

From surviving to living after a stroke

An initiative to structuring treatment after a CVA from the haptotherapeutic perspective

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Abstract

In this article, a case study is used to describe the recovery process following a right-hemisphere stroke from a haptotherapeutic perspective. This article also introduces three phases of recovery from a haptotherapeutic perspective: from surviving to recovering to living, inspired by the phases of recovery from psychological trauma as described by Judith Herman (Herman, 2017). The choice was made to use the theory and models of Frans Veldman (Veldman, 2007) as the underlying principle. Because this article also tries to give non-haptonomically trained healthcare professionals an insight into the ideas and working method of the haptotherapist, the latter are explained.

These phases may serve as the basis for developing a clinical practice guideline for haptotherapy in secondary healthcare after a cerebrovascular accident. Based on this clinical practice guideline the haptotherapist and client can formulate a meaningful treatment plan together, centred around the client's preferences. This clinical practice guideline can also serve as a theoretical document for further research on haptotherapy and CVA.

Keywords: affective touch, CVA/stroke, haptotherapy, haptonomy, phases of recovery, non-congenital brain injury, rehabilitation, sensory integration, trauma.

Introduction

Haptotherapy is a form of therapy in which touching, feeling (drawing on exteroception, interoception and proprioception), experiencing, being moved, connectedness, attachment and detachment are important core values. Feeling and touch can be seen as the language with which the haptotherapist communicates with his client. Through touch, one of the most important contact interventions in haptotherapy, the haptotherapist allows the client to become aware of their feelings, emotions and/or other signals from their body and how they communicate about this verbally or non-verbally. Haptotherapy is based on the knowledge of haptonomy, which originated from the holistic view of humanity

of phenomenological anthropology. In this area Veldman was inspired by Buytendijk, Rümke, Lersch, Van den Berg, Merleau-Ponty and Binswanger (Veldman, 2004; Verhoeven, 2013). It also overlaps with non-dirigiste psychological movements such as the existential and humanistic movements introduced by Rogers and Maslow, by whom Veldman was inspired (Veldman, 2004).

Haptotherapy is a form of treatment that aligns its interventions with the process and needs of the client. In general, the treatment starts with some introductory sessions (Instituut Toegepaste Haptonomie, 2017; Lindeboom, 2012; Veldman, 2004), which can also be called hapto-education (Klabbers, 2021). In these sessions, the haptotherapist allows the client to experience how they

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can access their own capacity to feel and what effects this has on their feelings of inner security, sense of self-determination, basic muscular tone, arousal, breathing and interaction with the other. The haptotherapist also follows the client's process and adapts the treatment accordingly. The vast majority of haptotherapists in the Netherlands work in private practice and are situated in primary healthcare.

Rehabilitation after a cerebrovascular accident (CVA) in the Netherlands is organised within the regional, integrated healthcare system. Until now haptotherapy has not been part of this integrated healthcare system, but for a few exceptions. If a patient who has had a stroke wishes to have haptotherapy, they must initiate it themselves.

In order to coordinate and guarantee the complexity of care offered, the various participating healthcare institutions and healthcare professionals have set out clear agreements. In the acute phase, the patient is still in the hospital's stroke unit and the neurologist is responsible for determining the priorities in treatment. Subsequently, an individual treatment plan for rehabilitation is drawn up by a multidisciplinary team. This team may consist of a neurologist, rehabilitation physician, general practitioner, medical resident, nurse practitioner, nursing and care personnel, physiotherapist, occupational therapist, speech therapist, dietician, social worker, psychologist, activities therapist, re-integration supervisor and/or adapted physical activity teacher. The composition of this multidisciplinary team may change depending on the care requirements during the course of recovery. These various healthcare professionals meet regularly for multidisciplinary consultations (MDC).

Depending on the complexity and range of symptoms, a choice will be made to have the patient rehabilitated from the home situation with 1) non-specialised primary care, 2) daytime therapy sessions or outpatient geriatric rehabilitation in the nursing home, or 3) outpatient rehabilitation treatment at the rehabilitation department of the hospital or at a rehabilitation centre. In the event of increased complexity or insufficient support in the home situation, then 4) clinical geriatric rehabilitation in a nursing home or 5) clinical rehabilitation in a rehabilitation centre is indicated (Limburg, Voogdt & Werkgroep Zorgstandaard CVA/TIA, 2012).

The objective of this article is to use a case study to describe and organise the recovery process after a CVA from a haptotherapeutic perspective. This description can then be developed into a theoretical guideline to be used by haptotherapy colleagues working in secondary healthcare, and which can then facilitate participation in the aforementioned multidisciplinary treatment teams.

The theory and models of Veldman (Veldman, 2007) were chosen as the starting point. Looking at the haptonomic phenomena, his theoretical concepts help to structure the recovery process after a stroke. This article introduces three phases of recovery from a haptotherapeutic perspective (surviving to recovering to living) to bring theory and practice together.

The haptonomic nomenclature

The founder of haptonomy, Veldman, observed the phenomena of touch (as he called it at the end of the 1960s and 1970s), studied them and documented his findings. Two of his books, "Haptonomie Wetenschap van de Affectiviteit" (Veldman, 1988) and "Levenslust en Levenskunst" (Veldman, 2007) are seen as the standard works of haptonomy. He introduced haptonomic concepts and models to describe, study and further develop the science of haptonomy. The concepts and terms that are most applicable to this case will be described briefly in this article. For further background and understanding of the nomenclature, reference is made to the two works mentioned above.

Extentus insensus, rationalis and affectus

A distinction is made within haptonomy between how a person relates to themselves, their fellow human beings and the world. The quality of reaching out within oneself and to others is subdivided into different extenti.

The extentus insensus is characterised by persons who are withdrawn into themselves, who approach others from a state of distrust and exhibit the need to maintain control over their lives. They have little awareness of their inner feelings and motives. Their motor skills are more stilted and jerkier, and they exhibit increased (muscular) tension.

In the extentus rationalis, persons are less tied up in themselves than in the extentus insensus. They are conscious of what they feel if they are made aware of it or if they remind themselves to pay attention to it. Their cognitive abilities are needed to become aware of the affective abilities. They connect with their fellow human beings because they have a reason to do so. The rigid motor skills are replaced more by resilience, as a result of which the tension (including muscular tension) in their bodies decreases.

The extentus affectus is characterised by persons who move at ease among their fellow human beings. They are self-aware and self-confident. They are able to relate to themselves and others with compassion. They allow their individuality to shine through in their motor skills, voice and presence. Their motor skills are fluid, resilient and relaxed.

The *extentus insensus* and *rationalis* belong to the mode of existence; the *extentus affectus* belongs to the mode of being. The mode of existence is more about surviving and the mode of being about living.

The *extentus* in which people find themselves can fluctuate depending on the situation and their environment. If a person is in an unsafe situation and is being threatened, chances are that they will revert to the *extentus insensus*. Back home in a safe and caring environment one can resume the *extentus affectus*. However, there are also people who always live with fear and distrust within themselves, although their environment is safe; they are continuously tied up in themselves. They live in the *extentus insensus*.

An example of the *extentus rationalis* are persons who primarily approach the situations that life throws at them from their intellect or reason, where their own feelings and sensations are seen as subordinate. Their own experiences that do not agree with reason are suppressed, ignored and/or denied.

Thymotactile versus psychotactile

In addition to verbal language, the haptotherapist also speaks the affective language. This is the first language in which a child makes itself known and understood. An unborn child already accepts contact in the mother's womb (it cuddles up to the hand resting on the mother's abdomen, as it were) or rejects contact (the child turns away from the contact). This way of interacting on an affective or emotional level with their as yet unborn child is taught to parents during the haptonomic pregnancy classes.

The affective language is how people express themselves non-verbally to others and what is also perceptible for our fellow humans when touched. The focus of this article will only deal with what is experienced by fellow humans when they are being touched. The haptotherapist always teaches and invites their clients to reciprocate in the touch. This reciprocity is necessary in order to be able to communicate in an affective manner. In this touch, clients consciously feel whether they are safe or unsafe, whether they experience it as pleasant or unpleasant, how the touch affects them. They also remain in the present, which is important in cases of psychological trauma. In this transparent, affective, person-centred, reciprocal touch, haptonomy makes a distinction between psychotactile and thymotactile contact.

In a psychotactile contact, the touch is connective, committed, and respectful. A certain distance still remains in the proximity to the emotions of the other person. This

contact appeals initially to the intellectual, objectifying, and sensitive perception.

In a thymotactile contact, one is in very close proximity to the other. Vulnerability and fragility can be shared. It is a very cautious, finely tuned, affective and safe touch. No one needs to explain to a mother that she should be careful and loving with her new-born child; she feels this instinctively. The haptotherapist has learned to be conscious of this language and has trained to use this language as a therapeutic tool.

The internal world of representation and the external world of representation

The haptonomy sees a person as a social being that cannot be seen separately from their social network and the world in which they live. A human being does not stand alone in the world. The presence of the other influences the inner experience. People are constantly, both consciously and subconsciously, in interaction with each other and influence each other, whether they are aware of it or not. A distinction is made between different worlds of experience: the Representative World (RW), the External World of Representations (EWR) and the Internal World of Representations (IWR).

The Representative World refers to the geographical worldview. People growing up in the Sahara have to develop very different skills and survival strategies than people in a big city. Nature has an influence on people's worldview.

A human being is a social creature and cannot do without his social environment. The External World of Representations represents the different social circles. A distinction can be made between strangers – acquaintances and colleagues – friends and family – closest loved ones (partner and children). In general, it can be said that the closer someone is in the social circle, the closer and more vulnerable one dares to be with the other. Haptotherapy deploys these close proximity relationships as a therapeutic tool. The haptotherapist will assume the necessary distance approximate to the client depending on what is appropriate and necessary to help the client deal with their issues. For example, an inconsolable child requires a different kind of vulnerability from an adult than a young person asking for directions.

The Internal World of Representations represents everything that people can feel within themselves. A distinction is made between the sensations of the locomotor system, the internal organs and what one experiences inside or, in other words, the state of mind. This is the inner map of the world, the emotions, feelings,

the formation of conscience and possible trauma signs. The IWR can become smaller if people suppress or ignore pain, leaving a part of the body outside of consciousness. An example of this on a psychological level is when people try to explain and understand another person's behaviour, so they don't have to feel their own anger. Then a part or an emotion of that person lies outside of their consciousness.

Basic presence

Basic presence manifests the presence of a person in the world; it is the perception of the foundation of being (Veldman & Soler, 2013). A person who is present in their base, their foundation, feels an inner security whereby they have the courage to be themselves even in the presence of others. They can express their boundaries and desires in a natural way. The individuality of the person is audible in their voice and visible in their movement and in their appearance. Their posture appears in balance and their movements appear resilient and supple. When looking at the physical body, the basis is contained in the pelvic plate (sacrum - pelvic diaphragm (the pelvic floor) – pubic symphysis). This plate is supported by the legs when standing; the spinal column extends upwards from this plate (Veldman & Soler, 2013) so that the breath can move freely on its course. The extent to which people are affectively connected to their basis indicates whether they can access feelings of (self)confidence, (self)security and individuality. This is an important benchmark within the haptotherapy. The haptotherapist will assess the quality and extent to which clients 'inhabit' their basis when determining the affective contact needed. People who emotionally occupy their own 'space' right down to the foundation of their base are obviously present in their basis.

The breath of life

The haptonomy distinguishes between existential breathing and the breath of life. The first is characterised by the fact that the inspiration and expiration can be influenced at will. All breathing exercises and techniques are based on this (Veldman, 2010). This breathing becomes visible in its more extreme form in situations involving structural overload, an overburdening, in situations in which willpower has the upper hand. The thoracic diaphragm becomes fixed, the accessory muscles of ventilation take care of the inhalation and expiration, the breath is high in the chest and the shoulders are pulled upwards.

The breath of life is independent of wilful influence and is controlled completely autonomously (Veldman, 2010). It

is characterised by a deep, quiet breathing. There is a natural interaction between the thoracic diaphragm and the pelvic diaphragm, and characterised by flexibility and resilience. The inner experience is expressed through this breathing. This breath is visible, for example, in a speaker who enthusiastically and passionately addresses his audience.

The recovery phases from a haptonomic perspective

Phases of recovery have already been described in both mental and somatic health care. Herman, psychiatrist, researcher, and lecturer at Harvard Medical School, distinguishes three stages of recovery in psychological trauma. The principal task during the first stage is to establish safety. After safety has been assured, space is created in the second stage for retelling the story of the traumatic event. The principal task of the third stage is re-establishing a connection with others; Herman also calls it reconnecting with others (Herman, 2017).

The CVA/TIA Care Standard also describes phases in CVA care, namely: the acute phase, the rehabilitation phase, and the chronic phase. The acute phase refers to the first few days, a question of survival. The rehabilitation phase usually encompasses up to six months. This phase is aimed at recovery: stimulating activity, limiting the consequences of a CVA in daily life to achieve the highest level of autonomy possible. The chronic phase is aimed at coping with permanent impairments, participation, and meaningful daily activities, and preventing functional decline (Limburg, Voogdt & Werkgroep Zorgstandaard CVA/TIA, 2012).

The phases as described from the perspective of psychological trauma are an appropriate starting point. Looking at the structure from a haptonomic perspective, the process goes from surviving to living. This is divided into the following three phases: 1) survival, 2) recovery and 3) living. These three phases are elaborated on from a descriptive viewpoint using the following case study.

Table 1. Phases of recovery from a haptotherapeutic perspective: from surviving to living

	First phase: Survival	Second phase: Recovery	Third phase: Living
Basic presence	Non-vital, very brittle and small basis.	Variable. Depending on the physical and emotional strain and loadbearing capacity it is either brittle, small and imbalanced or full and resilient.	The basis feels whole. When fatigued however, the basis on the affected side decreases in presence and 'volume or size'.
Extenti	Insensus.	Rationalis.	Affectus. At times when willpower dominates, the client lapses into extensus rationalis.
Internal World of Representation	Unrestricted, is not able to set boundaries in relation to others. The IWR and EWR flow into each other. Ruptured. Partially affected, alienated.	Starting to setting boundaries.	Is able to set boundaries. Automatic diaphragming (able to open and close oneself) is restored. Whole. When overtired, the affected side tends to become narrower.
A questioning approach	Very careful thymotactile approach. This phase requires confirmation, reassurance. The patient needs guidance. Not able to make this inner emotional movement on her own yet.	The psychotactile approach becomes possible. The patient can access own ability to make emotional movement to the other person. However, if the will to recover is dominant in this phase, then thymotactile contact is a challenge.	The person is resilient. They can anticipate and participate affectively again.
External World of Representation	Is limited to inner circle.	Expands to outer circles.	Social circle is almost identical to before the CVA. However, appointments must be spaced out more consciously.
Breath of Life	The physiological conditions for breath of life are lacking on the affected side. The basis is still too non-vital and the thoracic diaphragm lacks flexibility and strength.	Under the right conditions, the breath of life is mobilised.	Can access this under difficult circumstances. During physical training at times of overload the existential breath takes over again.

Theoretical explanation of the case

Female (46 years old) suffered an ischaemic cerebrovascular accident (CVA) three weeks ago. She has since been discharged from hospital. The choice was made for outpatient rehabilitation with a multidisciplinary hospital team, partly because the client wanted to remain in her own safe home environment and to be close to her husband and child. There is sufficient informal care available.

The diagnosis reads: Ischemic right hemisphere stroke with mild sensorimotor hemi-image on the left. No cognitive and/or communicative problems. Enthusiastic personality. The patient has little strength in her left hand and the feeling that it doesn't really belong to her body anymore. She tends to not use her left hand in the activities. She walks slowly with a wide gait, whereby she circumducts her left leg and has reduced arm swing with the left arm. There is a loss of strength in her left leg, diminished coordination of the left half of her body and she suffers from a disruption of balance. She has lost confidence, not only in the left half of her body, but in her entire body. She feels like her body has let her down. The natural feeling of safety in herself has gone. She is easily fatigued. Cognitive functions have also been affected; she has trouble remembering, double-tasking and switching gears quickly. She has difficulty accepting what has happened to her. She is driven and comes across as independent and a perfectionist, which is advantageous because she is highly motivated to work at recovery but presents a pitfall because she finds it difficult to guard her boundaries.

Before her CVA, the client was an energetic person, full of ideas and vision, certainly with respect to her work. She holds an executive position in her own business that she and her business partner set up together. She had a full social life, both personally and professionally.

The specific interesting haptic phenomena will be described per phase of recovery. Unless explicitly stated otherwise, only the affected side will be discussed.

How it started

During the first meeting at her kitchen table since the stroke just three weeks ago, it is clearly obvious to the client how unpleasant her body feels. It is primarily her left arm and hand that bother her. No matter how much she rubs her hand and arm, they do not warm up. She experiences them as 'dead, intensely cold, alien, very unpleasant' and would prefer to ignore this feeling, which leads to neglect. The somatic sensorium and motor control have been damaged. Sensation and self-perception are extremely disturbed; the corpus callosum and the insula are affected (Jenkinson et al., 2020). The client has no idea how to

reappropriate the affected part of her body. It is clear that she is struggling with this. The haptotherapist lays his hand on hers and asks her to seek out his hand from within. She really has to make an effort to find the path inside herself to the place where they meet, to find the point of contact with the haptotherapist's hand. The moment she succeeds in doing so, she feels life in her arm again. It is no longer a foreign object but has become her own again. Her arm feels warm, in contrast to the intense cold previously. The haptotherapist's thymotactile touch is safe, which normalises the arousal and creates the space to free herself from the survival strategy, freeze, fight or flight (Kolk, 2017; Levine, 2011). Because the client had to free the way inside herself to the hand, she instinctively reappropriated this part of her body. It is visibly apparent how much effort she had to make to comply with the seemingly simple question, "Can you feel my hand?". Based on this experience she decided to continue with this form of therapy.

Jenkinson and others suggest that affective touch promotes a feeling of ownership of their body among patients with an impaired sense of extremities due to a CVA in the right cerebral hemisphere (Jenkinson et al., 2020). Affective touch (IASAT, 2021) and the affective (psychotactile and thymotactile) contact as described within haptonomy seem very similar; however, they are not identical. For example, as described above, the haptotherapist placed his hand on the client's hand or arm. During the first four sessions, the haptotherapist consciously chose to lay his hand motionless on the client's arm, because a stroking movement caused the client to become frustrated and over-stimulated. Further research will have to determine how affective touch and the affective contact of haptonomy relate to each other.

In the 1e phase: survival

The client is driven to therapy by her husband or mother-in-law. She makes a very fragile and vulnerable impression at this stage. She wears loose-fitting, comfortable clothes. There is a faded look in her eyes, and she is hunched up on a chair in the waiting room when the haptotherapist invites her in for therapy. The treatments in this phase take place exclusively on the treatment table. First from a resting position in small doses and a slow, careful tempo, then to tangibly being moved in affective connection, subsequently to feeling and making contact and maintaining contact, and finally, to moving with more intensity and/or to moving with a higher degree of difficulty of coordination (for example, standing on one leg, eyes closed, walking a narrow line). Both the client and the haptotherapist can see and feel the moment that the

contact is disrupted. Muscle tension increases, the motoric system becomes rigid, and the client experiences a loss of control. At that moment she reverts into herself in the *extensus insensus*. When there is a connection with herself and the haptotherapist (from a common *extensus affectus*), then movement is relaxed and light-hearted. The exercise then becomes enjoyable, despite the fact that the client experiences the therapy as intensive. Loss of contact with herself or the haptotherapist is also a clear sign that the limit or dosage has been reached.

The familiar IWR from before the incident no longer exists. She has lost confidence in her body. It feels different and no longer does what she wants; it has let her down. What used to be normal and expected is no longer. Martine Bijl describes this very eloquently in her book about her own experience after a stroke, “*Rinkeldekink*” (Bijl, 2018).

The contrast between the healthy side and affected side is huge. The motor system and the sensory sensorium on the healthy side are still intact. This results in a rupture in the IWR. The IWR on the affected side is also so withdrawn that all stimuli from the EWR and the RW can enter unfiltered. The boundaries on the affected side cannot be felt. The diaphragm of the affect, in other words, the ability to open and close the mind against signals from the outside world is no longer intact, which the client experiences as over-stimulation and hypersensitivity.

It is the thymotactile touch, the reassuring, prudent, loving contact that best suits the client in this phase. This reassuring touch reduces the arousal, allowing the client to relax, and her breathing to fall. The alarm bells on the reptile (brain stem) and mammalian (limbic) levels of the brain briefly cease their clanging (Kolk, 2017; Levine, 2011).

In this phase, it takes a great deal of effort for her to feel the haptotherapist’s hand on her skin. She needs time. The hand on her skin provides a clear direction, and is experienced as an anchor. She has to appeal to her sensorium to feel the hand, so that her consciousness of herself can slowly grow and recover. This allows her to feel herself again and the affected body part comes back to life, so to speak. In this treatment, haptotherapy utilises a natural, basic human desire to feel connected, to attach to others, when one is not able to stand on one’s own two feet.

The client is tired and easily overstimulated. She has to take plenty of breaks in order to be able to continue throughout the day. Physical activities and the presences of others are still too stressful. Her days consist of appointments with therapists, resting and being together with her family. Visits are carefully planned and limited in time. Her social circle is very small.

Her breathing is careful, a small amplitude of inhalation and exhalation. Sometimes the breath is silent, stagnating. The breathing is mostly high and shallow.

Initially, she is still in a kind of state of shock. The stroke has taken her completely by surprise; she did not feel it coming. She knows what has happened to her, but she can’t take it in yet. Gradually, by practicing feeling, by recovering the IWR, and with the recovery of the entire spectrum of sensory sensorium, comes the awareness, the perception. She can allow the fear and other emotions that had been pushed away to resurface, because she is feeling increasingly confident and safe in her body. By making affective contact with her body again, the security in herself can also grow.

To summarise, in the survival phase, the client is very vulnerable, withdrawn in themselves (*extensus insensus*), often in an anxious mood because of the ruptured inner world; the IWR is damaged. The basic presence ranges from non-vital to very fragile. Because of this, the client is limitless, is not yet able to set their boundaries and protect themselves from others and the outside world. This applies in particular to the affected side (diaphragming/opening and closing the IWR is damaged with regard to the RW and EWR).

The physiological conditions for the breath of life are also lacking, particularly on the affected side; the breath is quiet and superficial. This requires the haptotherapist to take a prudent and reassuring attitude and approach (the thymotactile approach). It is advisable for the client to limit their world (the EWR and RW) in this phase.

In the 2nd phase: recovery

In this phase, the dependent client transforms increasingly into the personality she was before the stroke. She wears carefully coordinated clothing more often, set off by subtle make-up and sometimes accessorised with a piece of jewellery. Her attitude is open and her posture straight; she can engage in small talk. She is perceptively present. She is also less dependent on others; for example, she rides her electric bicycle to therapy more often.

The client wants to and is now able to play an active part in her own rehabilitation process. In other words, her intrinsic motivation and individual personality have emerged and can be expressed. The strength of her personality is recovering. This requires the therapist to adopt a different position with regard to the client, namely, to walk alongside the client rather than lead and guide. The client becomes frustrated by therapists who strictly follow their treatment plan or protocol, giving the client the feeling that it’s not about her, but about doing what has been prescribed. The haptotherapist takes this resistance

seriously and looks together with the client at what this feeling wants to tell her. As the client understands herself better, feels connected to her own IWR and is able to articulate this, she can then share this with the relevant person and develop a joint plan, or even form a compromise. In this way, she can indicate more and more clearly what she experiences as valuable or helpful in her rehabilitation. Therapists who have insufficient insight into this process see an increasingly difficult client because this client claims her place beside the therapist. In this phase, it is important for her to experience that she counts in society once again, that her voice and her personality have a say again. This same phenomenon is visible in other relationships as well.

The client is increasingly successful in staying connected to the feeling in the affected half of her body. Her IWR regains territory. The balance between the affected and unaffected sides of her body grows. She has fewer problems with over-stimulation from the EWR.

During haptotherapy the affective sensorium is drawn on and extended to passive movements on the treatment table, active movement, various postures, stabilising exercises and walking.

An example of a passive movement exercise of the client's affected leg is when she is invited to stay in touch with the haptotherapist, who is supporting her leg. She is also asked to feel the movement, to embody her leg and to anticipate what she is experiencing in the interaction throughout the movement. The haptotherapist opens himself up in order to make the client feel secure, affectively connecting himself to the whole person. In this way he automatically feels the limits of movement in for example her hip, or where the client needs a bit more support. He can also feel if he needs to slow down or when he can speed up during the exercise. It becomes a moving together, moving as one, experiencing joy and restoring the confidence in open-mindedly moving the affected half of her body.

An example of an active movement exercise is when the client and the haptotherapist are in tandem formation joined by holding each two sticks. The client is invited to feel through the stick into the hand of the haptotherapist standing behind her. Then she is invited to also connect with the haptotherapist affectively. The haptotherapist does the same, so he is getting information through touch where and when the client needs more support or where she needs more space to move. In the beginning the haptotherapist uses this touch information to support the client and later on to challenge her to push her boundaries, so she can exercise to improve for example her equilibrium. The other way round, this information

through touch and embodiment is reassuring the client, she is feeling supported and welcome. She is not standing alone, there is a felt sense of togetherness. The affective information throughout touch initiates anticipation on what is going to happen; this unconscious information system is faster than what we can observe consciously.

There appears to be a direct relationship between the basic presence and the stability of the torso. When the client is still fit and can feel her whole basis, she is stable and balanced, and her gait is almost normal. The narrower her basis becomes, usually due to fatigue, the more her walk regresses to circumduction.

The respiration in this phase also provides interesting information. On the one hand, the thoracic diaphragm is weakened on the affected side. The breathing movement is restricted and superficial and the auxiliary/accessory respiratory musculature has to compensate. As the client recovers, the strength and tone of the affected diaphragm normalise; this can be seen in the range and frequency of motion in the respiration. On the other hand, there is still the ongoing process of recovery from trauma. In addition to a physical trauma, a stroke is also a mental trauma. This process, moving from fear through control to trust is also manifested in the way of breathing. With fear, the diaphragm hardly moves, it appears rigid. With control, there is hypertonia with superficial respiration and a higher frequency. With confidence, the diaphragm has resumed its vitality, manifesting itself in deep, quiet breaths. The latter become visible at the end of this recovery phase but are still random occurrences.

In this second phase, this client asks more for the psychotactile approach. This is possibly because she now has more energy, and her willpower has been regained. In this phase the emphasis is on physical sensory 'training'. Her arousal is normalised, so that she has less need of reassuring contact. This client uses her willpower to train. For her, the struggle to get better comes from a positive mindset; she is in the *extensus rationalis*. It is her challenge to accept her limits, to seek out the *extensus affectus* as well. The drive to recover and get better can be seen as a vital desire to live. For this reason, the haptotherapist chose to not curb the client, but to join her in the search for a suitable balance between willpower and diligence.

By regaining her inner security, which makes her IWR whole again, there is room to process what has happened to her. She can do this within the safe relationships with her loved ones. This client doesn't need the haptotherapy for this.

Her EWR is also getting larger. She receives spontaneous visitors and allows them to stay. She attends parties again, but makes sure that she gets rest beforehand

and leaves for home in time. She also begins to resume her work.

In summary, in the recovery phase, the personality of the client begins to emerge more and more (recovery of the IWR). They become stronger and her resilience and stamina begin to make a recovery. They begin to trust their own body and themselves again (incidents of *extentus affectus* grow). When the trust and security are present, the breath of life begins. The basic presence is still variable because the balance between stress and stress capacity is still vulnerable. The inner world (IWR) recovers to how the client remembers it from before the accident; the experience of the affected side bounces back (recovery in diaphragm from IWR to EWR and RW). Because of increased resilience, the client can increasingly draw on their willpower (*extentus rationalis*) to recover. As the client is able to stand more on their own two feet, it requires the haptotherapist to stand beside the client, instead of leading them. The client can tolerate more distance in their relationship with the haptotherapist (the psychotactile approach), and sometimes the client asks for this implicitly. The client's world grows larger (the EWR and RW).

In the 3rd phase: living

The haptotherapeutic support is limited in this phase. Her rehabilitation in the hospital has officially been completed. The client has resumed working, in the meantime, but with regular breaks and an afternoon nap. There are times when her personnel forgets that she was so ill. She independently goes to appointments, and she may and can drive car again. She continues working on further recovery of her physical condition, coordination, and muscle strength under the guidance of a personal coach. Once again, she experiences her IWR as harmonious and whole. A difference can no longer be felt between her affected and her healthy side when touched, neither for the client nor the haptotherapist. During activities of daily living (ADL) her basis remains grounded and complete. She maintains her basic presence, which is evident in regained resilience and the ability to deal with stress. Her partner can still tell when she is tired. He helps her by sounding the alarm now and again, because her enthusiasm and drive are still her pitfalls, causing her to overstep her boundaries. Her greatest challenge is finding and maintaining balance between the stress load and stress load capacity.

Six months after completion of the haptotherapy treatment, the client returned with typical overload overuse symptoms in the neck and shoulder muscles. Examination showed that the overuse symptoms resulted from

contracted and clenched muscles in the thoracic diaphragm on the affected side, restricting breathing on that side. The accessory muscles of ventilation compensated for this, resulting in them also becoming overburdened. This led to the symptoms and the client's return. After an explanation and some stretching and relaxation of the diaphragm, the full breath of life was restored. This knowledge was also shared with the personal coach. He now also monitors her breathing movements during the training sessions and, where necessary, sets limits for the client.

To summarise, in the living phase, the client has regained the security and trust in themselves whereby they are capable of taking care of themselves in a loving way and still have sufficient reserve to do the same for others (*extentus affectus*). They are fully present in the basis. Their inner world feels harmonious again, and there are no longer different halves inside (the IWR has healed). The breath of life is present under both physically and mentally difficult circumstances. The client has access to their own capabilities and knows how to draw on them when needed (basic performance/has control of IWR). The haptotherapy moves into the concluding phase.

In conclusion

The haptotherapeutic treatment has made the client aware of the need to be careful with herself, careful in the sense of being loving and respectful towards herself. She is more attentive and sensitised to the signals of her body. Emotions, feelings, and sensations are no longer experienced as difficult, but as an 'inner language' that is trying to tell her something.

The stroke has left her with permanent brain damage. The affected side will remain vulnerable. This will manifest itself again when overburdening, a weak immune system and/or extensive stress occur. What matters is that the client now knows how to access her affective capacities in order to regain herself again.

Analysis

Not nearly everyone who has suffered a CVA recovers enough to return to the world of employment. Irreparable damage to the brain occurs more often. The woman in this case study had several factors in her favour which may substantiate why she was able to recover to the extent that she did. She is relatively young and has no comorbidity. She also had a stable, loving childhood, her basis is well developed, she has a healthy sense of self and has a strong, positive personality. The degree of self-development, self-awareness and body awareness before the trauma may have a positive influence on the recovery process. Haptonomy

assumes that a person who has a developed basic presence with age-appropriate self-development goes through a more favourable recovery process than an anxious person with little basic presence and a lack of self-confidence.

The added value of haptotherapy in this case consisted of:

- Providing the affectively secure relationship and contact that allowed the client to recover from the paralysis of psychological trauma (Kolk, 2017; Levine, 2011).
- Raising awareness, teaching and/or training skills in the areas of emotions, feelings, sensations, physicality, the movement of feelings within, connecting and interpersonal haptic communication.
- Helping the client to verbalise feelings and to communicate them.
- Supporting the process of the dependent client becoming jointly responsible for their recovery.

Haptotherapy does not only look at the somatic sensory recovery but takes the process of emotional recovery from trauma into account. This puts haptotherapy in a special position, with one foot in somatic health care and the other in mental health care. This position could allow haptotherapy to be a connective link between somatic and mental health care when needed. In this way, haptotherapy can contribute to a better match between the treatment offered and the specific preferences of the client.

Conclusions and recommendations

The haptotherapy recovery process after a CVA is described and structured in this article in three phases: surviving, recovering, living. This is a basic document to develop a clinical practice guideline for haptotherapy following a CVA.

In this clinical practice guideline, various interventions could be described per recovery phase. Based on this, the haptotherapist and the client can together formulate a meaningful treatment plan centred around the preferences of the client.

This clinical practice guideline can also serve as a theoretical document that could facilitate participation in scientific research and healthcare pathways.

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