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

Vol. 14 (2026) 5: 34-45
https://doi.org/10.61370/eydb4083

The development of a line of research in haptotherapy: a first step toward a discipline-specific conceptual framework

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Abstract

This article describes the development of a line of research in haptotherapy between 2011 and 2026. It is not a review of the field as a whole, but a retrospective reconstruction of publications to which I contributed as first author. The research questions evolved from identifying changes during haptotherapy to investigating possible processes of change and developing concepts to describe and study these processes. In retrospect, five candidate-building blocks can be identified for a discipline-specific conceptual framework: modes of approach, feeling, affective attunement, presence, and relational connectedness. In addition, RISP and *Impaired Ability to Feel* offer starting points for investigating possible barriers and processes of change. These concepts do not yet constitute a coherent or validated model. Their interrelationships and potential added value in relation to existing psychotherapeutic and body-oriented concepts require further investigation. This article provides a first step toward a discipline-specific conceptual framework for haptotherapy.

Keywords: haptotherapy; line of research; discipline-specific conceptual framework; affective attunement; feeling; relational connectedness; therapeutic change

Introduction

In the studies I conducted between 2011 and 2026, the focus gradually shifted from measuring changes during haptotherapy to exploring possible processes of change and the concepts used to describe and investigate these processes.

This line of research was not conceived from the outset as a single research program. Subsequent studies emerged from questions raised by earlier research and from issues encountered in haptotherapy practice.

Over time, I increasingly focused on concepts such as feeling, affective attunement, therapeutic presence, and relational connectedness. I also further elaborated the three modes of approaching the person: handling (Dutch: hanteren), psychotactile contact, and thymotactile contact (Klabbers, 2026a). In addition, concepts emerged to describe possible barriers to contact with bodily and affective experiences. These included Restrain Internal Sensitive Participation (RISP), referring to the withholding of inner, sensitive engagement (Klabbers, Wijma, Paarlberg, Emons, & Vingerhoets, 2014), and *Impaired Ability to Feel*, referring to a diminished capacity to feel (Klabbers, 2020; Klabbers, Bouwman, Dekker, Hagg, Harte-Sluman, Spil, & de Vos, 2023).

These concepts serve different purposes, and their interrelationships have not yet been empirically established. I therefore regard them as potential building blocks for a discipline-specific conceptual framework, rather than as components of a fully developed model. The central question is to what extent these concepts, taken together, can provide an initial basis for a discipline-specific conceptual framework for haptotherapy.

In this article, a discipline-specific conceptual framework refers to a provisional organization of concepts that are relevant to describing and investigating the distinctive characteristics of a discipline. Such a framework does not need to constitute an empirically established explanatory model. Rather, it can represent a first step towards its development by identifying relevant concepts, exploring their interrelationships, and formulating questions for further research. The term is used in this limited sense throughout this article.

Method and scope

This article reconstructs one line of research on the basis of publications from 2011 to 2026 to which I contributed as first author. It is neither a systematic review nor a narrative review of the scientific

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Article history: Manuscript submitted 29-7-2026, first revision 17-10-2026, second revision 19-11-2026, accepted 20-11-2026.

literature on haptotherapy. Publications by other researchers and publications to which I did not contribute as first author were not systematically collected or assessed. The article therefore does not provide a comprehensive overview of the field.

I retrospectively compared the selected publications, focusing on their research questions, methods, main findings, and conceptual development. I also examined how findings from earlier studies and theoretical reflections prompted new research questions. The connections between the studies were reconstructed retrospectively and had not been part of the original research designs.

This reconstruction yielded five candidate-building blocks for a discipline-specific conceptual framework: modes of approaching the person, feeling, affective attunement, therapeutic presence, and relational connectedness. These were derived from the concepts and themes investigated or theoretically elaborated in the publications.

The selection of these five candidate-building blocks was based on their recurrence and conceptual development across the publications, their conceptual distinctiveness, and their relevance to describing aspects of haptotherapeutic practice and experience. No predefined theoretical categories were used. The five building blocks were identified retrospectively as concepts that together highlight different, potentially interrelated aspects of haptotherapy. Their conceptual boundaries and added value require further investigation.

This retrospective identification and selection of the five building blocks constitutes an interpretive synthesis rather than the application of a predefined systematic coding procedure.

The five building blocks differ in function and level of abstraction. Their interrelationships have not yet been empirically tested as part of a single model.

This approach has limitations. Selecting publications based on first authorship and my own interpretation may have introduced selection bias and confirmation bias. Other publications, alternative interpretations, and findings that might qualify the proposed relationships may have been overlooked. The retrospective reconstruction may also suggest greater coherence than has been empirically demonstrated. The proposed relationships should therefore be regarded as a hypothesis arising from this interpretive synthesis. Comparison with publications by other researchers and independent assessment are needed to critically evaluate this reconstruction.

RISP and *Impaired Ability to Feel* are discussed separately. Both concepts provide starting points for investigating possible barriers and processes of change, but serve a different function from the five candidate-building blocks.

Making change measurable

The first study in this line of research arose from a practical question: how could changes during haptotherapy be systematically documented?

The study examined whether the Four-Dimensional Symptom Questionnaire (4DSQ; in Dutch, Vier-Dimensionale Klachtenlijst, 4DKL) was suitable for use in the primary care practices of haptotherapists (Klabbers, 2011, 2013). The aim was not to demonstrate the effectiveness of haptotherapy, but to determine whether an existing measurement instrument could make changes over the course of treatment visible. At that time, no measurement instruments specifically designed for haptotherapy were available.

The study made it possible to describe changes in psychological symptoms, but it also revealed the limitations of the 4DSQ. Although the questionnaire measures psychological symptoms, it provides little information about changes in how people experience their bodies, feelings, and relationships. This raised the question of which additional concepts and measurement instruments might be needed to investigate other changes relevant to haptotherapy.

The study was descriptive in nature. Changes observed over the course of treatment do not, in themselves, demonstrate that haptotherapy caused them. This would require comparison with the course of symptoms in the absence of treatment or with the outcomes of another treatment. This, in turn, raised the question of which processes might contribute to the changes observed during haptotherapy.

From documenting change to investigating effectiveness

Once changes during haptotherapy could be systematically documented, the question arose as to the extent to which these changes could be attributed to the treatment. To address this question, a controlled study design was needed.

The first step was to provide a more detailed theoretical and clinical account of severe fear of childbirth (Klabbers, van Bakel, van den Heuvel, & Vingerhoets, 2016). This publication provided a broader conceptual and clinical foundation for research into fear of childbirth and described, among other aspects, its characteristics, assessment, prevalence, determinants, consequences, and possible treatments. Subsequently, a multicenter randomized controlled trial was designed to investigate the potential effectiveness of haptotherapy for severe fear of childbirth.

As a first step, the study protocol was published, describing the study design, procedures, and methodological principles (Klabbers, Wijma,

Paarlberg, Emons, & Vingerhoets, 2014). The protocol thus described the first controlled study design in haptotherapy to investigate its potential effectiveness.

The results of the randomized controlled trial were published several years later (Klabbers, Wijma, Paarlberg, Emons, & Vingerhoets, 2017). Among women with severe fear of childbirth, haptotherapy had a positive effect on levels of fear of childbirth, psychological well-being, distress, depressive symptoms, and post-traumatic stress symptoms. The research on fear of childbirth formed part of my doctoral research, which also examined the relationship between haptotherapy and mother–child bonding (Klabbers, 2018).

Several limitations should be taken into account when interpreting these results. The target sample size was not reached, partly because of recruitment difficulties. In addition, 11 participants in the internet-based psychoeducation group and 14 participants in the usual care group crossed over to haptotherapy. These crossovers complicate interpretation of the results according to the original group allocation. The additional analysis based on the treatment actually received is also more susceptible to selection bias. The findings therefore provide indications of the potential effectiveness of haptotherapy for severe fear of childbirth, but should be interpreted in light of these limitations.

The study does not clarify which processes might explain any treatment effects (Klabbers, Wijma, Paarlberg, Emons, & Vingerhoets, 2017). Subsequent research therefore shifted its focus towards possible processes of change and clients' bodily, affective, and relational experiences.

What processes underlie these changes?

An initial attempt to answer this question was to formulate the concept of RISP (Restrain Internal Sensitive Participation) (Klabbers, Wijma, Paarlberg, Emons, & Vingerhoets, 2014). RISP describes how people may hold back their involvement in bodily and affective experiences without necessarily being aware of doing so. This restriction can be understood as an adaptive response when allowing oneself to experience bodily or emotional sensations is perceived as threatening or burdensome. The concept thus offered an initial explanation for the difficulty some people experience in allowing bodily signals, feelings, and relational attunement.

RISP emerged from clinical observations in haptotherapy and had not yet been empirically substantiated at that time. The concept provided a starting point for further investigation of possible processes of change.

In later publications, the capacity to feel was further elaborated through the concept of *Impaired Ability to Feel* (Klabbers, 2020; Klabbers, Bouwman, Dekker, Hagg, Harte-Sluman, Spil, & de Vos, 2023). In this reconstruction, I regard both concepts as part of a gradual development in conceptual understanding. Their relationship within a single conceptual framework is a retrospective interpretation and remains to be investigated.

RISP focuses on the possible process through which people restrict their involvement in bodily and affective experiences. *Impaired Ability to Feel* concerns the capacity to perceive, allow, and make sense of such experiences. In 2023, this latter concept was explored further through two case studies involving pelvic floor problems (Klabbers, Bouwman, Dekker, Hagg, Harte-Sluman, Spil, & de Vos, 2023). This provided an initial link between the theoretical concept and clinical practice.

Both concepts provide starting points for investigating how people's relationship with bodily and affective experiences relates to symptoms and relational functioning. Further research is needed to determine whether RISP and *Impaired Ability to Feel* describe distinct processes and to what extent these processes are associated with changes during haptotherapy.

Broadening the focus to routine clinical practice

The question was whether similar changes also occurred in other client groups. The research was therefore extended to clients with a variety of concerns in haptotherapy practice.

An initial study focused on people with chronic pain (Klabbers & Vingerhoets, 2021a). In addition to reductions in distress, anxiety, and pain catastrophizing, body awareness also increased. The changes therefore concerned not only pain symptoms, but also how clients experienced their bodies and themselves. As there was no control group, it cannot be determined whether these changes resulted from haptotherapy. Nor does the study clarify the processes underlying these changes.

Understanding what clients experience as helpful

In research on client experiences, clients described not only a reduction in symptoms, but also experiences of safety, genuine contact, trust, bodily experience, and the quality of the therapeutic relationship (Klabbers & Vingerhoets, 2021b). These experiences raised the question of the significance of contact between therapist and client for changes during treatment.

An exploratory study of crying during haptotherapy was closely related to this line of research (Klabbers & Vingerhoets, 2021c). Clients

described crying not only as an emotional release, but also as an experience in which bodily awareness, safety, and relational connectedness came together. Their accounts suggest that crying during haptotherapy may mean more than emotional release alone.

These studies show the significance clients attach to aspects of treatment. However, they do not demonstrate that these aspects cause change or function as mechanisms of change.

Towards a discipline-specific conceptual framework

Existing psychological measurement instruments primarily assess symptoms and psychological well-being. In haptotherapy, feeling, bodily experience, affective attunement, and relational connectedness are also important. The question was how these aspects could be further defined and investigated.

The aim was not to replace existing scientific concepts, but to further define and investigate concepts arising from haptotherapy practice. An earlier step in this development was an exploration of clinical reasoning in haptotherapy using SCEGS (in English: SCEBS), which also addressed questions of affectivity (Klabbers, 2023). In retrospect, the publication on clinical reasoning and affectivity can be regarded as one of the conceptual starting points for further development.

An initial step was the Haptotherapeutic Well-being Scale (HWS), which was examined in two studies published in 2021 and 2022 (Klabbers & Vingerhoets, 2021a, 2022).

The HWS comprises 14 items and distinguishes five subscales: psychological well-being, physical well-being, autonomy, relationships with others, and touching and being touched. An initial psychometric study involving 640 clients of haptotherapists and a comparison group of 151 people who were not receiving haptotherapy provided preliminary indications of the psychometric quality of the HWS.

Factor analysis yielded a single factor, and internal consistency was a = .86. The HWS total score and several subscale scores were associated with scores on the Four-Dimensional Symptom Questionnaire (4DSQ) and the World Health Organization-Five Well-Being Index (WHO-5) (Klabbers & Vingerhoets, 2022). Among clients with chronic pain, internal consistency across three measurement occasions ranged from a = .78 to .89 (Klabbers & Vingerhoets, 2021a). A Turkish validation study involving 242 women reported results from a confirmatory factor analysis and internal consistency values above .90 for both the total score and the subscales (Küçükkaya, Işık, & Rathfisch, 2024).

The unidimensional structure found does not readily correspond to the five distinct subscales. Further research is needed to establish whether the HWS measures the intended constructs with sufficient discriminant validity and is sensitive to change. Independent replication is also needed. High internal consistency, in itself, does not demonstrate that an instrument validly measures the intended construct.

Questionnaires also raise the question of what self-report actually measures. Experiences of feeling, bodily presence, and affective attunement cannot always be fully expressed in words. Clients describe these experiences retrospectively in response to statements formulated in advance. The resulting scores therefore provide a verbal representation of certain aspects of their experience, rather than a direct or complete measurement of that experience. This calls for careful consideration of what can be investigated using questionnaires and which aspects are less readily captured in this way.

I subsequently investigated whether similar changes were reported across different presenting concerns. A practice-based study examined outcome measures in clients who had attended an average of six haptotherapy sessions over approximately three months (Klabbers & Vingerhoets, 2024). Changes emerged in similar domains across different presenting concerns.

The study had no control group. It is therefore not possible to establish the extent to which the changes can be attributed to haptotherapy. Nor can possible influences of expectations, general therapeutic attention, the therapeutic relationship, natural recovery, and events outside treatment be distinguished from specific haptotherapeutic processes.

The similarity in the reported changes raised the question of whether, across different presenting concerns, these changes might be associated with common processes of change. This relates to the earlier exploration of *Impaired Ability to Feel*, although the available data do not demonstrate that the two findings point to the same process of change.

A further question concerned the distinction between general therapy factors and factors characteristic of the haptotherapeutic approach. An earlier theoretical exploration in Hapto-educatie distinguished, among other things, between general therapy factors and factors characteristic of the haptotherapeutic approach, such as insight-oriented conversations, skills exercises, and therapeutic touch (Klabbers, 2021). This line of inquiry continued in Mechanisms of Haptotherapy: Specific and Nonspecific Therapy Factors (Klabbers, Boot, Dekker, & Hagg, 2024). This publication further organized possible processes of therapeutic action,

with attention to affective touch, bodily presence, attunement, and genuine contact. This was a theoretical classification; the proposed mechanisms had not thereby been empirically demonstrated.

Presence was considered not only as a therapeutic stance, but also as a possible precondition for change, a therapeutic intervention, and something that can be addressed in treatment (Klabbers & Kegels, 2025). These different functions require separate definitions and investigation.

In parallel, the professional terminology of haptotherapy was mapped (Klabbers, 2025a). This involved examining the concepts haptotherapists use in practice, how they interpret them, and the extent to which a shared conceptual framework exists. The inventory identified a common core, but also differences in the meanings haptotherapists attach to the concepts they use.

Three modes of approach were subsequently distinguished: handling (Dutch: hanteren), psychotactile contact, and thymotactile contact (Klabbers, 2026a). In handling, the body is approached as an object of examination or treatment. Psychotactile contact emphasizes the person as a bodily present individual who has experiences. Thymotactile contact foregrounds the affective significance of bodily presence and contact. This classification offers a way of describing different orientations of attention within haptotherapy without reducing them to techniques alone.

The Scale for Affective Relational Attunement (SARA) was developed to investigate aspects of affective attunement and relational connectedness from the partner's perspective (Klabbers, 2026b). This marked an initial step towards investigating possible changes in the everyday relational context. Whether such changes can be attributed to haptotherapy has not yet been established.

Several concepts in this line of research also appear in other theoretical approaches, although not always with the same meaning or scope. Research on embodiment, among other things, examines the relationship between bodily experience, perception, and meaning-making. Affective neuroscience investigates bodily and neural processes involved in affective experiences. Interpersonal theories examine reciprocal influences between people, while mentalization concerns understanding behavior in terms of mental states. Direct experience and therapeutic contact also play important roles in experiential psychotherapy.

The theoretical traditions mentioned above have not been systematically compared in this article. The similarities provide a basis for further comparison but do not demonstrate that the concepts have the same meaning or that the haptotherapeutic approach offers an additional contribution. This requires conceptual analysis and empirical research.

From the individual client to relational effects

In haptotherapy, the person is viewed as bodily and relationally connected to others. This perspective raised the question of whether changes in feeling, affective attunement, and presence are also noticeable in contact with others.

A case report on trauma-related symptoms (Klabbers, 2025b) illustrated how recovery may involve not only a reduction in symptoms, but also rediscovering one's own bodily experience, regaining a sense of affective safety, and being able to remain present in contact with oneself and others. A case report can provide insight into a treatment process and the changes experienced, but it cannot demonstrate that these changes were caused by haptotherapy. The proposed relationship between bodily experience, affective safety, and relational contact is therefore a hypothesis for further research, not an established mechanism of change.

The article on closeness and tolerance (Klabbers, 2026c) developed this idea further. For some people, affective closeness may evoke tension or avoidance rather than a sense of safety. From this perspective, haptotherapy may contribute to people's ability to tolerate bodily and relational closeness without losing contact with themselves. This assumption also requires empirical testing.

This led to exploratory research into changes that partners observed in the client and in their relationship, and to the development of the Scale for Affective Relational Attunement (SARA) (Klabbers, 2026b).

The relational effects of haptotherapy

In an exploratory study, partners reported on possible changes in the client and in their relationship. The Scale for Affective Relational Attunement (SARA) was used for this purpose (Klabbers, 2026b).

Partners retrospectively reported changes in how they experienced the client and their relationship. These included affective attunement, emotional availability, communication, and relational connectedness.

Given the retrospective nature of the study and the absence of a comparison group, it cannot be established whether haptotherapy caused these changes. Nor is it clear which treatment processes may have played a role. Further research is needed to address these questions.

The study broadened the perspective within this line of research. The partner study added the

partner's perspective to earlier studies of client experiences. This made it possible to examine whether changes experienced by clients were also observed by their partners.

Discussion

The research questions within this line of research changed gradually. Questions arising from earlier studies repeatedly provided the impetus for further investigation. In retrospect, three phases can be distinguished: documenting change, investigating possible processes of change, and developing concepts to describe and investigate these processes. The individual studies were not designed within a single, predefined conceptual framework.

Initially, the studies drew primarily on existing medical and psychological research models. Over time, a need emerged for concepts that better reflected haptotherapy practice and experiences that existing concepts could only partially describe.

This reconstruction identifies five candidate-building blocks for a discipline-specific conceptual framework: modes of approach, feeling, affective attunement, presence, and relational connectedness. These concepts serve different functions and operate at different conceptual levels. Modes of approach concern the orientation of therapeutic action. Feeling refers to a capacity and a dimension of experience. Affective attunement and relational connectedness concern the relationship with the other person. Presence concerns the way the therapist is present in the therapeutic encounter. How these concepts relate to one another, and whether together they can form a useful framework, requires further investigation.

The possible significance of these five building blocks lies not only in the individual concepts, but particularly in their interrelationships. The different modes of approach describe how contact is established; feeling concerns the capacity to perceive and allow bodily and affective experiences; affective attunement and presence concern the quality of contact between therapist and patient; and relational connectedness concerns the experienced connection with the other person and with oneself. This conceptual organization provides a basis for investigating how these aspects relate to one another and jointly acquire meaning within haptotherapeutic contact. Whether and how this interrelationship differs from existing psychotherapeutic concepts remains a question for further research.

The proposed conceptual organization should therefore not be understood as an empirically established theoretical model, but as a provisional conceptual structure that can guide further theoretical development and research.

1. **Modes of approach**
   A recent conceptual elaboration distinguishes three modes of approach: handling (Dutch: hanteren), psychotactile contact, and thymotactile contact (Klabbers, 2026a). These concepts describe different ways of establishing contact and directing attention. Whether the distinctions are sufficiently precise and useful for research remains to be established.

2. **Feeling**
   In haptotherapy, feeling refers not only to registering bodily sensations. It also involves noticing and allowing bodily and affective experiences, making sense of them, and remaining connected with them. The experience of one's own body refers to how a person experiences their own embodiment. Both concepts concern bodily experience, but they emphasize different aspects. *Impaired Ability to Feel* is a proposed concept describing limitations in the ability to notice and allow bodily and affective experiences and to remain connected with them (Klabbers, 2020; Klabbers, Bouwman, Dekker, Hagg, Harte-Sluman, Spil, & de Vos, 2023). Further research is needed to establish how this concept relates to feeling and the experience of one's own body.

3. **Affective attunement**
   Affective attunement concerns perceiving and responding to bodily and emotional signals in oneself and others. In haptotherapy, it plays a role both in the therapeutic relationship and in relationships outside therapy. The development of the Scale for Affective Relational Attunement (SARA) was an initial attempt to investigate aspects of affective attunement from the partner's perspective (Klabbers, 2026b). The scale represents an initial step towards operationalization. Further research is needed to establish whether the SARA measures affective attunement with sufficient validity and the extent to which the aspects measured overlap with related constructs.

4. **Presence**
   Presence refers to the way the therapist is present in the therapeutic encounter. It involves not only physical presence, but also attention, receptivity, and bodily engagement. Previous work has described presence as a facilitating condition, a possible therapeutic intervention, and a factor that may change during treatment (Klabbers & Kegels, 2025). Further research needs to distinguish between these functions. A condition for treatment is not necessarily the same as an intervention or an aspect of treatment that can itself change.

5. **Relational connectedness**
   Relational connectedness concerns the experienced sense of connection with another person, while the relationship with oneself may also be significant. Research on mother–child attachment, client experiences, and the possible effects of haptotherapy on relationships has approached this theme from different perspectives (Klabbers, Paarlberg, & Vingerhoets, 2018, Klabbers, Wijma, van Bakel, Paarlberg, & Vingerhoets, 2018; Klabbers & Vingerhoets, 2021b; Klabbers, 2026b). The concept is related to attachment, connectedness, and relationship quality, but does not necessarily coincide with any of them. The question is whether relational connectedness encompasses aspects that are not already adequately described by concepts such as attachment, connectedness, and relationship quality.

RISP and *Impaired Ability to Feel* as process concepts

In addition to these five candidate-building blocks, RISP and *Impaired Ability to Feel* are relevant to investigating possible processes of change. RISP was introduced in research on severe fear of childbirth and refers to a possible restriction of internal, sensitive participation (Klabbers, Wijma, Paarlberg, Emons, & Vingerhoets, 2014). *Impaired Ability to Feel* focuses on possible limitations in noticing, allowing, and making sense of bodily and affective experiences.

The available studies do not establish whether RISP and *Impaired Ability to Feel* are interrelated, or whether these concepts help explain the changes observed during haptotherapy. The five candidate-building blocks and the two process concepts do not constitute a complete model. Comparison with existing psychotherapeutic and body-oriented concepts is needed to clarify which concepts overlap and which may make an additional contribution. It is also important to recognise that the five building blocks and the two process concepts do not serve the same function or operate at the same level of abstraction.

Psychometric evaluation of the HWS and the SARA

The psychometric evaluation of the HWS is not yet complete. The Turkish validation study reported results from a confirmatory factor analysis and high internal consistency values for both the total score and the subscales (Küçükkaya, Işık, & Rathfisch, 2024). These findings provide evidence of the internal consistency of the scores in that study population, but do not yet establish the validity or responsiveness to change of the HWS in Dutch haptotherapy practice. The five HWS subscales do not correspond directly to the five candidate-building blocks identified in this reconstruction. The questionnaire and the conceptual framework were developed in response to different research questions, and their relationship has not yet been established.

The findings do not resolve all questions concerning the construct validity of the HWS. Its responsiveness to change also requires further investigation, as already noted in the original study.

For the SARA, an exploratory factor analysis involving 75 partners yielded a three-factor structure: affective attunement, partner well-being, and perceived client well-being. Internal consistency was high (Cronbach's α = .96). However, a high alpha coefficient does not, in itself, demonstrate that the proposed constructs are being measured validly. Independent replication, confirmatory testing of the factor structure, and investigation of convergent and discriminant validity are needed. It has also not yet been established to what extent the SARA is sensitive to changes over time.

For both instruments, internal consistency, validity, and responsiveness to change must therefore be evaluated separately.

Limitations of conceptual development and measurement

Caution is needed when interpreting this line of research. Several concepts emerged from clinical observations and theoretical reflection within haptotherapy. These were subsequently translated into research questions and measurement instruments. The findings provide starting points for further testing but do not constitute independent confirmation of the concepts on which the instruments are based.

A change in self-reported scores initially shows that respondents answer the statements presented to them differently. It does not necessarily follow that the hypothesized underlying process has changed, nor that this process caused any treatment outcome. Expectations, general attention, the therapeutic relationship, natural recovery, and events outside treatment may also contribute to reported changes.

There are also limits to verbal self-report. A questionnaire can make aspects of bodily and affective experience accessible to research, but it is not equivalent to the experience itself. Questionnaires and theoretical concepts must therefore be evaluated separately in terms of what they actually measure or describe.

The randomized controlled trial on fear of childbirth provided indications of the potential effectiveness of haptotherapy. However, limitations in the conduct of the study, attrition, and crossover between treatment groups complicated interpretation of the results. The practice-based

studies and case reports provided insight into changes and experiences, but could not establish the extent to which these were attributable to haptotherapy. The psychometric evaluation of the HWS and the SARA is also incomplete. Nor has it been demonstrated that the five candidate-building blocks together constitute an explanatory model.

In retrospect, the successive publications can be related to one another, but this coherence is not, in itself, empirical evidence of an underlying process. Because this reconstruction is based primarily on publications to which I contributed as first author, my selection and interpretation may make the coherence appear stronger than a broader assessment would suggest. The proposed arrangement of concepts should therefore be regarded as a working hypothesis requiring critical evaluation, with room for alternative explanations and findings that do not support the proposed relationships. This evaluation should also establish where concepts lack sufficient distinction, are incomplete, or prove unsuitable for research.

The place of haptotherapy within the psychotherapeutic landscape

Haptotherapy does not exist in isolation from other psychotherapeutic and body-oriented approaches. Attention to bodily experience and the interplay between bodily and psychological processes are also found in other approaches. A systematic review and meta-analysis of body psychotherapy found indications of effects on psychopathology and psychological distress, although the interventions and study designs examined varied considerably (Rosendahl, Sattel, & Lahmann, 2021). The effects of touch have also been investigated across a range of interventions. A systematic review and meta-analysis found indications of beneficial effects on various physical and psychological outcomes (Packheiser, Hartmann, Fredriksen, Gazzola, Keysers, & Michon, 2024). Touch is therefore also used in other forms of treatment, although its nature and function may differ. In haptotherapy, touch takes the form of contact-oriented affective therapeutic touch, built up methodically and not directed solely at the body as an object of treatment. It also addresses the person as an embodied, feeling individual, and what can be experienced affectively in the encounter. Through this approach, clients may learn to notice and allow bodily and affective sensations and to experience their significance in contact with another person. Whether, and to what extent, this combination of contact-oriented affective therapeutic touch, methodical development, and learning to feel distinguishes haptotherapy from practices used in other forms of treatment requires further conceptual analysis and empirical research. The following comparison therefore focuses on concepts that are related in content to the five candidate-building blocks.

The choice of these five comparison frameworks is based on their conceptual relevance to the candidate-building blocks. Interoception and emotion regulation provide points of comparison for examining the concept of feeling in relation to existing insights into bodily awareness and affective experience. Therapeutic presence and the therapeutic alliance offer points of comparison for considering the role of the therapist and the quality of the therapeutic relationship. Attachment provides a theoretical framework for examining relational connectedness and experienced safety. This selection is not intended as an exhaustive comparison with existing psychotherapeutic theories, but as a focused exploration of concepts that are most directly related in content to the proposed building blocks.

The first comparison concerns body awareness and interoception. Interoception refers to the perception, interpretation, and integration of signals from the body. Body awareness is a related but not clearly delimited concept that concerns, among other things, attention to bodily sensations and how a person responds to them. Mehling, Price, Daubenmier, Acree, Bartmess, & Stewart, (2012) developed this multidimensional approach in the Multidimensional Assessment of Interoceptive Awareness (MAIA), which includes dimensions such as noticing bodily sensations, attention regulation, emotional awareness, and self-regulation.

This overlaps with the concept of feeling in haptotherapy. In this line of research, feeling also encompasses the affective significance of bodily experiences and the possibility of remaining in contact with them. This difference in formulation does not automatically mean that distinct processes are involved. Research is needed to establish the extent to which this understanding of feeling corresponds to existing operationalizations of body awareness and interoception, and whether it encompasses aspects that are insufficiently described by these concepts.

A second point of comparison concerns affect and emotion regulation. Gross (2015) describes emotion regulation as the processes through which people influence which emotions they experience, when they experience them, and how they experience or express them. In haptotherapy, too, attention to bodily sensations and affective attunement may concern how people relate to their emotions. In the approach described here, the emphasis is not solely on changing or controlling emotions, but also on noticing, allowing, and tolerating affective experiences. This emphasis is not necessarily unique to haptotherapy. Research is needed to determine the

extent to which feeling and affective attunement complement or overlap with existing accounts of affect and emotion regulation.

Therapeutic presence and the therapeutic alliance also provide points of comparison. Geller and Greenberg (2012) describe therapeutic presence as a way of being present in which the therapist is available for therapeutic contact with attention, openness, and engagement. This resembles the concept of presence in haptotherapy, where the quality of the therapist's presence also plays a role. The concepts are not, however, necessarily equivalent. Further research is needed to establish how presence in haptotherapy relates to therapeutic presence and to existing concepts of the therapeutic alliance.

Bordin (1979) distinguishes three components of the therapeutic alliance: agreement on treatment goals, agreement on tasks, and the relational bond between therapist and patient. Therapeutic presence and affective attunement do not coincide with these three components of the alliance. A therapist may be present in an attentive and attuned way without agreement on treatment goals or methods. Conversely, a strong therapeutic alliance need not involve a central role for bodily experience or touch. Presence, affective attunement, and the therapeutic alliance are therefore related concepts, but they are not interchangeable.

Research is needed to establish how presence, affective attunement, and the therapeutic alliance relate to one another in haptotherapy, and whether the haptotherapeutic understanding of presence can be adequately investigated using existing measurement instruments.

A fourth point of comparison is attachment and relational safety. Attachment theory provides a framework for investigating how relational experiences relate to seeking support, experiencing safety, and dealing with vulnerability. In psychotherapy, research has examined how attachment patterns relate to the therapeutic relationship, the treatment process, and treatment outcomes. The therapeutic relationship may also provide a secure base and contribute to change (Slade & Holmes, 2019). Relational connectedness in haptotherapy touches on these themes but is not equivalent to attachment or perceived relational safety.

The concept may also encompass contact, mutual attunement, and involvement without implying the identification of an attachment pattern. Whether this perspective highlights aspects not adequately captured by existing attachment and alliance concepts remains to be investigated.

The comparison shows that the five candidate-building blocks overlap with concepts already used in psychotherapy and body-oriented practice. The question is not whether these concepts occur exclusively in haptotherapy, but whether describing them together helps to define haptotherapy more precisely and compare it with other forms of treatment.

The potential contribution of this conceptual organization may therefore lie less in the individual concepts themselves than in the way they are brought together. Their possible interaction within contact-oriented affective therapeutic touch may provide a more comprehensive description of haptotherapy than any of these concepts alone. Whether this combination represents a meaningful conceptual distinction, and whether it can be substantiated theoretically and empirically, remains to be investigated.

The three modes of approach provide a starting point for distinguishing different forms of contact. The concept of feeling encompasses not only the perception of bodily sensations, but also the affective significance of experiences and the capacity to remain in contact with them. Affective attunement, presence, and relational connectedness highlight other aspects of therapeutic contact and the relationship with another person.

RISP and *Impaired Ability to Feel* also require comparison with existing concepts. Research should examine the extent to which these concepts correspond to processes already described and whether they bring additional aspects to light. It also remains to be established whether the three modes of approach can be distinguished reliably in practice.

International comparison requires clear definitions, appropriate measurement instruments, and independent evaluation. This approach may also be relevant to other practice-based disciplines: concepts arising from professional practice can be made explicit and critically compared with existing theories. In doing so, a distinction must be maintained between descriptive concepts and assumptions about processes or outcomes that require empirical testing.

Implications for the further development of haptotherapy

The proposed concepts first need to be defined more precisely. Their differences and relationships to existing psychotherapeutic and body-oriented concepts can then be investigated.

Several steps are needed for empirical development. Existing measurement instruments should be further validated where necessary, and new instruments should be examined for reliability and validity. Longitudinal research may provide insight into the relationships between possible processes of change and treatment outcomes. Replication and

research in other populations and treatment contexts are needed to establish the generalizability of the findings. Comparative research with other psychotherapeutic and body-oriented approaches may help establish the extent to which the proposed concepts correspond to existing concepts and how they may differ.

Conceptual development does not replace outcome research. Randomized controlled trials remain necessary to assess the effectiveness of haptotherapy. Research into treatment outcomes and research into possible processes of change address different questions and should therefore be conducted in parallel.

Conclusion

Between 2011 and 2026, this line of research in haptotherapy evolved from investigating treatment outcomes to examining possible processes of change and developing concepts to describe these processes.

In retrospect, five candidate-building blocks can be identified for a discipline-specific conceptual framework: modes of approach, feeling, affective attunement, presence, and relational connectedness.

The five candidate-building blocks can be regarded as different, interrelated perspectives on haptotherapeutic contact. Their possible significance lies not only in the individual concepts, but particularly in how they relate to and may influence one another within the therapeutic encounter. This interrelationship provides an important starting point for the further conceptual development of haptotherapy, but remains to be investigated theoretically and empirically.

In addition, RISP and Impaired Ability to Feel provide starting points for investigating possible barriers and processes of change. These concepts do not yet constitute a coherent or validated model.

Further theoretical and empirical work, including comparison with existing psychotherapeutic and body-oriented concepts, is needed to determine whether the five building blocks together offer a useful and distinctive perspective on haptotherapy. The proposed conceptual framework should therefore be regarded as a first step toward further conceptual development, not as an empirically established model.

Acknowledgements

This line of research would not have been possible without the participation of the many clients, partners, and haptotherapists who took part in the various studies. I am very grateful to them.

I would also like to thank my colleagues for their involvement and contributions. At various stages, they offered their thoughts on the research design and contributed to the development and theoretical elaboration of concepts. Their contributions and critical feedback have helped shape this line of research and bring this article to completion.

Finally, I thank the reviewers for their critical and constructive feedback, which has helped improve the article.

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