotherapy in pelvic floor issues.

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Contributions from the authors

This article was written by the first author, GAK, in collaboration with PMB, MD, JWH, RRHS, CS and RHdV. All of the authors have read and approved this article.

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