International Journal of Haptonomy and Haptotherapy
e-ISSN: 2214-5087
www.ijhh.org

Vol. 13 (2025) 2: 10-16

https://doi.org/10.61370/batx9525

Haptotherapy for trauma-related symptoms: description of a case history

Gert A. Klabbers[1]

Abstract

This article describes a series of haptotherapy sessions with a patient presenting trauma-related symptoms, who was referred by their general practitioner due to suspected disturbances in affective functioning. The aim of this case description is to provide insight into the processes and dynamics that take place within the practice of haptotherapy. The haptotherapist's method is illustrated with concrete, practice-based examples. Evaluation revealed that the patient was satisfied with the outcome of the therapy. The effectiveness of the haptotherapy was supported by positive changes in scores on both the Four-Dimensional Symptom Questionnaire (4DSQ) and the Haptotherapeutic Wellbeing Scale (HWS), administered before the start of therapy and after eight sessions. While the positive results from this single case are encouraging, no general conclusions can be drawn based on a single case description. It is therefore recommended to conduct quantitative research to validate and substantiate the observed effects, preferably in the form of a randomized controlled trial (RCT).

Keywords: trauma-related symptoms, haptotherapy.

Introduction

The patient (P.) in question has given permission for the anonymised publication of this case history description.

Background

P. (54 years old) works four days a week as a nurse in homecare services. She is a widow and lives with her two adult daughters.

At the start of the first session, she immediately stated: "I'd rather not be here at all, but I've been nervous and jumpy my whole life, and now I'm just sick of it."

In the ensuing conversation, it became apparent that she had rarely voiced her struggles, likely due to being raised with the motto: "Be strong and carry on." As the intake interview progressed, however, she quietly began to cry as she recounted her experiences.

P.: "Nothing really bothered me when I was young, but it all started after I was assaulted once by my brother-in-law when I was 22."

She immediately downplayed the incident: "Not much happened actually, he just put his hands on my breasts, but it felt horrible, and things became very uncomfortable afterward. Since then, I get startled easily and jump whenever someone comes too close unexpectedly or touches me without warning."

Request for help

P.: "My husband died six years ago, and I want to make new friends, but I feel held back from taking the initiative because of how jumpy I am. My husband understood it, he had gotten used to it, but I don't think I'll find another man like him. I don't want to keep reacting like this, getting startled whenever someone comes near me or touches me innocently."

Referral and intake

P. was referred by her family doctor due to a suspected 'impaired ability to feel' (Klabbers, 2020), a condition for which haptotherapy might be beneficial.

During the initial interview, it became evident that the grieving process following her husband's death was still ongoing. The persistent grief was likewise acknowledged by the general practitioner; however, the patient expressed reluctance to place undue focus on it. As she articulated: "I do not wish to forget my husband, and my process of mourning simply requires additional time." Therefore, additional consultation with a psychiatrist for further diagnostic assessment in this regard was not recommended at this time.

She also reported physical symptoms, including frequent headaches and muscle pain in the neck and

[1] **Dr. Gert A. Klabbers.** Correspondence: praktijk@gertklabbers.nl

Article history: Submitted: 16-04-2025, first revision 04-06-2025, second revision 18-6-2025, accepted 23-06-2025.

lower back. These symptoms were considered by the general practitioner to be most likely manifestations of stress- and tension-related factors.

4DSQ and HWS Questionnaires

At the start of the haptotherapy treatment, and after eight sessions, the Four-Dimensional Symptom Questionnaire (4DSQ) (Terluin et al., 2006) and the Haptotherapeutic Well-being Scale (HWS) (Klabbers & Vingerhoets, 2022) were administered.

Haptotherapeutic Well-being Scale

The HWS was developed to measure patient wellbeing from a haptotherapeutic perspective (Klabbers & Vingerhoets, 2021a, 2022). The HWS consists of fourteen clinical items, each rated on a 5-point Likert scale. The scale is divided into five subscales: psychological well-being (items 1, 9, 11, 14), physical well-being (items 2, 3), autonomy (items 4, 7, 10), relationship to others (items 5, 6, 8), and touching and being touched (items 12, 13). In a study on the effects of Haptotherapy on patients with chronic pain, the Cronbach's alpha for the HWS, measured at three different time points, ranged from .78 to .89 (Klabbers & Vingerhoets, 2021a). The reliability of the HWS was confirmed in two further studies (Klabbers & Vingerhoets, 2022; Küçükkaya, Işık, & Rathfisch, 2024).

The total HWS score was 29, which is considered low on the linear HWS scale ranging from 14 to 70. The subscale scores paint the following picture: *Psychological well-being:* 6 out of 20 points (30%), *Physical well-being:* 5 out of 10 points (50%), *Autonomy:* 11 out of 15 points (73.3%), *Relationships with others:* 4 out of 15 points (26.7%), *Touching and being touched:* 2 out of 10 points (20%).

Four-Dimensional Symptom Questionnaire

The 4DSQ comprises 50 items concerning psychological and psychosomatic symptoms listed in the DSM-5-TR (American Psychiatric Association, 2022). Symptoms of distress, anxiety, depression, and somatization are measured as separate dimensions (Terluin et al., 2006). The 4DSQ scales have a high internal consistency (Cronbach's Alpha: 0.84 to 0.94) (Terluin et al., 2006). The 4DSQ is frequently used in HT and is included in the reporting guideline for HT (Intramed, 2022).

The 4DSQ scores were as follows: *Distress:* 24 out of 32 (75%), *Depression:* 1 out of 12 (8.3%), *Anxiety:* 6 out of 24 (25%), *Somatization:* 16 out of 32 (50%). These scores indicate, respectively: the presence of significant tension with a high risk of functional impairment; a depression disorder is unlikely; an anxiety disorder is not present; and there may be signs of somatization with a risk of dysfunction.

SCEBS + A (Dutch: SCEGS + A)

During conversations with P., the SCEBS model (Somatic, Cognitive, Emotional, Behavioural, and Social domains) (Hoedeman, Wijers, van der Beek, & te Koppele, 2006) was used as a tool to explore possible explanations for her symptoms and to arrive at a shared problem definition. The model was extended with an additional domain: Affectivity (Klabbers, 2023). ***S****omatic:* P. reported headaches, tension in the neck and shoulder muscles, and painfully tense lower back muscles. ***C****ognitive:* She recognizes that it would be beneficial to change her long-standing coping style of "Be strong and carry on." ***E****motional:* She occasionally feels sad but tends to suppress these emotions. At the start of therapy, it was not yet clear whether this sadness was related to the inappropriate behaviour she experienced, the grieving process, or other underlying issues. ***B****ehavioral:* P. tries hard to keep those around her happy and finds it difficult to set boundaries. ***S****ocial:* She enjoys focusing on others but prefers not to be the centre of attention herself. ***A****ffective:* P. grew up in a warm family environment where warmth, openness, and affection were valued. However, she now feels that, as she puts it, "that feeling has been taken from me."

Examination

Observation

Upon arrival, P. offers a handshake, but only her fingers make contact, there is no full hand engagement, and the gesture feels distant. As she takes a seat, she looks around the room somewhat uneasily. During the initial interview, she displays noticeable motor agitation, and her breathing is shallow.

Physical

P. reports pain in her neck and shoulder muscles, and there is evident tension throughout her upper body. She expresses a lack of awareness in her lower body, stating: "I don't feel my legs."

Contact

During the exercises, P. participates willingly, but remains emotionally detached. She is unable to truly engage, not out of unwillingness, but due to an apparent incapacity. She herself acknowledges this, stating: "I can't do it; I mean, I do it, but it feels like I'm not really here."

Contra-indications

For the sake of completeness, the contraindications for haptotherapy include the presence of serious psychiatric symptoms that are not fully or sufficiently under control, even with the support of complementary psychiatric treatment,

rendering an effective therapeutic relationship impossible.

Additionally, language or communication barriers that hinder participation in haptotherapy also serve as contraindications.

In this case, no contraindications were identified.

Treatment

Plan

A treatment plan was jointly developed with P., based on the findings from the intake, examination, and questionnaire results. It was agreed that P.'s request for help would remain central, while also addressing the grieving process related to her husband's death and the aftermath of the assault.

Objective

P. states that she will consider the therapy successful if her startle responses decrease and she feels more at ease in her interactions with others. She also hopes for a reduction in her physical symptoms.

Treatment Report

The first (intake) session placed significant demands on the cognitive capacities of both the patient and the therapist. Completing questionnaires, asking and answering questions, jointly identifying the core issues, and discussing a treatment strategy are all primarily cerebral activities, even if a few tears were shed along the way.

To become familiar with the working method of haptotherapy, it was agreed that, following the initial (intake) session, at least two sessions would be dedicated to exploring some body-oriented experiential exercises and the affective, contact-oriented therapeutic touch.

Introduction to three exercises

"People are capable of perceiving themselves through feeling, of sensing the space around them, and of being attuned to others. They can empathize, sense intuitively, feel deeply, share in another's feelings, and above all, they can become aware of and consciously experience inner emotional states within themselves and in others." (Klabbers, 2020).

However, all of these feelings originate and reside within oneself. When a life event disrupts this internal balance, a carefully structured approach is required to help a person regain their footing. In this case, the structure was as follows:

Exercise on the chair

During the first (intake) session, P. sat continuously on the edge of her seat, and at the start of the second session, she again sat forward as if preparing to stand up. Therapist (T): "Would you be willing to slide back until you're sitting all the way into the chair, place your feet flat on the floor, and let your back make contact with the backrest?" P. complied willingly with everything T. asked.

However, she still gave the impression that she was ready to stand up. Therapist (T): "Could you remove your right shoe and notice if the contact with the ground feels different with your right foot compared to your left?" P.: "Yes, it does feel different." T.: "If you could choose now, would you rather put your right shoe back on, or take off your left shoe?" P.: "I'd rather take off both shoes." T.: "You are now feeling with your feet. In the same way, can you feel the seat of the chair with your bottom and the back of the chair with your back?" And she did this. T.: "Do you notice a difference in the way you are sitting now?" P.: "Yes, before I was sitting on the chair, but now I'm sitting more in the chair, and my legs are more relaxed."

From the reader's perspective, the completion of this exercise may seem to take roughly five minutes, but in practice, it lasted much longer. During the exercise, conversations about her daily life arose, and in these conversations, P. realized that when she sat on a chair, she never truly sat down. She was moved by the realization that such a simple exercise could help her stop and feel something, even if it was just the sensation of sitting in a chair, with the feeling of sitting without shoes being more comfortable than with them on.

Exercise with yourself

T.: "Could you touch your right leg with both hands, starting from your upper leg, moving to your knee, and then down your lower leg as far as you can? Take your time and repeat this several times." P. performs this task mechanically at first. T.: "Do it as if you have a washcloth in your hands and you're washing your leg." After repeating this a few times, T. asks P.: T.: "Do you notice a difference now between your right leg and your left leg?" P.: "Yes, it seems like my right leg feels more present now, or I can feel it better." T.: "Why do you think that has changed?" P.: "Because I touched that leg." T.: "Which leg feels better now?" P.: "My right leg." T.: "So what could you do now?" P. laughs and says: "Touch my other leg too?" T.: "So what's stopping you? Go ahead."

Following this exercise, a conversation emerged about self-care and the importance of touching one's own body. These are small steps on the path to becoming more comfortable with touch.

In the meantime, three sessions and six weeks have passed, during which the intake and both exercises have taken place and been repeated, and for the next session, the topic of 'contact' is on the agenda.

Exercise together with the therapist

P. lies clothed on her stomach on the treatment table. T.: "May I place my hand on your back?" P.: "Okay." T. places his hand on her back and notices that P. stiffens, bracing herself for what's coming. T.: "Do you remember when we did the exercise on the chair, where you felt the ground with your feet, the seat of the chair with your bottom, and the back of the chair with your back? Could you try to feel the treatment table you're lying on in the same way?" As P. directs her attention to the treatment table, she seems to become somewhat less alert. The contours of the muscles in her neck soften, and she almost fully lowers her head. T.: "Really lay your head down on the bench and take your time to adjust to all the impressions around you." After a moment, P. let's out a deep sigh, releasing control and appearing to forget T.'s hand on her back. T. waits a moment and then says: T.: "Just as you can focus on what you feel from the treatment table you're lying on; you can also focus on what you feel from my hand on your back. Notice that there is an arm attached to the hand, and that arm is connected to me." As P. continues to search, T. says: T.: "We're not in any hurry, take your time to feel what's there." A little later, P. suddenly sits up and says: P.: "That's enough." T.: "Fine. Come sit back in the chair so we can talk a little."

In the conversation that followed, P. shared that it felt good to let go for a moment, but she was startled when she truly felt the contact for the first time. P.: "I really can't help it, in one way it feels good, but before I realized it, I was sitting up." T.: "Could it be that what you're seeking, warmth, openness, affection, and true human contact in which you can give yourself, is something you need, but that your tolerance for it right now is very low?" This was confirmed by P.

At the end of this fourth session, a tipping point in the therapy was reached. P. realized that, in order to rediscover feeling in her life, a form of exposure was necessary. In her own words:

P.: "The therapy always brings me to a crossroads, where I have to choose whether or not to continue, and that's where I confront my emotions. Next time, let's just keep going."

Recovery and processing

The therapist used affective, contact-oriented therapeutic touch with P. in an inviting and respectful manner, helping her reconnect with her body and feel where and how she is present in it. During the fifth session, P. became intensely emotional. At that moment, it was crucial for the therapist to remain present both within himself and with P. during the affective, contact-oriented therapeutic touch, providing her with the space to stay in the here and now, connected to her emotions and body.

Affective, contact-oriented therapeutic touch can serve various purposes: as encouragement, protection, a means to release emotions, reassurance, affirmation, or a way to open and confront hidden issues (Leijssen, 2006).

Haptotherapy emphasizes that affective, contact-oriented therapeutic touch helps the patient become comfortable with both opening and closing themselves to emotional impressions, observing themselves through their emotions, being emotionally present, developing a sense of the space around them, and attuning to others in the same space (Klabbers, 2021).

The dynamic of this session was clearly different from the early sessions in the therapy.

The first four sessions primarily focused on building trust and restoring the (impaired) ability to feel, while during the fifth session, the focus shifted toward the psychological processing of the traumatic event.

After a while, the therapist asked: "How are you now?" P.: "I feel relieved, and I want to tell you something." This led to a conversation about the traumatic event that had happened many years ago. P. had briefly mentioned it during the initial session, but now she began to speak about it in detail, with tears falling freely. This process was repeated several times in the following sessions, from sessions 6 through 8.

Evaluation

After 8 sessions of haptotherapy, the 4DSQ and HWS were administered again. The 4DSQ scores were as follows: *Distress:* 8 out of 32 (25%), *Depression:* 1 out of 12 (8.3%), *Anxiety:* 5 out of 24 (41.7%), and *Somatization:* 12 out of 32 (37.5%), i.e., results compared to the first measurements: Distress -16, Depression 0, Anxiety -1, Somatization -4. These 4DSQ-results indicated a notable reduction in stress symptoms, particularly.

The HWS score was 48 out of 70 (64%), reflecting a substantial improvement in overall well-being. The sub-scale scores were: *psychological well-being* 14 out of 20 (70%), *physical well-being* 7 out of 10 (70%), *autonomy* 11 out of 15 (73.3%), *relationship to others* 10 out of 15 (66.7%), and *touching and being touched* 6 out of 10 (60%), i.e., results compared to the first measurements: psychological well-being +8, physical well-being +2, autonomy 0, relationship to others +6, and touching and being touched +4.

These positive results from both the 4DSQ and HWS were confirmed by P.'s own evaluation. She reported feeling much better, with fewer headaches and less back pain.

Although she had not yet made new friends, she understood that such connections take time to develop. P. felt freer and more comfortable in her

interactions with others and was confident that this would continue to improve.

By this point, P. had enrolled in a painting class, joined a sports club, and felt generally satisfied with her progress. P.: "The greatest gain for me is that I'm less startled and more emotionally present in the here and now."

While P. still experienced moments of sadness and grieved the loss of her husband, it appeared that she had largely processed this before starting therapy. At the beginning of therapy, the traumatic event that occurred when she was 22 was her primary concern. However, over the course of therapy, this issue had been addressed enough that she could say the process of dealing with it had begun.

After completing this initial treatment cycle of 8 sessions over the span of about three months, both therapist and P. agreed to reduce the frequency of sessions.

This change would allow more time between appointments for P. to implement the skills she had learned into her daily life.

Thereafter, two follow-up appointments were arranged at approximately four weeks and four months, after which the therapy was concluded. No further measurements were conducted upon termination.

Discussion

Haptotherapy appears to have had a positive effect. Data on long-term outcomes are not yet available. Haptotherapists utilize insightful conversations, body-oriented experiential exercises, and affective, contact-oriented therapeutic touch. Specific and non-specific therapeutic factors within haptotherapy were recently discussed in detail in two articles (Klabbers & Vingerhoets, 2021b; Klabbers, Boot, Dekker & Hagg, 2024). It is likely that these factors also apply to this case.

However, in order to determine the most essential factor within the multitude of specific and non-specific therapeutic factors that likely play a cumulative role in haptotherapy, more scientific research is needed.

Even if this factor were known, the question of how it works remains, i.e., what exactly happens in the "black box" of haptotherapy?

It is well known that the quality of the therapeutic relationship is one of the most important factors for a successful therapy outcome (Horvath, Del Re, Flückiger, & Symonds, 2011).

However, according to the author, the most favourable outcomes are likely to occur when this is combined with a robust methodology.

In this case description, after establishing a safe therapist-patient relationship, the psychological processing of a traumatic experience and the restoration of a (disrupted) ability to feel are described. It may be assumed that these processes within haptotherapy are closely linked, and in this case, haptotherapy appears to be effective.

Although numerous touch-based interventions have been studied (Packheiser, Hartmann, Fredriksen, Gazzola, Keysers, & Michon, 2024), there remain few randomized controlled trials (RCTs) demonstrating the effectiveness of haptotherapy. Therefore, to be able to generalize these findings, further scientific research on haptotherapy is necessary.

Prolonged Grief Disorder

Although the therapeutic intervention was considered successful, the author/haptotherapist, subsequently reflected on whether the grieving process had been sufficiently addressed during treatment. In particular, the question arose as to whether the patient's symptomatology aligned with the diagnostic criteria for Prolonged Grief Disorder, as defined by the DSM-5-TR (American Psychiatric Association, 2022).

P. explicitly indicated a preference to limit emphasis on the grieving process, a preference that was respected by the treating haptotherapist. However, this avoidance may itself represent a potential manifestation of Prolonged Grief Disorder.

A key consideration in the clinical reasoning was that P.'s primary complaints, namely nervousness and heightened startle responses, preceded the death of her spouse. Furthermore, her social and occupational functioning remained largely unimpaired.

The presenting symptoms might alternatively be explained by a prior traumatic experience involving sexual assault.

Trauma Processing on Multiple Levels

Within haptotherapy, trauma processing is approached as a multifaceted process that unfolds on several interconnected levels. Traumatic experiences leave imprints not only on cognitive and emotional functioning but also become embedded in the body, affecting the patient's relational and existential awareness.

Cognitive schemas may become rigid or avoidant, disrupting processes of meaning-making and undermining mental representations of safety (Ehlers & Clark, 2000). Emotionally, trauma often manifests in suppressed or dysregulated responses, with feelings such as fear, shame, or powerlessness impeding access to one's emotional self (Van der Kolk, 2014).

On a physical level, this is frequently expressed through increased muscle tension, impaired bodily awareness, or a lack of affective attunement to the body (Ogden, Minton, & Pain, 2006; Levine, 2010).

In haptotherapy, the bodily level is explicitly addressed through affective, contact-oriented therapeutic touch and body-based experiential exercises.

These interventions aim to restore embodied presence and facilitate renewed affective attunement. At the relational level, trauma often disrupts the ability to engage in safe, trusting connections, particularly concerning proximity and vulnerability.

The haptotherapeutic relationship offers a safe and attuned context in which patients can re-experience contact without becoming overwhelmed or rejected (Herman, 1992).

In some cases, trauma also affects existential dimensions, such as the loss of meaning or a sense of disconnection from oneself and the world. Haptotherapy creates space to make these deeper layers tangible in the bodily here-and-now, supporting integration between feeling, thinking, and being (Levine, 2010).

The case discussed here illustrates how engaging with these various layers can initiate a process of healing and reconnection.

Limitations

This article describes a single case history, and general conclusions cannot be drawn from just one case. However, it provides a valuable impression of the potential significance of haptotherapy.

That the 4DSQ and the HWS were not reassessed at the time of termination highlights a common challenge in clinical practice, where cases initially managed as routine care are later considered for academic reporting.

The absence of additional standardized measurements at therapy termination may limit the depth of empirical analysis and the robustness of outcome evaluation.

Prospective awareness of research intentions could encourage more systematic data collection, thereby enhancing the validity and generalizability of case-based evidence. This underscores the importance of integrating a research-minded approach into clinical workflows to optimize both patient care and scientific contribution.

Strong Points

This case description demonstrates high ecological validity, offering a clear insight into what haptotherapy may contribute to the treatment of trauma-related symptoms and how the therapy is structured.

Conclusion

While the positive results from this single case are encouraging, no general conclusions can be drawn based on a single case description. It is therefore recommended to conduct quantitative research to validate and substantiate the observed outcomes, preferably in the form of a randomized controlled trial (RCT).

Acknowledgements

I am grateful to my colleagues Henriëtte van de Goor, Willem Hagg, and Renske Harte Sluman for their invaluable feedback on all or parts of the draft versions of this article.

Author's details

[1]Dr. Gert A. Klabbers, Haptotherapist, Therapy Center Ietje Kooistraweg 25, 7311 GZ Apeldoorn, the Netherlands & Postdoctoral Researcher at Tilburg University, Warandelaan 2, 5037 AB Tilburg, the Netherlands.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.; DSM-5-TR). American Psychiatric Publishing.
ISBN-13: 978-0-89042-576-3

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38*(4), 319–345. https://doi.org/10.1016/S0005-7967(99)00123-0

Herman, J. L. (2015). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror* (Orig. pub. 1992; Rev. ed.). Basic Books.
ISBN-13: 978-0465061716

Hoedeman, R., Wijers, J. H. L., Beek, E. J. van der, Koppele, A. te (2006). Toepassing van het SCEGS-model in de begeleiding van somatiserende werknemers. Tijdschrift voor Bedrijfs- en Verzekeringsgeneeskunde. 14: p. 441 444.
https://doi.org/10.1007/BF03074454

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9-16. https://doi.org/10.1037/a0022186

Intramed (2025). Intramed online for haptotherapy. Available from: https://www.intramed.nl/wp-content/uploads/Intramed-Online-voor-haptotherapie.pdf.

Klabbers, G. A. (2020). Impaired ability to feel: indication for haptotherapy. *International Journal of Haptonomy and Haptotherapy*, *3*, 12-14. https://doi.org/10.61370/fjnc3900

Klabbers, G. A. (2021). *Hapto-educatie: een kerntaak van de hands-on gezondheidszorghaptotherapeut.* Available via: https://www.gertklabbers.nl/wp-content/uploads/2021/01/Hapto-educatie.pdf.

Klabbers, G. A., & Vingerhoets A. J. J. M. (2021a). What is the effect of haptotherapy on patients with chronic pain? International Journal of Haptonomy and Haptotherapy, 1:1-9. https://doi.org/10.61370/xzug1370

Klabbers, G. A., & Vingerhoets, A. J. J. M. (2021b). Satisfaction and specific and non-specific therapy factors: haptotherapy from a patient perspective. *International Journal of Haptonomy and Haptotherapy*, *3*, 20-29. https://doi.org/10.61370/llsi4445

Klabbers, G. A., & Vingerhoets A. J. J. M. (2022). Measuring patient well-being: an exploratory study of the Haptotherapeutic Well-being Scale (HWS). *International Journal of Haptonomy and Haptotherapy, 1*:1-7. https://doi.org/10.61370/vnby4466

Klabbers, G. A. (2023). Clinical reasoning in Haptotherapy: Use of the SCEBS and Questions about Affectivity. *International Journal of Haptonomy and Haptotherapy, 11*(2):9-11. https://doi.org/10.61370/idvx9733

Klabbers, G. A., Boot, B., Dekker, M., & Hagg, J. W. (2024). Mechanisms of Haptotherapy: specific and nonspecific therapy factors. *International Journal of Haptonomy and Haptotherapy*, *12*(1), 1-7. https://doi.org/10.61370/veme5018

Küçükkaya, B., Işık, H. K., & Rathfisch, G. (2024). Turkish validity and reliability of the Haptotherapeutic Well-Being Scale. BMC Complementary Medicine and Therapies, 24(1), 323. https://doi.org/10.1186/s12906-024-04613-z

Leijssen, M. (2006). Validation of the body in psychotherapy. *Journal of humanistic psychology, 46*(2): p. 126-146. https://doi.org/10.1177/0022167805283782

Levine, P. A. (2010). *In an unspoken voice: How the body releases trauma and restores goodness*. North Atlantic Books. ISBN-13: 978-1556439438

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. W. W. Norton & Company. ISBN 0-393-70457-2

Packheiser, J., Hartmann, H., Fredriksen, K., Gazzola, V., Keysers, C., & Michon, F. (2024). A systematic review and multivariate meta-analysis of the physical and mental health benefits of touch interventions. *Nature human behaviour*, *8*(6), 1088-1107. https://doi.org/10.1038/s41562-024-01841-8

Terluin, B., Marwijk, H. W. van, Adèr, H. J., Vet, H. C. de, Penninx, B. W., Hermens, M. L., Boeijen C. A. van, Balkom A. J. L. M. van, Klink J. J. L. van der & Stalman, W. A. (2006). The Four-Dimensional Symptom Questionnaire (4DSQ): a validation study of a multidimensional self-report questionnaire to assess distress, depression, anxiety, and somatization. *BMC Psychiatry, 6*(1), 1-20. https://doi.org/10.1186/1471-244X-6-34

Van der Kolk, B. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. *New York*, *3*.