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When touch is not common practice: *The haptonomic approach and therapy for higher-functioning children and adults diagnosed with autism spectrum disorder (ASD)*

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Abstract

Within regular healthcare and counselling of high-functioning children and adults with autism spectrum disorder (ASD), the approach most commonly taken assumes structure and predictability are key concepts in the treatment. This article raises the possibility of a haptonomic approach with this target group. Instead of assuming that touch is impossible, this article focuses on exploring and discovering the latent haptic ability for touch that is present, based on practical examples. The haptonomic approach offers an opening and room for development in mutually meaningful contact, thus providing an important contribution to the individual possibilities for personal development for high-functioning people with ASD.

Key words: Autism spectrum disorder (ASD), haptotherapy, haptonomy, affective physical approach, emotional development, touch, emotional contact.

Introduction

This article expands on both in theory and practice the development of the capacity to feel and to experience mutual touch in highly-functioning children and adults with ASD. The regular treatment of ASD is commonly an approach in which structure and predictability play key roles. In this approach, the assumption is made that a person with ASD cannot feel sense or empathise, and thus cannot or does not know how to handle the logic of sense, touch and feelings in daily life. The daily life of a person with ASD is then structured and organized in terms of time, environment, actions and tasks, both in school and training situations and also within interpersonal contacts. Structure and predictability are supposed to offer stability and clarity to the person with ASD. Haptonomy, however, appeals to the person's innate capacity to feel what's present and the latent possibilities for mutual emotional contact that are present.

First of all, the differences between the existing viewpoints will be underlined: the cognitive theory and the social-emotional theory. Then, the vision and haptonomic affective physical approach will be further explored, paying attention to the importance of physical touch and the development of one's own emotional basis. A case study will help to examine what is so recognizable in highly functioning people with ASD. Under the heading the Haptotherapeutic Practice, presence, the spatial presence or awareness and building towards meaningful contact, are discussed.

Clarifying ASD

High functioning children and adults with autism

Autism is generally assumed to include three limitations that pertain to socialisation, communication and imagination. Within the broad spectrum of autism exists a group of children and adults whose intellectual capacities fall within the general average. These higher functioning people with autism are different from those with 'classic' autism, as they actively seek contact with others (Yirmiya & Sigman, 1991). The way in which they do so, the means of making contact and the quality of their interactions, however, are often unusual, inadequate or inappropriate. This is exhibited, among other things, in a more coercive means of contact geared towards their own interest, eye contact or a touch that does not fit a peculiar conduct, posture, gestures and facial expressions (Wing, 1997).

High functioning people with autism may be rigid or inflexible during contact, despite the fact that they possess an extensive verbal vocabulary. Now and again, they become aware of their discomfort, which can lead to frustration (Loveland & Tunali-Kotoski, 1997). High functioning children and adults with autism have a preference for regularity and routine. Unexpected events, new people

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and a new environment can give rise to frustration and discomfort. In his earliest observations, Kanner (1943) writes that the behaviour of a child is governed by a fearful and obsessive desire to preserve the state of affairs as is. Schopler and Mesibov (1992) report that the resistance to change in autism has to do with the difficulty in understanding what is happening in their environment and a feeling of constant insecurity. This indicates that the insistence on uniformity is functional for the individual with autism. It represents a way to create order and give meaning in an otherwise confusing world (Howlin, 1997).

Routine, schedules clear boundaries and rituals all help to create order in an intolerably chaotic life. Leaving as much as possible the same lessens the dreadful fear. (Jolliffe et al., 1992, cited in Howlin, 1997, p.98). It also suggests that the need for unambiguity is functional for the individual with autism.

Despite the fact that people with ASD often have good language skills, they still encounter linguistic problems. Conversations are often focused on a limited number of subjects. Use of language is often arrogant and formal using full sentence or questions, not adapted or tailored to the context. They lack the ability to recognise and read the facial expressions of their listeners during the conversation. They cannot be involved in a reciprocal conversation despite having adequate language possibilities. High functioning people with autism are then considered to be 'very verbal' and yet simultaneously 'poor communicators'.

Because of their possibilities, high functioning children with autism are placed in school situations where age-appropriate social behaviour is expected. They often struggle with these expectations. These persons are then susceptible to a wide range of problems as a result of their increased levels of activities and interactions with their environment (Howlin, 1997). Since autism is conceptualised across a broader spectrum, a larger group of children and adults is diagnosed as such (Gillberg, 1998b; Wing, 1996).

Cognitive discussions (Baron-Cohen, Leslie & Frith, 1985; Frith, 1985) assume an impossibility to 'mind-read' and view this as the primary deficiency in autism. The social-emotional discussions (Capps, Yirmiya & Sigman, 1992) state a deficiency in the possibility of recognizing and understanding emotions.

Theory of mind

Most children of approximately 4 years of age are able to understand that other people have thoughts, expectations and desires that influence their behaviour (Attwood, 1997).

The general hypothesis is that autism implies a deficiency in acquiring a 'theory of mind' (Baron-Cohen, Leslie & Frith, 1985). This means that these children fail in their ability to identify or distinguish the mental state of others and of themselves. This failure has serious consequences for understanding social interactions and for communicating their own needs. In the more modern literature, this is described as the capacity to be able to mentalize. The assumption is made that this impossibility to 'mind read' contributes to three shortcomings in autism: socialisation, communication and imagination (Happe, 1994). This way of thinking often leads to a cognitive approach and treatment of people with ASD. Structure and predictability are then employed for the benefit of the person himself and the way he makes contact. ToM is aimed at furthering the social-cognitive development in children ages 5 to 12 years old with ASD. The objective is that they become less vulnerable and can conduct themselves more adequately in social situations. (Rooijen & Rietveld, 2017)

Social-emotional theory

The social-emotional theory assumes that the primary deficiency in autism is a diminished development in the affect. Kanner first described this deficiency in his article, 'Disturbances of affective contact' (1943). In this article Kanner describes autism as an innate (congenital) impossibility to achieve the normal, accessible and biological given of affective contact with people. The article illustrates that the affective contact and the affective development of people with ASD is not a natural matter of course.

This characteristic of autism, however, has received less attention than the cognitive perspective. The social-affective theorists view the 'theory of mind' as secondary with regard to the affective deficiency. This theory asserts that children with autism lack the innate (congenital) possibility of receiving (recognizing) the affective expressions of others and reacting to them (Happe, 1994). Hobson (1986), in addition to Kanner, is the most important adherent to this theory. He suggests that there is an 'emotion perception' deficiency in autism that reveals itself in an inability to decipher and label emotions. Emotional behaviour is seen as the basis of communication in understanding yourself and others (Loveland & Tunali-Kotoski, 1997). Treatment and counselling is directed at recognising and understanding expressions and emotions using pictographs, photos and within direct face-to-face contact. Recognition often remains caught up in fixed concepts.

Scientists do not agree whether or not the primary deficiency in autism is cognitive or affective (Yirmiya & Sigman, 1991). It is assumed that the lack in both areas contributes to the disturbances pertaining to autism.

(Happe, 1994b; Prior, Dahlstrom & Squires, 1990).

Neither of these theories mentions or recognises the personal experience of corporality, or the possibilities of developing physical touch and capacity for emotion, the source and essence of emotional contact.

Haptonomic theory and approach

Haptonomy studies, emphasises and illustrates the fundamental importance of affective, affirmative contact (both physical and emotional) in the development, genesis and realisation of a person as an individual (Veldman, 2007). The affective affirmative contact offers the other person space to develop their own emotional foundation and the related basic inner sense of stability. Feeling whole or complete creates an internal emotional stability, which opens the possibility for real and essential contact with the other.

Feeling the emotions

In the short book 'Psyche', the Dutch writer Couperus (1898) carries his reader to a world where feeling takes on essential substance. Senses lose their detachment by adding to them another dimension. The act of looking turns into the experience of seeing. The act of listening turns into the experience of hearing. The act of physically touching becomes the experience of feeling. The detached observation changes into an inner awareness. One becomes involved as a person and so experiences that things take on substance, significance and meaning.

Touching or feeling is first of all physical, feeling present. Feeling means being aware, reaching out, opening oneself, discovering, experiencing, being stirred to emotion and mobilising oneself. Feeling means recognising, experiencing and discerning within oneself what something does to one, what feels 'right' and what 'doesn't feel right'. Feeling includes distinguishing what one experiences as 'beautiful' and what is 'not'. Feeling for beauty and elegance, appreciation and thankfulness arise from the internal, physical experience. The basis of this intelligence, not to be confused with intellect, lies entrenched in the ability to feel. The physical-sensory touch and more specifically the hapsis (the internal experiential emotion and meaningful experience) are seen within haptonomy as inextricably bound to each other.

In people with ASD, a lack in affective communication can be seen and experienced. The physical emotion seems uninvolved in the mutual understanding. This physical distance is converted in the total person, in his presence, his comings and goings, and it determines the mutual communication. Because of this, people with ASD have an alienating effect on their environment. As an outsider, you get the feeling that you're not making actual contact. Aloofness is noticeable in their approach, their attitude, in their thought process, in their engagement, anticipation and participation in things, such as a conversation. The concepts of anticipation and participation here refer to expanding the depth of emotion.

Development of an emotional basis

The emotional contact between parents and child plays an important role in the development of the child's affective capacity. The intentional feelings the mother expresses towards her child, and the child's response to these expressions towards its mother, reciprocate and affirm each other. Children focus on the mother as a source of well being, where they can revitalize themselves and where they feel cherished and known. Within this basic support, a child feels sustained and experiences its own autonomy and can be open; it can raise itself up and orient itself in and towards the world.

Circumstances can disrupt this possibility of making contact. When contact has been disrupted, an affective approach, touching, inducing and awakening the affective domain in this child, is essential, before the child can make any actual affective overtures to another person.

When basic emotional trust and security within the child have not been allowed to develop sufficiently, this creates a sense of internal uncertainty and insecurity, which is then often compensated by seeking external security or by sinking into passive resignation. (Ainsworth, Blehar, Waters, & Wall. 1978).

In ASD, a cognitive, rationally-oriented therapy addresses the cognitive and thus keeps this person imprisoned within his cognitive disposition and limitations. If the treatment does not address this contact, the isolation of this child or adult with ASD is perpetuated and made permanent. Examples of this are the aforementioned structural approach, the over-valuation of the rational approach and the application of long-term pyscho-medication.

Casus: Recognition in high-functioning people with ASD

The client is a 44-year-old woman with a highly-intellectual development. After years of conflict in her work, resulting in a burnout, dismissal procedure and a lot of remorse, she ended up seeing a psychiatrist who diagnosed her as a high functioning person with ASD with the following characteristics: not feeling accepted, perfectionistic and extremely high commitment levels.

The client followed various cognitively-focused therapies in order to process the conflicts still present and to gain insight into her ASD. Her psychiatrist advised her to go in haptotherapy to deeper explore her feelings and her experiential perceptions.

The client wrote a personal report after her three-year course of haptotherapeutic treatment. This report is organized below into a number of characteristic elements within the process of alienation (Doornenbal, 1978), which is also so recognizable in high functioning people with ASD.

Isolation

In considering ASD as a specific psychopathological phenomenon lurks the danger of reducing these people to a category. People with ASD get the idea that they are 'like that'; 'I'm autistic, that's just the way I am'. The image or idea that these persons have identified with not only alienates them from themselves, but also from their fellow creatures. This impedes any real possibility for growth. Any therapy focused on pursuing true contact will, in the course of treatment, encounter this 'false' identification. (Doornenbal, 1978, pg.138)

"I didn't understand the first sessions of haptotherapy and it confused me. I didn't know what feeling was. I knew of course that I had a body, but I didn't understand the idea of feeling my body.

I wanted to know what would happen. I wanted a clear and predetermined plan. I knew where I stood: other people didn't understand me.

The haptotherapist indicated that I was getting more feeling in my leg, but I wasn't experiencing that yet. I needed a lot of repetition. Gradually I could feel that my legs belonged more to me. The contact between my body and the treatment table also changed. I lay deeper in the mattress. But when he asked, 'What feels better for you? The one leg laying deeper in the mattress or the other one laying more on top of it.' I couldn't answer him. And yet I felt different.

With these little changes in my body, the rigidity in me changed too."

Rigid thinking

Thinking reduces, objectifies and abstracts from reality. The given becomes a composition of data. Reality as a whole however, cannot be reconstructed. The construction we have formed concerning reality is not the totality. We are missing the connection to the whole. We are missing the feeling that what we have constructed is now also a living reality. When thinking rigidifies in its form of understanding, it becomes alienated from reality. (Doornenbal, 1978, pg.122)

"The affective world was an intangible and incomprehensible world to me. I tried to understand the world from my head. My life was like world-class sport. I had to know in advance what I could expect, which options I had, how people might react and what people expected of me. This was necessary for me to carry on in the world. Every step of the way was well thought-out in advance. I had examined every possible option and variant. That's how I painted a picture of the world around me and how I could stand my ground in it. My thinking gave me a moderate grip on things. At least I knew what to expect, what I might encounter and how I should react. I felt that nobody understood me whatsoever. No one took me into account and I felt the constant threat of losing my grip. Luckily, I was intelligent, which allowed me to express myself well."

Self-realisation

Humans have a need to feel safe and secure and tend to ward off the strange and unknown, or to treat it with mistrust. Doornenbal (1978) concentrates on a change in the fundamental attitude, whereby a certain curiosity overcomes fear and transforms into a deeper desire to walk into the unknown and learn to know it.

Veldman (2007) describes it as a fundamental change in a life, from a limited, rationally-driven manner of existence, often controlled by fear, into a more unobstructed, emotionally open and approachable way of being that leads to self-realisation and self-actualisation.

"Overtime moments came that I could let go of my grip on the world for a moment. That I could just sit there and watch what was happening around me without having to do anything. I was really happy about this. I hadn't known what it was like to just be and not to have to do anything. I began to see more of my environment and surroundings; I could enjoy the sun shining down on me. But the pressure could wash over me at any time and then I was locked inside my head again. That pressure on myself continued to wear me down. I began to see how much stress I was putting on myself. I was shattered after work. I had no desire to do anything at home. I sought peace and quiet and couldn't abide anyone else there with me."

Emotional disownment

In alienation, one knows the experience of being cut-off from his fellow human beings, from himself, from the surroundings and objects. When a new development germinates in the 'self' of a person (his fundamental essence), this signifies not only an inner change but also one in respect of the outside world. Perception also changes. The person then experiences himself not only as

the alienated but undergoes a change in this that brings him closer to others and to himself.

"Within the haptotherapy I could increasingly surrender to feeling 'good'. My body became less of a mechanism. More and more, I could live in-touch. I now experienced that the pressure could be released, that I could enjoy more, that my resistance diminished; I could experience relaxation. I left therapy in a different state than when I had arrived.
Now I can quiet my head and be more in touch with my emotions and be more in contact with others, such as at work. I experience this as liberating for myself and for the contact I have with others."

Haptotherapeutic process

Nick is a normal, intelligent boy of 14 years old, with a diagnosis of high functioning ASD, whose presence is not stable. He has been in treatment at a closed psychotherapeutic facility for almost a year and a half. There he has learned to function on a strict, task-oriented, daily routine. The first thing that you notice about Nick is his non-vital attitude. Nick stands with stiff, hyper-extended and endorotated legs with the knees almost touching each other. His pelvis is not really supporting him. A light pressure on his shoulders and his pelvis gives way. It seems as if he is trying to keep himself upright by hyper-extending his legs. His upper body shows a pronounced and forced presence, giving him an air of arrogance about him. When sitting he slouches down to his lower back. The totality leaves the impression of decreased vitality, sluggishness (inertia), apathy and being un-present.

Presence and spatial awareness

We walk to his school together. Nick often walks close behind me, head down, hardly seeing or hearing anything around him. Even when I draw his attention to what can be seen or heard at any given time, Nick doesn't really respond. Suddenly he says, "I want to be an engine driver on the Thalys some day..." and then a long account about trains follows. He comes and walks a little closer to me, just behind and to the right, but as soon as his story ends, he lags behind me again.

He is unaware that we are approaching a dangerous intersection. When he is confronted with it, he is startled as if he has just stepped into another world. The shock wakes him up a little. He starts to walk more beside me and an actual conversation develops. We are walking in step with each other. Contact has been made, both within the conversation, but also in physically walking together. We start walking together in synchronization; our bodies attuned to each other. This makes the walking much easier. A short time later, this stops. When he has to cross the road again, he almost knocks down a passing cyclist. Nick is locked in himself again and has lost the environment around him.

Another day, we are walking to school again and choose a longer, quieter route, along a pond, no traffic, and a twenty-minute walk. Nick starts talking almost immediately. He is completely absorbed in his fantasy world and talks and talks. This lasts for more than 10 minutes before he falls quiet. I adjust my stride so that we are walking more side by side. Repeatedly, he falls behind me again. After a while he comes round; we get in step with each other and Nick stays more beside me. Then he says, 'I have such stiff legs'. 'That's right, Nick, I can see that and it's not easy to walk then.'

Haptotherapeutic intervention: fostering the physical-encountering contact

A. From *'having a body to feeling and being present'* in the physical body

When Nick is asked to sit on a large kangaroo ball, he doesn't move. He gets bogged down in reasoning 'how' he is supposed to do that. When encouraged to just try it, he walks over to it, but continues to dawdle around it. You actually have to go over to him and say, "Come on, sit down." Nick hesitates. Eventually, after a great deal of effort, Nick is able to get a grip and remain seated on the kangaroo ball.

His feet feel strange: thick, puffy, rigid, passive, little reflex and almost inanimate. Not a foot that responds immediately to touch. It seems as if Nick isn't present in there. With my hands on his upper legs, more subtleties can be felt in his movements: A 'listening' feeling, seeking and working with the kangaroo ball. Nick discovers the difference between sitting 'on' the ball and being more 'in' and 'with' the ball. He discovers that you can move while feeling around and in the middle of the ball. The tightness around his pelvis and his legs disappear. I can increasingly let him 'go' and he goes off himself to investigate and explore.

Eventually he is successful in finding the point of balance and even manages to lift his feet from the floor. Nick and the kangaroo ball are becoming more of a whole and it looks much less convulsive. His movements are steadier and one can see that he is physically more present in his body, 'feeling' it more, instead of trying to control and direct it mentally.

B. From physically experiencing to physically sensing and physical awareness

While lying on his stomach, I allow Nick to experience the full contour of his left leg through the contact of touch. I touch his leg tentatively, listening as I go to determine if he is with me in the way he is feeling and experiencing it. When asked, "Do both legs still feel the same?" he answers directly with a "no". I invite him further exploration. "Can you also tell me what feels different?" He answers, "I have more of a leg".

When his left leg is now moved back and forth by gently rocking his left foot, the rocking movement resonates more through his whole left leg, as compared to his right leg. He also confirms this. "Would you like to do the same thing with your right leg?" 'Yes!' No hesitation here. His legs allow the response; they soften, gain elasticity and flexibility. The most beautiful thing is hearing him say, "I can feel my legs. I can feel them down to my feet." When this feeling is awakened within him, his body comes to life for him.

C. Tapping into the self-bearing capacity

Nick stands with stiff, fixated and hyper-extended knees. His knees are almost pushing against each other (knock-knees). The experience on the treatment table is now transferred to his standing posture. Standing, I again touch his left leg and allow him to feel through the length of his leg, all the way to his feet. The over-extension disappears, as does the hardness. He starts really standing on his legs more and doesn't have to make the effort as much to keep himself upright. Once he is able to stand on both legs, the tension in his pelvis disappears. His legs and his pelvis become a weight-bearing whole, or in other words, he is discovering now that he's standing and that he can carry himself better.

In this way, he is much more physically present in his body, feeling it and experiencing the emotion of it. As he put it, 'an empty and 'deadish' body' blossoms into a lively, contact-seeking physical being. The dullness and blankness in his face have disappeared. Pleasure dances around his mouth. He has stepped to the outside and allows himself to be seen.

D. Being present, feeling the physical and emotional sensation of contact

Sitting on a stool in the middle of the room, Nick stands in front of me with his back to me. I place my hands on his hips and again feel how stiff he is standing on his legs. I ask him, "Nick, can you feel my hands?" He immediately experiences the feeling of my hands and responds. The pelvic area softens and expands. He moves his legs instinctively, adopts a wider stance, relaxes more through the knees and maintains physical contact through to his feet.

"Nick, have you noticed something has changed?" "Yes," he answers, "I'm standing more relaxed." Now he can move his legs easily from the pelvis and follows the movements in which I physically guide him: forwards, backwards and sideways.

Then I feel through his body: upwards. Without any indication or verbal instruction, he follows me in my feeling and focuses on his head. He calmly starts looking around as if he is exploring and becoming more aware of his surroundings. Nick has more awareness now, in feeling himself, the space around him and also towards me.

I help him to expand this 'feeling' listening further by taking him by the hand and leading him around the stool, passing by on one side of the stool or making space so that we can pass with the stool between us. The movements are supple, flowing, attune to and in harmony with each other and natural, even if I let Nick lead. The movements become more dancelike, the leading and following alternating seamlessly, without verbal instructions.

E. Working towards feeling physical presence within the contact

In the treatment space, lies a kangaroo ball in the shape of a large peanut. With Nick standing behind me, we hold the peanut ball between our bodies. "Nick, now lead me through the room. Around the table, the chairs and in the corners, without losing the peanut."

He takes me with him flawlessly. Not by pushing me forward in front of him, but by indicating with his body and being what he wants and waiting until I go with him. Moving forward goes easily. But when we end up stuck in a corner, he has to take me with him by moving backwards. He then starts thinking and consequently loses the contact. The peanut falls. At this time, he has to sense carefully and be very clear in his contact with me, waiting until I respond to his invitation and continuing to listen when we move backwards.

F. Intention, vitality and intimacy

In earlier sessions, Nick's movements show that he seldom reaches out to others. When you give him an object, he remains standing where he is, waiting until the other person stretches to offer it to him. Nick himself doesn't move; he remains at a distance.

We start by throwing and catching, using a sticky ball and a sticky paddle. With a bit of practice, he manages to

aim and throw the ball and to catch it on the sticky paddle. When catching with the sticky paddle, he holds his arm stiff and repeatedly dives with his upper body stretched backwards. His whole lower body remains fixed to the floor.

This is a typical posture of Nick's: stiff in the legs, a fixed pelvis, stomach pronouncedly forward and his upper body bending backward. In daily life, this comes across as haughty and arrogant.

We put the things aside to try to make his body more free. Standing in front of me, I lay my hands on his hips. Almost directly, he unconsciously moves his feet and stands more relaxed on his legs, less locked. Then I lay one hand on his pronounced stomach area, which feels hard, and I put my other hand on his upper back, which is hard and immovable. "Feel my hands, the hand in front and the hand behind. Those two hands are communicating with each other. Feel it." Gradually he seeks out both hands with his feeling. The front of him softens and a little later so does his back. The pronounced thorax relaxes and falls and the backwards overextension in his upper back disappears.

From the upper body, I allow him, through the contact of my hands, to experience that he can feel downwards, towards his legs. The upper body and lower body become more of a whole entity, a mobility that flows from above to below and flows back again from the legs and the pelvis to his upper body. The aloofness in Nick disappears; he appears more open and looks around. He is more in contact and is standing on his own legs.

Standing across from each other, we take a stick between us with our right hands. Through the stick I make an appeal to him in his entirety so that he focuses on me. From my whole body, I make my intention clear, which he goes along with naturally. He follows me, well-attuned. The roles are reversed and it's Nick's turn. He thrusts directly from the arm. I take over again. I help him to feel through the stick how he can stand in his wholeness. I coach him in the contact: "The effort comes from your whole body. Don't do anything yet, feel your legs, feel your pelvis, feel your upper body, and feel through your arm, through the stick and then feel to my hand and further, through my arm, my upper body and through my legs to the ground. Let me feel where you want to go." This creates a listening-feeling movement in which one person can lead the other, without pushing or pulling, without force but 'with' the other. It's a game of alternately leading and following. The feeling of togetherness and teamwork moves him emotionally. "It's almost like dancing," he says.

To do your best is not enough, you must make contact

The foregoing examples illustrate clearly how important it is to explore the development of the ability for feeling and emotion in high functioning people with ASD.

This is a change that has a huge impact on the person himself and creates an opening for mutual feeling and emotional contact; this is the prelude to finding the way to empathetic and responsive action. The path that is travelled is one of experiencing a shift from cognitive control to one of exploratory feeling.

In both high-functioning adults with ASD as well as with Nick, the invitation to engage in contact must be frequently presented and offered before the emotional security becomes anchored in a person. This requires great patience and creativity of the therapist to repeatedly find a way of offering these moments of contact, suitable for that person.

In Nick's case, these changes manifested themselves in becoming less absent, among other things; his daily tasks seem to have become more natural, he displays a greater independence, and he seems less fixated inside his thought realm. He travels to school by bicycle now and takes public transportation independently. His parents report that they can go out to eat with him and that it's very enjoyable. Now and again, Nick surprises his parents by responding adequately to conversations. In the haptotherapeutic sessions, Nick also spontaneously relates examples from his daily life that are connected to the exercises that we do together.

Conclusion and discussion

Conclusion

Haptonomy and haptotherapy offer insight into the fundamental and essential role that developing the capacity for feeling plays in the practice, understanding and extension of mutual emotional contact. The development of this affective, physical capacity for contact, for touch, is formative to the individual. It fosters and affirms the person in the sense of developing self-worth, individuality, an internal sense of security, self-confidence, a sense of purpose and a zest for life.

When working with high-functioning persons with ASS, haptonomy approaches and invites people to develop their latent capacity to feel and to be in contact. This creates new possibilities for these persons to become more emotionally in contact with themselves, with others and with the world.

Recommendations

A. Parent(s) and care

With many instructions coming from the world of 'professional healthcare', parents have begun to think more along the lines of direct, manageable and practical directions and schedules that can be implemented. "What do I need to do? Do you have exercises that Nick can do at home?"

Of course, they can do something with Nick at home. But this ends up sounding like an assignment, while the idea is more about the approach to take towards Nick. The parent's own personal contribution is crucial in this approach. Anything other than an inviting, empathetic and discerning approach, offering clarity and certainty will not do. It is not simply about carrying out an assignment, but more of a reaching towards him and offering an opening for contact. Coaching of and support for parents, therefore, form an important part of the haptic therapy for children with ASD. This article doesn't cover this aspect. The emphasis of this article accentuates more strongly the importance of developing the capacity for emotional and physical contact in adults and children with ASD in general, which forms the basis for mutual emotional contact.

B. Education

Much more could also be done within the educational world about the development of the emotional and physical experience of feeling and the related emotional contact. The emphasis on cognitive performance is much too strong.

The introduction of musical subjects such as dance, drama, music and singing, and the expressive subjects such as drawing, painting, moulding and movement education would be a very valuable addition to the development of the capacity for haptic contact.

C. The use of psycho-pharmaceuticals

Long-term use of psycho-pharmaceuticals not only suppresses the capacity to feel but also the capacity for emotional contact. A numbing occurs and a loss of the perception of reality, individual initiative and actual emotional contact. Basic experience, a 'sense of well-being', a 'sense of life', sensitivity to beauty, being able to appreciate and enjoy, and vitality all fade into the background. For the persons themselves, this means an alienation from themselves, an estrangement. However, the outside world also experiences this person as aloof, estranged from the world, or even 'strange' and often then reacts by either ignoring or sometimes rejecting this person. The use of psycho-pharmaceuticals can then push the person with ASS into a double isolation, both internally and externally. Over the course of haptonomic treatment, a reduction in the dosage of these kinds of medicines is often possible in consultation with the attending psychiatrist.

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