

What Is ReAttach? A Developmental, Qualitative, and Literature-Based Synthesis of the Core Method, Training Pathway, and Emerging Research Environment

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Abstract

The purpose of this article is to formulate a coherent and transferable account of the development and fundamental concept of ReAttach. ReAttach was developed by Dr. Paula Zeestraten-Bartholomeus from clinical practice in 2010 ; and it was subsequently advanced through practice-based research, professional training, international collaboration, and the development of open-access scholarly platforms. The present synthesis was undertaken partly as a knowledge-transfer project. The developer has reached the age of 60 and wishes to make the intervention's underlying reasoning sufficiently explicit for future practitioners, trainers, and researchers. The aim is not only to describe individual techniques, but also it is to identify the ordered clinical and educational structure that should be protected when ReAttach is implemented, taught, or further developed.

Four principal groups of sources were analysed: the 2018 edited volume *Autism: Is There a Place for ReAttach Therapy?*; likewise, the 2021 doctoral thesis on ReAttach, publications from the first year of the ReAttach Affect Coach Journal, and transcripts of training sessions and sessions with patients and trainees. Additional material included remote sessions with patients with Functional Neurological Disorder (FND), conference submissions, current training information, NeuroLog-related research, and an occupational therapy pilot concerning persistent post-concussion symptoms.

The published literature and the transcripts were analysed separately according to their evidential function. Theoretical interpretation, clinical protocol descriptions, practice-based studies, controlled pilot research, conference abstracts, participant reports, and training demonstrations were not treated as equivalent forms of evidence. Across the materials, a stable fundamental structure emerged. ReAttach first establishes a regulated relational and multisensory learning condition. It subsequently supports sensory integration, associative processing, social cognition, perspective-taking, adaptive identification, and active learning through Cognitive Bias Modification. The practitioner regulates and facilitates the process but does not determine the participant's personal associations or meaning.

Several related techniques and later developments can be positioned within this architecture. Wiring Affect with ReAttach is a focused method for negative-affect regulation. The Forgive and Forget Hood (FFH) supports the repositioning of persistent mental and sensory material. New Mind Creation extends the intervention toward secure exploration and developmental possibility. The Sensory Override Technique supports acute regulation during hypervigilance or cognitive dissonance. M.I.S.T. supports individual and systemic formulation.

The current international training pathway mirrors the clinical sequence by moving from accessible remote self-regulation, through supervised face-to-face competence, toward complex formulation and advanced developmental intervention. Emerging research reflects a gradual distribution of responsibility. This includes university-based research by Dr. Mohadeseh Bitá, patient-originated FND research infrastructure developed by Steven Painter, and occupational therapy research led by Sieto Reitsma. Reitsma's completed pilot in persistent post-concussion symptoms is currently under peer review; consequently, no unpublished quantitative outcomes are reproduced in this synthesis.

The available material supports a coherent internal consensus regarding the identity, order, and educational structure of ReAttach. Evidence for comparative clinical effectiveness and specific neurobiological mechanisms remains more preliminary and requires continued independent, controlled, and interdisciplinary research.

Keywords: ReAttach, affect regulation, sensory integration, social cognition, Cognitive Bias Modification, W.A.R.A., New Mind Creation, Functional Neurological Disorder, persistent post-concussion symptoms, occupational therapy, transdiagnostic intervention

Introduction

ReAttach is a brief, structured, transdiagnostic intervention for children and adults with psychological, developmental, psychosomatic, and related functional difficulties. It was developed by Dr. Paula Zeestraten-Bartholomeus from her work as an educational psychologist in private practice. The first ReAttach session was developed on 26th February, 2010. The original intention was to create a condition in which the brain could process sensory information and enter a state associated with play, curiosity, and learning. The phrase “playing is processing” expresses an early assumption that has remained central throughout the intervention’s development: cognitive or verbal information cannot be expected to produce adaptive learning when the person’s sensory, affective, attentional, or relational state is not ready to process it (Bartholomeus, 2021).

Since 2010, ReAttach has moved through several overlapping phases. It began as a clinically developed intervention influenced by educational psychology, schema therapy, developmental disabilities, and the practical needs of children and adults whose development had become obstructed. It was subsequently described as a multimodal intervention for autism and developmental difficulties, developed into a transdiagnostic method, investigated through practice-based studies, and extended through focused self-regulation techniques, systemic formulations, and professional training programmes.

This development occurred with limited institutional and financial resources. ReAttach did not originate in a large university research centre or a commercial treatment organisation. It arose from private practice and was further developed through ReAttach Academy and the ReAttach Therapy International Foundation. The Academy has remained predominantly founder-led, while practitioners, trainees, researchers, editors, allied health professionals, and people with lived experience have contributed because they share an interest in accessible, affordable, and growth-oriented psychological care.

This organisational context is relevant to the interpretation of the evidence. Intervention development, practitioner training, implementation, supervision, publication, and early research have often taken place within the same professional network. This creates strong continuity between the intended model and its practical implementation. It also means that affiliation, mentorship, and founder involvement should be described transparently and that progressively more independent research remains necessary.

The same context creates an important responsibility. Most of the detailed knowledge of ReAttach is embodied in the founder’s timing, clinical observation, demonstrations, language, and moment-to-moment decisions. At the age of 60, Zeestraten-Bartholomeus has expressed the wish to make this knowledge sufficiently explicit so that the method can be

implemented responsibly by future generations and will not remain dependent on the tacit knowledge of one person (P. Zeestraten-Bartholomeus, personal communication, 12th July, 2026).

The present article is not merely a summary of an intervention. It is a developmental synthesis and knowledge-transfer document. It asks which elements have remained stable throughout the development of ReAttach, which techniques and instruments were added later, how these components relate to each other, and which order should be protected in future implementation and training.

The developer’s publications have appeared under the names Paula Weerkamp-Bartholomeus, Paula Bartholomeus, and Paula Zeestraten-Bartholomeus. These names refer to the same person and the same continuing programme of intervention development.

Aim

The central aim of this article is:

To construct a coherent and transferable account of the development, fundamental concept, clinical sequence, educational pathway, and emerging research environment of ReAttach by integrating published literature with qualitative evidence from training and session transcripts.

This aim includes five related objectives:

To identify the stable core principles of ReAttach.

To distinguish the core ReAttach protocol from focused techniques, advanced modules, assessment systems, and wider research models.

To analyse how ReAttach is taught, performed, and experienced in training and session transcripts.

To describe the current international order of ReAttach professional training.

To distinguish consistently between theoretical interpretation, practice-based evidence, participant experience, emerging research, and established findings.

The word *consensus* is used cautiously. In this article, it refers to convergence across the ReAttach literature, the developer’s practical research, external conceptual interpretations, training materials, session transcripts, and current educational structure. It does not imply that an independent scientific consensus has already been reached concerning the clinical efficacy or mechanisms of ReAttach.

Materials and Method

Source Corpus

1. The first source was the 2018 edited volume *Autism: Is*

There a Place for ReAttach Therapy? A Promotion of Natural Self-Healing Through Emotions Rewiring (Weerkamp-Bartholomeus, 2018). This book contains a preface by Professor Michael Fitzgerald, a conceptual chapter by Dr. Soren Petter, an anxiety-focused contribution by Ashutosh Srivastava, and a chapter by Weerkamp-Bartholomeus on autism and overlapping symptom networks.

2. The second source was the doctoral thesis *ReAttach: A Transdiagnostic Intervention for Adults and Children With Mental Health Problems* (Bartholomeus, 2021). The thesis contains practice-based studies concerning adults with active early maladaptive schemas, children and families, autistic children and adults, W.A.R.A., remote W.A.R.A., and resilience.
3. The third source was the collected first-year publication record of the *ReAttach Affect Coach Journal*. This corpus includes theoretical articles, clinical protocols, single-case studies, pilot studies, observational analyses, and study protocols published during 2025 and 2026.
4. The fourth source group consisted of ReAttach training transcripts and anonymised transcripts of sessions with patients and trainees. These included training in the conditions required for social-cognitive work, W.A.R.A., the Forgive and Forget Hood, Parts 1 and 2 of the ReAttach protocol, Cognitive Bias Modification, New Mind Creation, and remote work with patients with Functional Neurological Disorder.

Additional materials included three conference submissions associated with Dr. Mohadeseh Bitá, a conference abstract submitted by Dr. Joachim Lee, and a conference submission by occupational therapist and ReAttach Affect Coach Sieto Reitsma.

The Reitsma material was considered at two levels. A study protocol on persistent post-concussion symptoms was published in the *ReAttach Affect Coach Journal* in 2025 (Reitsma & Mehrad, 2025). The subsequent clinical study was completed and submitted as a full manuscript for peer review. Because its quantitative findings have not yet appeared in a final peer-reviewed publication, the present article discusses only its design, professional context, and contribution to the development of the research programme. It does not reproduce the unpublished results (Reitsma, 2026; P. Zeestraten-Bartholomeus, personal communication, 12th July, 2026).

Current information concerning the international training order, the development from C.A.T. to M.I.S.T., the history of JRTDD, Crossref membership, editorial succession, current trainer roles, and the organisational context was supplied directly by Zeestraten-Bartholomeus in July 2026.

Analytical Strategy

The published literature and transcripts were analysed separately before being integrated. The documentary analysis examined:

1. How ReAttach was defined at different stages;
2. Which mechanisms were proposed;
3. Which populations were studied;
4. How the protocol and training system changed;
5. And what level of evidence supported each claim.

Sources were classified according to their principal function, including theoretical interpretation, clinical protocol description, uncontrolled pilot study, controlled pilot study, conference submission, single-case report, observational analysis, completed study under peer review, or future study protocol.

The qualitative transcript analysis used a reflexive thematic approach. The materials were examined for recurring descriptions of:

1. The conditions required before ReAttach begins;
2. The decisions and responsibilities of the practitioner;
3. The order of the procedure;
4. The task of the participant;
5. The use of tactile rhythm, affect, silence, and verbal prompts;
6. The formation of personal associations;
7. Subjective emotional and bodily experiences;
8. And the transition from co-regulation toward self-regulation.

The analysis did not attempt to count themes statistically. The transcripts differed in purpose, duration, context, and participant group. They were treated **as qualitative** process material rather than as a standardised research sample.

Evidential Boundaries

The different source types support different conclusions. Training transcripts can show how ReAttach is explained, sequenced, and demonstrated. They cannot establish general clinical effectiveness. Participant reports can describe calmness, emotional release, clearer thinking, vivid imagery, or increased agency. They cannot prove that these changes are lasting or that they were caused specifically by ReAttach. Uncontrolled pre-post studies can identify promising associations. They cannot exclude expectancy, spontaneous change, concurrent treatment, therapeutic relationship, or selection bias. Controlled pilots provide stronger comparisons, but small samples, short follow-up, and founder affiliation may still limit interpretation. Conference submissions can indicate current research activity. They should not be treated as equivalent to complete peer-reviewed articles. A completed study under peer review has a different status from a study protocol but should still be discussed cautiously before final publication. The research has been carried out, but its full method, analyses, and conclusions remain subject to peer review. Conceptual publications can clarify theories and

guide future studies. They cannot confirm proposed biological mechanisms unless those mechanisms were directly measured.

This distinction is especially important because many sources were written by the developer or by colleagues within the ReAttach network. Founder involvement provides conceptual continuity and detailed intervention knowledge, but it also makes independent replication necessary.

Positionality

The present synthesis is based substantially on founder-authored, founder-provided, or founder-affiliated material. It should therefore be understood as an internal developmental synthesis rather than as an independent systematic review. This position is both a strength and a limitation. It provides unusual access to the origin, intended sequence, practical reasoning, and continuing development of the method. At the same time, it requires caution when evaluating efficacy claims and proposed mechanisms.

The Development of ReAttach

Clinical Origin

According to the thesis, Zeestraten-Bartholomeus developed the first ReAttach session in 2010 and initially performed the intervention on herself. She attempted to create a state in which sensory information could be processed and play could become possible. She experienced what she interpreted as a rapid positive change in cognitive bias and subsequently began practical research with children and adults whose development was hindered by psychological or developmental problems (Bartholomeus, 2021).

The intervention developed from an educational and developmental perspective. Rather than beginning only with a diagnosis and asking which disorder-specific protocol should be selected, the method began with a different question: Which conditions for processing, learning, social understanding, and development are currently unavailable, obstructed, or insufficiently integrated?

This orientation later became compatible with transdiagnostic psychiatry. ReAttach focused on processes that appear across diagnostic categories, including arousal, sensory processing, negative affect, social cognition, self-concept, coping, cognitive bias, and executive functioning.

Conceptual Consolidation in the 2018 Book

The 2018 book represented an important stage in the conceptual positioning of ReAttach. It presented the method in relation to autism, anxiety, psychiatry, psychotherapy, developmental theory, and symptom networks.

Professor Michael Fitzgerald: Sensing Before Cognition

In his preface to our joint E-book, Professor Michael Fitzgerald cited Dr. Soren Petter with *cogito ergo sum* and described ReAttach as an integrative and dimensional therapy containing arousal regulation, tactile stimulation, joint attention, multisensory processing, conceptualisation, and Cognitive Bias Modification. He argued that sensory and affective experience precedes cognition developmentally. His phrase *sentimus ergo sumus*—we sense, therefore we are—captured the idea that sensing and affect should not be treated as secondary to verbal reasoning (Fitzgerald, 2018). Fitzgerald also placed ReAttach within a dimensional rather than strictly categorical interpretation of psychopathology. He emphasised diagnostic overlap and comorbidity and argued that integrative intervention may be better suited to complex clinical presentations than a single-modality approach. His preface is best understood as expert interpretation and endorsement. It does not constitute an empirical evaluation of ReAttach. Its importance lies in identifying the sensory-first, relational, dimensional, and integrative character of the intervention.

Dr. Soren Petter: Ontology, Pathology, and Therapy

Dr. Petter examined ReAttach from the perspective of psychotherapy theory. He asked which view of healthy human functioning is implied by the method and organised his analysis around ontology, pathology, and therapy (Petter, 2018). His interpretation suggests that ReAttach assumes that human beings are sensing, affective, relational, and socially organised. Psychological difficulties can therefore be understood as disturbances within interacting systems rather than only as isolated symptoms or defective thoughts. Dr. Petter's account also helps explain why ReAttach can be transdiagnostic. When an intervention is directed toward shared processes such as arousal, sensory integration, affect, social cognition, and coherent self-organisation, the same general architecture can be adapted across diagnoses without assuming that all participants require identical content. Dr. Petter clearly presented his chapter as one possible conceptualisation rather than as the only correct explanation or a procedural manual.

Dr. Ashutosh Srivastava: Information Processing and Anxiety

Dr. Srivastava applied ReAttach to anxiety disorders. He argued that people with anxiety may become strongly occupied by bodily sensations and threat-related interpretations, making ordinary verbal psychotherapy difficult. ReAttach was presented as an intervention that could influence information processing and cognitive bias without requiring the practitioner to debate every anxious thought (Srivastava, 2018). The chapter presented three case studies. Each participant received five ReAttach sessions, and anxiety and depression scores decreased at post-treatment and follow-up. These findings were clinically interesting, but the study was an uncontrolled three-person

case series. It provided an early clinical signal rather than generalisable evidence of efficacy.

Weerkamp-Bartholomeus: Autism and Symptom Networks

The developer's chapter described autism and overlapping difficulties from a network perspective. Autism was presented as heterogeneous, with interactions among sensory processing, social cognition, communication, executive functioning, affect, behaviour, and daily functioning (Weerkamp-Bartholomeus, 2018). Practice-based findings were presented for a wider clinical group and for defined symptom networks. These findings supported the hypothesis that ReAttach might influence connected transdiagnostic processes rather than one isolated symptom. The data were uncontrolled and collected in routine clinical practice. The main conceptual contribution of the chapter was therefore the movement from diagnostic categories toward interacting symptom and process networks.

The 2021 Doctoral Thesis

The doctoral thesis is the most systematically organised research source in the supplied corpus. It documents the movement from clinical innovation toward practice-based investigation and contains a cautious discussion of the limitations of the evidence.

Adults and Early Maladaptive Schemas

A group of 82 adults with psychological stress and active early maladaptive schemas received five ReAttach sessions. The mean total Young Schema Questionnaire score decreased from 627.34 to 476.60. Significant reductions were reported across all 18 schema domains, with a large total effect size of 1.28 (Bartholomeus, 2021). These findings suggest an association between participation in ReAttach and reduced schema activation. The study did not include a control group or follow-up assessment. The sample was heterogeneous, and information about concurrent medication and other treatments was incomplete. It therefore remains unclear whether the findings reflected enduring schema change, temporary reduction of stress, expectancy, therapeutic relationship, or a combination of factors.

Children and Families

The child study included 83 children with parent-reported emotional or behavioural difficulties. Each child received five ReAttach sessions, and the parents were offered one session. Mean Child Behavior Checklist scores decreased, with a reported large effect size. Parents reported that a subgroup of children no longer showed clinically significant complaints after the intervention (Bartholomeus, 2021). The systemic design is relevant. The child was not treated as an isolated individual. Parental stress, schemas, expectations, and co-regulation were considered part of the child's developmental environment.

The study could not distinguish the contribution of the child sessions from the parental session. Outcomes were also based on parent reports, which may themselves have been influenced by changes in parental stress or perception.

Autism

The autism pilot used the Autism Treatment Evaluation Checklist before and after five ReAttach sessions. Improvements were reported in communication, sociability, sensory and cognitive awareness, and health and behaviour. The thesis noted that the practitioners were selected partly because they had autism expertise and enthusiasm for ReAttach. This limits generalisability. The study also highlighted the importance of predictability, reassurance, and preparation before autistic participants can engage in the intervention.

W.A.R.A.

Wiring Affect with ReAttach was evaluated in a randomised crossover pilot involving 101 adults. W.A.R.A. produced a greater immediate reduction in negative affect than distraction (Weerkamp-Bartholomeus et al., 2020). This study provided a more direct comparison than the uncontrolled studies of the complete protocol. It supported an immediate affect-regulation effect but did not isolate the mechanism. Associative activation, tactile input, expectation, attention, interpersonal co-regulation, and other factors may all have contributed. Remote W.A.R.A. was subsequently evaluated in participants with stress-related complaints. Negative affect decreased, but the reduction was smaller than in a comparison group receiving face-to-face W.A.R.A. (Weerkamp-Bartholomeus, Marazziti, & van Amelsvoort, 2021). The thesis therefore positioned remote W.A.R.A. as a possible psychological first-aid or self-regulation tool rather than as a replacement for the complete ReAttach protocol.

General Conclusions of the Thesis

The thesis concluded that the findings were promising but preliminary. Causality, superiority over other interventions, and generalisability were not established. The developer's dual role as intervention designer and researcher was acknowledged. The thesis called for continued independent research and identified accessibility, affordability, and quality as important aims for future development (Bartholomeus, 2021).

Expansion Through the ReAttach Affect Coach Journal

The first publication year of the *ReAttach Affect Coach Journal* documents a further developmental phase. The journal includes ReAttach protocols and research concerning eating disorders, autism, adoption and foster care, adverse childhood experiences, psychosomatic problems, pain, Functional Neurological Disorder, persistent post-concussion symptoms, fibromyalgia, personality difficulties, and related presentations. The journal

also publishes work that is not directly about ReAttach. Its inaugural editorial welcomed contributions from clinical and organisational psychology, special education and rehabilitation, disability studies, pedagogy, social work, and social policy (Zeestraten-Bartholomeus, 2025a). The corpus contains several types of publication:

1. Theoretical and clinical integrations;
2. Descriptions of new protocols;
3. Single-case studies;
4. Observational analyses;
5. Pilot studies;
6. And study protocols for research that had not yet been completed when published.

The journal is therefore particularly valuable for understanding the current direction of the ReAttach programme. It should not be treated as one homogeneous body of outcome evidence. The terminology also expanded. Later publications increasingly used concepts such as salutogenesis, growth mindset, systemic co-regulation, emotional phenotypes, psychobiosocial conditions, autonomic states, and digital phenotyping. These developments may support individualisation and research, but they also create the risk that the original core method becomes difficult to recognise. The core intervention, later techniques, assessment frameworks, research models, and external theories should therefore be distinguished explicitly.

What Is ReAttach?

A coherent working definition can be formulated from the literature and transcripts: **ReAttach is a brief, structured, trans-diagnostic, systemically informed, and developmentally oriented intervention that first establishes a regulated relational and multisensory learning condition.** Through co-regulation, predictable rhythmic tactile input, associative processing, social-cognitive perspective work, adaptive identifications, and carefully timed active learning, the participant is supported in developing more coherent and flexible representations of the self, other people, the body, relationships, and the future. The order is structured, while the participant's personal associations and meaning remain their own.

This definition contains several central principles:

State Before Content

The clearest principle in the training transcripts is that technique precedes content. The practitioner does not begin social-cognitive or adaptive-learning tasks simply because a session has started. Arousal, affect, attention, tactile tolerance, relational contact, and sensory processing are addressed first (Zeestraten-Bartholomeus, 2026a). ReAttach therefore treats learning as state-dependent. The same words may have a different effect when a person is overwhelmed, shut down,

hypervigilant, distracted, or relationally unavailable.

Co-Regulation Before Advanced Self-Regulation

The practitioner initially contributes rhythm, emotional presence, predictability, pacing, and interpersonal safety. This is co-regulation. The person is not expected to produce all necessary regulation independently from the beginning. Self-regulation exercises can later be taught, but the complete intervention begins within a relational process.

Sensory and Affective Integration Before Cognitive Modification

ReAttach does not begin by challenging the logical content of thoughts. It first works with sensory processing, bodily state, affect, attention, and relational availability. This order is consistent with Fitzgerald's interpretation that sensing and affect precede cognition developmentally (Fitzgerald, 2018).

Association Before Explanation

The participant is given short prompts and time to form personal associations. A name, role, quality, or relationship can activate a wide network of memories, images, emotions, and meanings. The participant is not required to explain every association. Silence is therefore an active component of the intervention. It protects the participant's internal process and prevents the practitioner from imposing meaning.

Identification Before Active Learning

Adaptive qualities are first made available as possible aspects of the self. Only then is the participant asked to practise a related behaviour, expectation, or cognitive route. A quality that initially appears to belong only to other people may gradually become something the participant can imagine learning or expressing.

Structured Order and Personalised Content

ReAttach has a recognisable order, but the names, relationships, qualities, learning objectives, and pace are adapted to the individual. The intervention is therefore neither completely scripted nor completely improvised. The process is structured, while personal meaning remains individual.

Facilitated Rather Than Imposed Meaning

The practitioner creates conditions and introduces concepts but does not construct the participant's personal story. The practitioner may place two concepts beside each other, but the participant forms the psychological connection. This protects autonomy and prevents the practitioner from taking ownership of the person's internal experience.

Qualitative Findings From the Transcripts

Regulation Before Reflection

The training transcripts repeatedly instruct practitioners to wait for signs of readiness. Facial expression, body posture, affect, responsiveness, and spontaneous social initiative are observed. The practitioner should not force eye contact or social engagement. When the required contact and regulation do not develop, the social-cognitive phase should not begin (Zeestraten-Bartholomeus, 2026a). This indicates that tapping alone does not define ReAttach. Tactile rhythm is part of a larger relational and regulatory process.

The ReAttach Practitioner as a Conductor

The ReAttach Practitioner is compared with a conductor. This metaphor captures the coordination of rhythm, touch, arousal, voice, silence, transitions, and task complexity. The conductor does not play every instrument. Similarly, the ReAttach practitioner does not generate all of the participant's personal associations. The practitioner organises the conditions in which the participant's own networks can become active.

Participant-Generated Association

Participants frequently described images, memories, people, bodily sensations, or mental films. At times, several associations appeared simultaneously. The process was not always experienced as a clear verbal thought. One trainee described becoming temporarily distracted and then re-entering the process because the continuing rhythm and structure remained available. Another described the session as a film moving through the mind. These reports support the interpretation of ReAttach as an associative rather than primarily explanatory intervention.

Emotional and Bodily Responses

Participants reported calmness, vivid imagery, clearer thinking, warmth, movement of bodily sensations, laughter, tears, and emotional release. Some experienced a sense that processing continued without conscious effort after the active phase. These reports are meaningful descriptions of experience. They are not proof of a particular neurological mechanism. Not every reduction in arousal was immediately comfortable. One participant experienced calmness as strange and temporarily frightening because high arousal had become more familiar than relaxation. This suggests that recognition and tolerance of a regulated state may itself require learning.

Increased Overview Without Erasing Difficulty

One patient entered a ReAttach session feeling nervous and unable to oversee the complexity of accumulated life experiences. During the session, the patient reported that everything became calmer. Difficult experiences and emotions remained present, but moments of hope or light also became

accessible. This account suggests that the subjective purpose is not necessarily to remove all negative information. The person may become able to hold more of their experience without being completely dominated by one affective state.

Wiring Affect With ReAttach

Published Literature

W.A.R.A. is a short ReAttach-derived exercise intended to reduce the immediate dominance of negative affect or sensory over-responsivity. It is the ReAttach component with the clearest direct experimental comparison in the supplied literature. The randomised crossover pilot found a greater immediate reduction in negative affect after W.A.R.A. than after distraction (Weerkamp-Bartholomeus et al., 2020). Remote W.A.R.A. was also associated with reduced negative affect, although face-to-face delivery produced a larger change (Weerkamp-Bartholomeus, Marazziti, & van Amelsvoort, 2021). These studies concern immediate affect regulation. They do not establish that W.A.R.A. alone treats complex trauma, developmental disorders, personality difficulties, or chronic psychiatric conditions.

Qualitative Transcript Evidence

W.A.R.A. begins with attention to an unpleasant bodily sensation or after-feeling. The participant is not always required to identify the emotion or explain its cause. During slower tapping, the sensation is made accessible. The practitioner then activates a rapid sequence of concepts expected to evoke a strong, familiar, and preferably positive associative network. Examples in the transcripts include food, celebrations, enjoyable activities, playful objects, familiar people, and holidays. The tapping rhythm or pressure subsequently changes. The participant is then invited to revisit the original sensation. Participants described sensations becoming less prominent, moving through the body, receding, or being followed by a clearer feeling in the head.

Integrated Interpretation

W.A.R.A. can be understood as an attempt to change the sensory and associative context in which an unpleasant experience is processed. The exercise does not mainly challenge the sensation through reasoning. It first makes the sensation accessible and then places it in relation to a broader and more strongly activated associative network. W.A.R.A. should be taught as a specific technique, not as a shortened synonym for ReAttach. The training also contains an important limitation. Negative affect may have a protective or informative function. Feelings related to actual danger, illness, harmful behaviour, or personal boundaries should not automatically be removed. W.A.R.A. is therefore a targeted regulation tool, not a method for eliminating all discomfort.

The Forgive and Forget Hood

Published Literature

The Forgive and Forget Hood, called the *VergeetMuts* in Dutch, was developed as an accessible self-regulation exercise for mental burden, rumination, persistent images, negative thoughts, sensory over-responsivity, and difficulty letting go of emotionally charged material. Journal publications describe it as a technique that may be practised independently after it has been learned. Literature concerning obsessive-compulsive disorder also states that the technique should not replace established disorder-specific treatment in moderate or severe OCD (Zeestraten-Bartholomeus, Krzysztofik, Bitá, Mehrad, & Marazziti, 2025).

Qualitative Transcript Evidence

In the transcripts, the participant first enters a calmer state. Unwanted sensations, images, thoughts, self-criticism, interpersonal irritation, or other mental “data” are collected in the area above the eyebrows. With the eyes closed, the participant looks upward and imagines moving the collection slowly toward the back of the head, where it can fall into the imaginary hood. One participant described the images as initially becoming larger before becoming smaller and appearing to fall away. Afterward, she reported less emotional intensity and said that the material was no longer as prominent. She later performed the procedure independently (Zeestraten-Bartholomeus, 2026b).

Integrated Interpretation

The technique should not be described as literal memory deletion. The transcripts do not show that autobiographical facts have been erased. A more defensible interpretation is that the material changes its attentional, emotional, and spatial position. It becomes less dominant in the foreground of experience. The exercise also supports autonomy. The practitioner does not need to know every item placed in the imaginary hood. The participant remains in control of the content and can later repeat the procedure independently.

ReAttach Protocol Part 1: Social-Cognitive Training

Published Literature

The literature identifies arousal regulation, tactile input, joint attention, multisensory processing, conceptualisation, mentalisation, and social cognition as central elements of ReAttach. In the thesis, these processes were established before individual Cognitive Bias Modification and active learning were added (Bartholomeus, 2021).

Qualitative Transcript Evidence

ReAttach Protocol Part 1 begins only after the conditions

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for social-cognitive training have developed. The practitioner continues tactile regulation while presenting brief associative prompts. The sequence commonly moves through:

1. The self;
2. Significant other people;
3. Differentiation between self and other;
4. Perspective-taking;
5. Relationships;
6. And adaptive identifications.

A participant may first hear their own name and the names of significant people. The participant may then be invited to imagine being another person, to look at themselves through that person's perspective, or to consider two people in relation to each other. The exact associations remain private.

Adaptive Identifications

Adaptive identifications are qualities, roles, or descriptions linked to the participant's self-concept. Examples include being friendly, social, spontaneous, capable, supported, attractive, valuable, or a good parent. In one trainee session, the concepts “mother” and “a good mother” produced a strong emotional response. During the reflection, the participant connected this with caring for three young children and judging herself critically. The practitioner explained that she had supplied the two concepts but had not created the participant's personal meaning. The participant had formed the connection herself (Zeestraten-Bartholomeus, 2026b).

Integrated Interpretation

Part 1 is not merely an introduction to the active part of treatment. It is the social-cognitive and integrative foundation of ReAttach. Its purpose is to make coherent representations of self, other people, relationships, qualities, and perspectives more available. Identifications appear to bridge the distance between a quality that is recognised in the outside world and a quality that may become part of the participant's own learning potential. The sequence can therefore be expressed as: *Identification precedes active learning*.

The Complete ReAttach Protocol and Cognitive Bias Modification

Published Literature

Cognitive Bias Modification was already part of the model described in the 2018 book and the thesis. The practice-based adult, child, autism, and anxiety studies provide preliminary indications that complete ReAttach sessions may be associated with changes in beliefs, distress, behaviour, or daily functioning. These studies do not isolate Cognitive Bias Modification from tactile regulation, sensory integration, associative processing, social cognition, expectation, or therapeutic relationship. They

therefore support investigation of the complete multimodal package more strongly than any single mechanism.

Qualitative Transcript Evidence

ReAttach Protocol Part 2 is added after the foundations of Part 1 are sufficiently established. It includes search tasks and active-learning modules. The search tasks support access to long-term information. Cognitive Bias Modification is then used to introduce new self-related, relational, emotional, behavioural, or future-oriented learning. Three broad areas can be distinguished.

Self- and Other-Related Modification

Participants may be invited to look at themselves more compassionately, recognise continuity between the present and desired self, establish personal boundaries, or experience being seen and heard. In one session, a participant imagined standing before a mirror, smiling and winking at herself, looking at features she normally judged, and placing the person she wanted to become beside her present self. She was invited to notice how much the two versions already resembled each other.

Access to Positive Affect

Participants may recall enjoyment, laughter, playfulness, or other positive states and reconnect with their bodily quality. This does not merely ask the person to state that something pleasant has happened. It attempts to make the affective state more accessible during regulation.

Future-Oriented Learning

Participants may imagine a future associated with satisfaction, confidence, gratitude, or the possibility that things can become manageable. This is not presented as a prediction that nothing difficult will occur. It is practice in making a more adaptive future route psychologically available.

Integrated Interpretation

Cognitive Bias Modification in ReAttach is the active-learning phase of a process that has already prepared the participant to process and integrate new information. The complete protocol therefore follows a developmental order: *regulation* → *sensory and relational readiness* → *associative integration* → *social cognition* → *identification* → *adaptive learning*. Removing the earlier phases and retaining only positive suggestions or future imagery would change the intervention's fundamental logic.

ReAttach New Mind Creation

Published Literature

New Mind Creation is an advanced development within ReAttach. It is described as supporting secure attachment, exploration, adaptive schemas, creativity, spontaneity, ReAtt Aff Co 2(2): 158-177 (2026)

optimism, and a growth mindset. Recent publications specify several prerequisites before the technique is offered:

1. Relational attunement must be sufficiently available;
2. Sensory integration must be adequately established;
3. Social-cognitive training must have taken place;
4. Optimism bias must be trained or restored;

And the participant must be able to reconnect with positive affect (Zeestraten-Bartholomeus, Painter, Bitá, & Mehrad, 2026a).

The current literature presents New Mind Creation as promising, but it does not yet include a controlled trial in which New Mind Creation has been isolated from other ReAttach components.

Qualitative Transcript Evidence

In the transcripts, New Mind Creation begins with a pleasant feeling. The participant locates it, strengthens it, remembers it, and learns to return to it. The technique may include a comparison between development under actual circumstances and development under more supportive conditions. The participant is invited to explore which qualities might have developed more freely in the presence of safety, encouragement, and suitable opportunities. In one demonstration, positive affect was used metaphorically as an eraser for unpleasant thoughts or sensations. This should not be interpreted as literal deletion. It provides an experiential way to bring a positive, regulated state into contact with negatively organised material.

Procedure, Protocol, and Technique

The current international training distinguishes three levels. The *procedure* concerns the readiness conditions that must be present. The *protocol* concerns the individual formulation and developmental direction. The *technique* concerns the actual performance of New Mind Creation. This distinction is important. New Mind Creation is not a stand-alone imagery script that can be used after reading instructions. The practitioner must first determine whether it is indicated, whether the participant is ready, and how it should be formulated.

Integrated Interpretation

New Mind Creation can be understood as an experiential form of developmental reorientation. It does not deny history and should not be described as replacing a person's original mind. It creates a representation of continuing developmental possibility. Its central proposition is that adaptation to earlier circumstances does not need to remain the only available route. Under sufficiently safe, regulated, and integrated conditions, exploration, trust, self-compassion, and new learning may become more accessible.

The Sensory Override Technique

Position in the Source Corpus

Compared with W.A.R.A. and the standard ReAttach protocol, the Sensory Override Technique appears mainly in the clinical and remote session materials. It is used in situations involving hypervigilance, rapid sensory escalation, acute stress, or cognitive dissonance. The later journal literature also describes a technique called ConFusion. The precise relationship between the transcript-based Sensory Override Technique and the later named ConFusion technique should be operationally clarified in future manuals. They should not automatically be treated as identical without a formal procedural description.

Qualitative Transcript Evidence

In the remote FND sessions, the participant uses fast tapping and finger pressure while attending to a confusing, escalating, or uncomfortable state. Repeated cycles of tapping and pressure are introduced. Cognitive dissonance is explained as an uncomfortable state in which beliefs, expectations, or bodily responses conflict. The immediate aim is not to decide which belief is correct. It is to prevent the resulting sensory and arousal response from controlling the entire processing situation. Because the work is remote, the participant produces the tapping and pressure independently under practitioner guidance (Zeestraten-Bartholomeus, 2026c).

Integrated Interpretation

The Sensory Override Technique appears to be a practice-derived acute-regulation method. It introduces a predictable sensory-motor pattern when internal alarm or confusion is becoming dominant. It should presently be classified as an emerging ReAttach-related module. Before broad implementation, it would benefit from:

1. A standard operational definition;
2. Clear indications and contraindications;
3. Distinction from W.A.R.A. and ordinary ReAttach tapping;
4. Fidelity criteria;
5. Adverse-effect monitoring;
6. And prospective research.

M.I.S.T.: Mapping the Individual State of Mind

Development From C.A.T. to M.I.S.T.

ReAttach Computer Adaptive Tool (C.A.T.) was an earlier framework for tailoring ReAttach sessions. M.I.S.T.—Mapping the Individual State of Mind—was launched in August 2025 as its improved successor (P. Zeestraten-Bartholomeus, personal communication, July 12, 2026). Historical publications may continue to refer to C.A.T. This should be understood as part of the developmental history. M.I.S.T. is the current formulation ReAtt Aff Co 2(2): 158-177 (2026)

framework.

Function of M.I.S.T.

M.I.S.T. is not primarily a categorical diagnostic instrument. It is an interview and mapping system that examines ten transdiagnostic factors and helps the practitioner determine how they are currently expressed. The later literature refers to factors such as arousal, social reward, sensory and information processing, conceptualisation, emotion regulation, coping, and cognitive bias. The complete operational definitions should follow the current M.I.S.T. manual. M.I.S.T. performs two major functions. First, it supports individual formulation. It helps the practitioner tailor pacing, sensory emphasis, identifications, and active-learning content. Second, it maps systemic co-regulation. It considers how parents, partners, caregivers, or other significant people may soothe, activate, overprotect, demand, withdraw, escalate, or support recovery. This systemic function is important because co-regulation is not automatically beneficial. A family member may communicate anxiety, unintentionally reinforce passivity, provide insufficient support, or overestimate what the person can manage.

Integrated Interpretation

M.I.S.T. represents a movement from intuitive tailoring toward a more explicit and teachable formulation system. It does not replace clinical judgement. It helps practitioners explain why a particular session is paced or formulated in a particular way. M.I.S.T. should be distinguished from the core intervention. It is an assessment and formulation framework used to tailor ReAttach, especially in complex cases.

The Current International Training Pathway

By 2026, ReAttach had developed into a staged international training structure. The order is clinically meaningful and should be treated as part of the method's implementation model. According to the current founder-defined pathway, professionals progress through four stages (P. Zeestraten-Bartholomeus, personal communication, 12th July, 2026).

Stage 1: ReAttach Affect Coach Online Program

The ReAttach Affect Coach Online Program is the first international introduction to ReAttach. The programme teaches and assesses ReAttach-related techniques that can be delivered remotely. It includes an introduction to the fundamental principles, selected remote self-regulation methods, practical online application, and a practical examination. The programme has two main purposes. First, it offers an accessible and comparatively affordable entry point for international professionals. Second, it teaches techniques through which clients may regain a degree of self-control before more complex intervention is attempted. The programme is not equivalent to complete face-to-face ReAttach Practitioner training. Remote work cannot provide every form of direct tactile co-regulation,

proximity, and moment-to-moment physical observation that occurs in a face-to-face session.

Self-Control as the First Clinical Goal

The importance of self-control became especially visible in remote work with patients with Functional Neurological Disorder. The practitioner did not begin by collecting a complete account of every symptom or past event. The patient was first taught how to use their own hands, tapping rhythm, and finger pressure to influence arousal and sensory state. Qualitatively, these sessions suggest that loss of agency may be a central immediate difficulty. A patient may already understand that stress, symptoms, fear, and hypervigilance interact but may feel unable to influence the process. A repeatable sensory-regulation action can create an early experience of controllability. The current FND work should be described as an initial pilot and feasibility evaluation of the remote techniques included in the online programme. Further research is in progress. It is not yet a completed controlled evaluation of the entire 2026 curriculum.

Stage 2: ReAttach Practical Training

After the introductory online route, international professionals proceed to face-to-face practical training. This training covers ReAttach Protocol Parts 1 and 2 and the performance of complete sessions. Participants learn to:

1. Regulate and monitor arousal;
2. Establish safe contact;
3. Observe spontaneous social initiative;
4. Support sensory integration;
5. Conduct perspective-taking;
6. Select adaptive identifications;
7. Allow associative processing time;
8. And match Cognitive Bias Modification with earlier identifications.

Practical competence cannot be reduced to theoretical knowledge. The practitioner must decide when to wait, when to change rhythm, whether touch is tolerated, when the participant is ready for social-cognitive work, and when active learning would be premature. Successful completion of the practical training and examination leads to the *ReAttach Practitioner* diploma.

Development of Practical Trainers

As part of the transfer of founder knowledge, multiple selected professionals are being trained to support practical education in their own fields. Zeestraten-Bartholomeus trained occupational therapist Sieto Reitsma as a ReAttach Basic Skills Trainer with a particular focus on paramedical and allied health professionals (P. Zeestraten-Bartholomeus, personal communication, 12th July, 2026). This development is ReAtt Aff Co 2(2): 158-177 (2026)

important because the application of ReAttach in rehabilitation requires translation into daily functioning, activity, participation, pacing, and practical recovery goals. Reitsma's background in occupational therapy and neurorehabilitation provides a bridge between the psychological structure of ReAttach and the functional priorities of allied health practice. Training selected professionals does not remove the need for shared standards. It increases the importance of trainer calibration, treatment-integrity criteria, and consistent practical examinations.

Stage 3: M.I.S.T. Specialisation

After establishing competence in the core protocol, the practitioner learns to use M.I.S.T. This stage supports work with more complex patients by mapping ten transdiagnostic factors, tailoring sessions, and examining systemic co-regulation dynamics. The sequence protects against premature complexity. The practitioner first learns how to perform ReAttach before using an advanced formulation system to adapt it.

Stage 4: New Mind Creation

New Mind Creation is taught during an additional, fourth practical-training day. The training covers:

1. The readiness procedure;
2. The formulation of the protocol;
3. And the performance of the technique.

Before New Mind Creation can be offered, sensory processing must be sufficiently activated, positive affect must be accessible, and optimism bias must be available or retrained. Completion of the required specialisation and practical assessment leads toward the *full ReAttach Affect Coach* diploma.

The Educational Sequence Mirrors the Clinical Sequence

The educational order can be summarised as: *accessible self-control → embodied co-regulation and core competence → individual and systemic formulation → advanced developmental learning*

This mirrors the clinical order: *state before content → integration before modification → identification before active learning → secure conditions before New Mind Creation*. The curriculum therefore does more than organise course modules. It expresses the internal logic of ReAttach.

Functional Neurological Disorder and Related Neurorehabilitation Research

Why Functional Neurological Disorder Is Relevant

Functional Neurological Disorder (FND) makes the need for an integrated approach particularly visible. People may experience altered movement, functional seizures, sensory symptoms, fatigue, pain, cognitive difficulties, hypervigilance,

loss of agency, and emotional distress. No single technique or profession is likely to address every part of this presentation. The remote FND sessions show an initial focus on regulation, agency, and self-control. The participant learns to alter tapping speed and pressure rather than remaining completely dependent on the practitioner. This may be particularly important when symptoms are accompanied by fear that the body is uncontrollable.

NeuroLog

NeuroLog was developed by Steven Painter, who has lived experience of FND. The platform enables people to record symptoms, emotions, possible triggers, and changes over time. Its patient origin is significant. The platform begins with daily experiences that people with FND consider important, rather than only with variables selected by clinicians or institutions. Zeestraten-Bartholomeus supported Painter's work and the creation of research collaborations around the database. Painter remains the developer of NeuroLog and the Symptom Amplification Model. Zeestraten-Bartholomeus contributes the ReAttach intervention, clinical questions, and treatment-development perspective. This collaboration is best described as patient-originated, clinically supported, and collaborative research.

Symptom Amplification Model

The Symptom Amplification Model provides a framework for examining how biological, emotional, behavioural, and social factors may relate to changes in symptom severity. The *ReAttach Affect Coach Journal* has published:

1. A NeuroLog flare-prediction protocol;
2. A protocol for evaluating ReAttach-related remote techniques;
3. A pilot comparison involving functional seizures;
4. Work on emotional phenotypes;
5. And an observational analysis of functional movement symptoms (Painter, 2025; Painter, Zeestraten-Bartholomeus, & Mehrad, 2025a, 2025b, 2025c).

A later real-world analysis examined thousands of patient-reported logs and found associations between emotional states and functional motor symptom presence or severity. The study also acknowledged substantial limitations, including self-selection, self-reported diagnoses, missing demographic information, possible confounding, and inability to determine whether emotional states preceded symptoms or resulted from them (Painter, Zeestraten-Bartholomeus, Pattison, Adeyemi, & Akulwar-Tajane, 2026). NeuroLog can therefore support hypothesis generation, ecological monitoring, subgroup identification, and prospective research design. Observational associations should not be interpreted as proof that one emotion causes a symptom or that a specific intervention will change that symptom.

Integration With Remote Sessions

In one remote transcript, the participant was asked to record ReAttach tapping in NeuroLog. The purpose was to examine whether daily symptom patterns changed after practising the technique. This provides qualitative evidence of how patient-generated measurement and remote self-regulation were combined in practice. The evidential distinction remains important:

1. The transcript describes implementation and participant experience;
2. NeuroLog provides observational patient-reported data;
3. Prospective controlled studies are required to evaluate treatment effects.

Occupational Therapy and Persistent Post-Concussion Symptoms

Development of the Research

Sieto Reitsma and Aida Mehrad published a research protocol in 2025 concerning the use of ReAttach within occupational therapy for adults with persistent post-concussion symptoms (Reitsma & Mehrad, 2025). The protocol proposed an integrated intervention rather than ReAttach in isolation. It combined ReAttach with psychoeducation and activity-oriented occupational therapy. Outcomes included post-concussion symptoms, perceived stress, occupational performance, and activity-related functioning. This design is significant because it extends the evaluation of ReAttach beyond psychological symptom scores. Occupational therapy is concerned with whether people can return to meaningful activities, organise their day, tolerate demands, resume social roles, and participate in work or family life.

The Completed Pilot

The subsequent pilot study was completed in a first-line occupational therapy practice. The congress submission describes a prospective case series involving ten adults with persistent symptoms following mild traumatic brain injury. Participants received four ReAttach sessions integrated with psychoeducation and activity-focused coaching. Assessment took place before treatment, after the intervention period, and at later follow-up. Measures included post-concussion symptoms, perceived stress, and occupational performance (Reitsma, 2026). The full quantitative findings are part of a manuscript currently under peer review. In accordance with the author's request and the status of the paper, those unpublished outcomes are not reproduced in the present synthesis.

Evidential Interpretation

The completed study represents an important development in several respects. First, the research was conducted in a rehabilitation practice outside the founder's own private

practice. Second, it was led by an occupational therapist and therefore included functional and participation-related outcomes. Third, it examined ReAttach as part of a multimodal rehabilitation intervention rather than presenting psychological regulation as separate from graded, goal-directed activity. Fourth, it reflects knowledge transfer from the founder to an allied health practitioner who has also been trained to teach basic ReAttach skills to paramedical professionals. The design nevertheless has clear limitations. A ten-person prospective case series does not establish comparative effectiveness. Without a control group, improvement cannot be attributed with certainty to ReAttach. Because the intervention combined ReAttach, psychoeducation, and occupational coaching, the contribution of each component cannot be isolated. The value of the study lies in feasibility, clinical development, follow-up measurement, and the connection between regulation and occupational participation. Its final evidential weight should be judged after peer review and publication of the complete method and results.

Persistent Post-Concussion Symptoms and FND

The Reitsma submission discusses persistent post-concussion symptoms from a functional-neurological and autonomic-regulation perspective. This should not be interpreted as a claim that persistent post-concussion syndrome and Functional Neurological Disorder are always the same condition. The study is better understood as examining an area of possible clinical overlap: persistent symptoms, altered stress regulation, sensory sensitivity, reduced activity tolerance, and functional impairment may interact even when diagnostic formulations differ. This is another reason why interdisciplinary assessment is important. Neurological, rehabilitation, psychological, occupational, and functional perspectives may each contribute different information.

The Global ReAttach Summit as a Broader Scientific Meeting

The Global ReAttach Summit has a broader scope than ReAttach alone. The supplied conference materials include contributions concerning FND, functional seizures, trauma treatment, psychoeducation, memory-focused intervention, attachment, identity, persistent post-concussion symptoms, occupational rehabilitation, and complementary therapeutic frameworks. The Summit can therefore be described as a forum in which ReAttach-related work is presented alongside other psychological, rehabilitative, psychoeducational, and evidence-based approaches.

Dr. Joachim Lee

Dr. Joachim Lee was trained by ReAttach Academy as a practical-skills trainer and contributes from Neurotherapy Singapore. He is also the developer of Brain-Switch 2.0. His conference abstract proposes a sequential framework integrating W.A.R.A., Brain-Switch 2.0, and ReAttach. W.A.R.A. is positioned as an initial

stabilisation method, Brain-Switch 2.0 as a method intended to update emotionally charged autobiographical memories, and ReAttach as supporting multisensory integration, social cognition, executive functioning, and generalisation into daily life (Lee, 2026). The abstract explicitly presents the approaches as complementary rather than competing. It should be classified as a conceptual conference contribution supported by preliminary clinical observation. It does not report a controlled evaluation of the combined framework. Its importance for the present analysis is organisational and conceptual. It demonstrates that professionals trained in ReAttach may bring their own methods into dialogue with ReAttach rather than being required to present ReAttach as a complete explanation for every clinical problem.

Dr. Mohadeseh Bitá

Dr. Mohadeseh Bitá was trained by Zeestraten-Bartholomeus and later became part of the wider research and training network. She defended her doctoral work on June 30, 2026 and submitted three controlled studies for presentation at the Global ReAttach Summit (P. Zeestraten-Bartholomeus, personal communication, 12th July, 2026). Her doctoral research represents one of the first university-based controlled investigations of ReAttach in Iran, focusing on attachment, identity distress, egocentrism, and love schemas among female university students with insecure attachment styles.

The first study used a quasi-experimental pretest–posttest control-group design with 30 female university students with insecure attachment. Ten ReAttach sessions were associated with lower insecure-attachment scores and reductions in Personal Fable and Imaginary Audience scores (Bitá, 2026a). The second study included 30 female students and examined love schemas. Ten ReAttach sessions were associated with reductions in clingy, avoidant, and unstable love schemas and an increase in secure-love-schema scores. Indifferent and not interested schemas did not change significantly (Bitá, 2026b). The third study involved 30 female university students and reported reductions in insecure attachment and identity distress after ten ReAttach sessions (Bitá, 2026c). These conference presentations represent part of an ongoing publication programme, with several manuscripts currently under preparation or submitted to peer-reviewed journals. These studies represent an important development because they include comparison groups and were conducted in a university context beyond the founder's own clinical practice. At the same time, they currently exist as conference abstracts. Complete methodological information, treatment-fidelity data, follow-up, adverse-event reporting, and full peer-reviewed articles are not yet available. Dr. Bitá is both a researcher and a former trainee and collaborator. The studies can therefore be described as trainee-led and university-based research that marks a meaningful step toward greater research independence within an existing mentorship and professional network.

Dr. Bitá continues to collaborate with Dr. Paula Zeestraten-Bartholomeus and the ReAttach Academy in research, scientific

writing, training, and the international development of ReAttach. This continuing collaboration reflects the Academy's commitment to developing independent university-based research while maintaining close scientific cooperation and shared quality standards.

Sieto Reitsma

Reitsma's conference contribution adds an allied health and neurorehabilitation perspective. His presentation concerns the completed pilot in persistent post-concussion symptoms and describes the clinical architecture connecting regulation, psychoeducation, occupational performance, and graded activity (Reitsma, 2026). The congress contribution does not reproduce the full paper and should not be treated as the final publication. Its role at the Summit is to present the rationale, practical design, and rehabilitation perspective while the full results remain within the peer-review process. Reitsma's inclusion further confirms that the Summit is not limited to psychological theory. It includes occupational therapy, neurological rehabilitation, functional recovery, and participation in daily life.

Scholarly Infrastructure

JRTDD

In 2018, the ReAttach Therapy International Foundation helped establish the *Journal for ReAttach Therapy and Developmental Diversities*. The thesis described JRTDD as an open-access, peer-reviewed scientific journal with an independent editor-in-chief and editorial board. Its purpose was broader than publishing ReAttach studies alone and included psychology, disability, rehabilitation, education, and developmental diversity (Bartholomeus, 2021). According to Zeestraten-Bartholomeus, the Foundation sold and transferred the journal in 2023 because managing it had become too demanding alongside the development of the Academy and its online learning environment (P. Zeestraten-Bartholomeus, personal communication, 12th July, 2026). This history should be represented carefully. Publications from the Foundation-led period belong to the early scholarly history of ReAttach. Later editorial and publishing decisions following the transfer should not automatically be attributed to the founder or Foundation.

ReAttach Affect Coach Journal

The *ReAttach Affect Coach Journal* was established in 2025 as a new peer-reviewed, open-access journal published by the ReAttach Therapy International Foundation. Its scope is broader than ReAttach. The inaugural editorial invited work from clinical and organisational psychology, special education, rehabilitation, disability studies, pedagogy, social work, and social policy (Zeestraten-Bartholomeus, 2025a). The contents of the first publication year reflect this wider scope. In addition to ReAttach protocols, the journal published work concerning:

1. Functional Neurological Disorder;

2. Functional seizures;
3. Persistent post-concussion symptoms;
4. Fibromyalgia;
5. Parkinson's disease;
6. Psychosomatic conditions;
7. Occupational therapy;
8. Social networking;
9. Emotional intelligence;
10. And other psychological and rehabilitative subjects.

Dr. Zeestraten-Bartholomeus founded the journal and initially served as editor-in-chief. Editorial leadership was subsequently transferred to Professor Dr. Aida Mehrad. Mehrad is described as a committed editor who provides opportunities for young and early-career researchers, while Zeestraten-Bartholomeus remains the founder and an editorial-board member (P. Zeestraten-Bartholomeus, personal communication, 12th July, 2026). Reitsma is also involved in the journal's editorial network. His presence represents the inclusion of occupational therapy and neurorehabilitation within the journal's interdisciplinary scope. The journal is a member of Crossref and is working toward further indexing and abstracting. Crossref membership and DOI registration support persistent identification and citation metadata. They should be distinguished from acceptance into individual bibliographic indexing databases, which is a separate process. The most accurate description is therefore that the journal is a young, peer-reviewed, open-access, Crossref-supported journal that is pursuing wider indexing and abstracting.

Scholarly Infrastructure Is Not the Same as Evidence

A journal, conference, database, or research network makes scholarship possible. It does not automatically validate every intervention or mechanism discussed within it. This distinction protects scientific credibility. The journal and Summit are platforms for research, discussion, mentorship, and professional exchange. The evidential value of each study must still be assessed according to its design, sample, measures, analysis, replication, and publication status.

A Wider Collaborative Research Culture

The journal, NeuroLog collaboration, Summit, and current research projects show a gradual distribution of responsibilities around the founder. Dr. Zeestraten-Bartholomeus remains the developer of ReAttach, W.A.R.A., the Forgive and Forget Hood, and New Mind Creation. Dr. Mehrad provides editorial leadership and research mentorship. Painter contributes lived-experience-based digital infrastructure and the Symptom Amplification Model. Dr. Bita contributes to university-based controlled research. Reitsma contributes occupational therapy, neurorehabilitation, practical training for allied health

professionals, and practice-based research into persistent post-concussion symptoms. Other practitioners contribute case studies, condition-specific protocols, and rehabilitation experience. This distributed structure should not be described as if every contributor were a completely independent ReAttach investigator. Some are trainees, former trainees, trainers, editorial colleagues, or research collaborators. At the same time, professional affiliation should not be treated as a reason to disregard their work. In a small and minimally funded practice-based research environment, collaboration is the practical means through which training, data collection, writing, publication, and international exchange become possible. The appropriate safeguards are:

1. Disclosure of roles and professional relationships;
2. Clear authorship;
3. Reporting of non-significant findings;
4. Transparent distinction between protocols and completed studies;
5. Preregistration where possible;
6. Treatment-fidelity assessment;
7. Accessible data-governance procedures;
8. And gradual involvement of researchers who are not professionally dependent on the Academy.

A Coherent Consensus on the Fundamental Concept

Across the literature, transcripts, and current training pathway, eight principles appear sufficiently stable to define the core of ReAttach.

State Before Content

The practitioner first establishes a state in which processing and learning can occur.

Co-Regulation Before Advanced Self-Regulation

The practitioner initially contributes regulation, rhythm, attention, predictability, and safety. Self-regulation is subsequently developed.

Sensory and Affective Integration Before Cognitive Modification

ReAttach begins with embodied and relational conditions rather than with verbal correction of thoughts.

Association Before Explanation: The participant's personal networks are activated without requiring immediate verbal interpretation.

Social-Cognitive Integration Before Complex Behavioural Learning: Representations of self, other people, perspectives,

and relationships are strengthened before later active-learning tasks.

Identification Before Active Learning: Adaptive qualities become psychologically available before the person is asked to practise them.

Fixed Order With Personalised Content: The intervention protects a developmental order while adapting names, qualities, relationships, goals, and pace.

Facilitated Rather Than Imposed Meaning: The participant forms personal connections. The practitioner organises the conditions but does not claim ownership of the participant's meaning.

A ninth developmental direction is visible across the later literature: regulation should ideally support exploration, autonomy, participation, adaptive learning, secure relationships, and growth.

What ReAttach Is Not

ReAttach is not tapping alone. Tapping without relational observation, arousal adjustment, sensory integration, social cognition, and adaptive learning does not represent the complete method. ReAttach is not merely relaxation. Some phases increase alertness, curiosity, surprise, or playful engagement. The objective is an appropriate learning state rather than the lowest possible arousal. ReAttach is not positive thinking. Adaptive concepts are introduced within a multisensory, relational, and associative process. ReAttach is not literal memory deletion. The Forgive and Forget Hood may reduce the prominence or emotional dominance of material but should not be described as erasing factual memory. ReAttach is not a collection of parallel techniques that can be selected without regard to order. W.A.R.A., the Forgive and Forget Hood, Sensory Override, M.I.S.T., and New Mind Creation have different functions and require different competencies. ReAttach is not necessarily a stand-alone treatment for every complex psychiatric, neurological, or rehabilitation presentation. Complex cases may require medical, neurological, psychiatric, rehabilitative, occupational, or other psychological care in combination with ReAttach. The Reitsma study illustrates this point. ReAttach was embedded within psychoeducation and occupation-focused rehabilitation rather than presented as a replacement for broader post-concussion care.

Discussion

Continuity Across Development

The fundamental structure of ReAttach has remained relatively stable since 2010. The early model emphasised preparation of the learning state, sensory processing, relationship, social cognition, play, and adaptive development. Later publications added new language, techniques, and applications but did not replace this sequence. The development can be described in five phases. The first phase was the clinical-developmental formation

of ReAttach as a method for restoring conditions for processing and play. The second phase linked the intervention with schema therapy, autism, developmental difficulties, and multimodal work. The third phase positioned ReAttach as a transdiagnostic and network-oriented intervention. The fourth phase expanded the method through condition-specific protocols, self-regulation tools, systemic work, and New Mind Creation. The fifth phase concerns international training, remote delivery, M.I.S.T., patient-generated data, allied health implementation, journal development, and wider interdisciplinary collaboration.

The Training Sequence as a Form of Treatment Integrity

The 2026 training structure is not an administrative arrangement added to the method. It reflects the method's clinical logic. Professionals first learn accessible techniques that can support self-control. They then learn the complete embodied and relational intervention. Only after demonstrating core competence do they learn advanced formulation and complex developmental work. This sequencing reduces the risk that practitioners learn memorable techniques without understanding the conditions under which they should or should not be used. The development of additional trainers, including Reitsma for paramedical professionals, is part of the transfer of founder knowledge. It also creates a need for explicit shared standards. A trainer should not merely demonstrate how to tap or repeat a verbal protocol. Trainers must be able to teach clinical observation, readiness, pacing, adaptation, boundaries, and the difference between regulation and active learning.

The Contribution of Allied Health Research

Reitsma's work adds an important dimension to the developing evidence base. Earlier ReAttach studies concentrated largely on psychological stress, schemas, autism-related functioning, negative affect, and resilience. Occupational therapy introduces questions of activity and participation:

1. Can the person organise daily tasks?
2. Can they tolerate cognitive and sensory demands?
3. Can they return to meaningful roles?
4. Can they balance activity and recovery?
5. Does improved regulation translate into functional participation?

These outcomes are important because a person may report less distress without yet returning to work, parenting, study, mobility, or social activity. The persistent post-concussion pilot therefore broadens the research agenda from symptom reduction toward functional recovery. At the same time, the multimodal nature of the intervention must be respected. If improvement is observed after ReAttach, psychoeducation, pacing, and activity coaching, the study cannot determine which component produced the change. This is not a weakness unique to ReAttach. It is a common challenge in real-world rehabilitation. It means that later studies may need comparison

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groups, component analysis, or carefully specified mediation questions.

Internal Consensus and External Evidence

The supplied sources support a coherent internal conceptual consensus. Founder publications, external interpretations, training transcripts, and the educational pathway all converge on the importance of regulation and sensory-affective integration before higher cognitive learning. The empirical consensus is less developed. The thesis contains promising practice-based findings. The W.A.R.A. crossover study provides a controlled comparison for an immediate outcome. Dr. Bitá's emerging studies add university-based comparison groups. NeuroLog offers large-scale real-world data. Reitsma adds a completed prospective rehabilitation case series with follow-up measurement. However, much of the evidence remains uncontrolled, founder-affiliated, observational, small-scale, preliminary, or available only in abstract form. Independent replication, longer follow-up, comparison with established interventions, fidelity assessment, and component analysis remain necessary. The current corpus can therefore define what ReAttach is intended to be more confidently than it can determine how effective it is relative to other treatments.

A Small Academy and Collaborative Development

The close relationships among developer, trainees, researchers, editors, trainers, and collaborators should be described openly and respectfully. ReAttach was not developed with the infrastructure of a large research institution. It emerged from private practice and a small Academy. Collaboration has been the practical means through which training, data collection, publication, and international research became possible. Affiliation should not be treated as a reason to dismiss the work. Neither should it be ignored. Scientific quality is strengthened when:

1. Roles are disclosed;
2. Non-significant findings are retained;
3. Outcome measures are appropriate;
4. Peer-review status is reported accurately;
5. Data analysis is transparent;
6. And progressively more independent teams become involved.

The decision not to reproduce the unpublished findings of the Reitsma study before completion of peer review is consistent with this principle.

The Risk of Conceptual Drift

Expansion creates several risks. The first risk is reduction of ReAttach to its most visible feature, namely tapping. The

second risk is the opposite: describing every new assessment tool, autonomic model, digital database, clinical protocol, rehabilitation application, or complementary technique as if it were part of the original core intervention. The third risk is mechanistic overstatement. Terms such as mirror-neuron activation, amygdala recalibration, interbrain synchrony, memory reconsolidation, predictive coding, polyvagal regulation, or autonomic setpoints may be useful theoretical hypotheses. They should not be taught as confirmed mechanisms unless a study directly measured the proposed process. The fourth risk is terminological inconsistency. Terms such as therapy, intervention, protocol, module, technique, affect coaching, rehabilitation model, and training method sometimes overlap in the literature. Future manuals should clearly distinguish:

1. The core ReAttach protocol;
2. Focused ReAttach-derived techniques;
3. Advanced developmental modules;
4. Assessment and formulation frameworks;
5. Condition-specific clinical applications;
6. Rehabilitation combinations;
7. And external or complementary explanatory models.

The Value of a Broader Conference and Journal

The broader scope of the Global ReAttach Summit and the *ReAttach Affect Coach Journal* is an important strength. Dr. Lee brings a complementary intervention model. Painter contributes lived experience and digital infrastructure. Dr. Bitá contributes university-based research. Reitsma contributes occupational therapy, functional outcomes, and neurorehabilitation. Dr. Mehrad provides editorial leadership and mentorship. This wider environment reduces the risk that ReAttach becomes isolated from other clinical and scientific perspectives. ReAttach can be developed most responsibly when it is defined precisely and then placed in dialogue with other interventions rather than presented as a complete explanation for all psychological, neurological, or rehabilitation problems.

Implications for Implementation and Training

Establish a Core Standard

A formal ReAttach core standard should contain:

1. One canonical definition;
2. One process model;
3. One list of mandatory elements;
4. Clear readiness criteria;
5. And explicit stopping or postponement rules.

The standard should specify what must occur before social-cognitive training and active learning begin.

Maintain a Version History

Later additions should be dated and classified. New Mind Creation, M.I.S.T., the Forgive and Forget Hood, the Sensory Override Technique, ConFusion, and condition-specific protocols should not be retrospectively presented as if they had always been identical parts of the original intervention. Similarly, the distinction between C.A.T. and M.I.S.T. should be documented historically.

Separate Core Competencies From Specialisations

Training should first establish competence in the complete ReAttach basic architecture (ReAttach Practitioner Diploma). Only after the ReAttach practitioner can perform and adapt the core protocol should they progress to M.I.S.T., advanced systemic formulation, and New Mind Creation (ReAttach Affect Coach Diploma). Condition-specific applications, including FND and persistent post-concussion rehabilitation, should be taught as adaptations requiring relevant professional competence rather than as universal scripts.

Teach Decision Rules, Not Only Scripts

The transcripts show that practitioner judgement is central. Competence includes knowing:

1. When to wait;
2. When to proceed;
3. When arousal is unsuitable;
4. When touch is not tolerated;
5. When the person is not socially available;
6. When an identification is inappropriate;

And when active learning or New Mind Creation should be postponed.

Practical examinations should therefore assess observation and decision-making, not only verbal reproduction of a protocol.

Calibrate Practical Trainers

As more trainers contribute to education, trainer calibration becomes increasingly important. A Basic Skills Trainer should teach the same fundamental readiness criteria, sequencing rules, safety boundaries, and distinction between facilitation and imposed meaning. Discipline-specific trainers can enrich implementation without changing the core. For example, Reitsma can translate ReAttach into occupational therapy language concerning participation, activity balance, pacing, sensory demands, and functional goals. This should occur within an agreed core standard. ReAttach Academy provides these standards by embedding the Practical Skills Training in the ReAttach Practitioner Program and ReAttach Affect Coach Program. Practical Skills Trainers do not work alone but are included in the ReAttach Academy International team.

Label Claims by Evidence Level

Training and publications should identify whether a statement is:

1. A defining principle of ReAttach;
2. A founder-derived clinical observation;
3. A participant report;
4. A theoretical mechanism;
5. A treatment protocol;
6. an uncontrolled pilot finding;
7. A controlled research finding;
8. A completed study under peer review;
9. Or a hypothesis awaiting investigation.

This will help practitioners communicate accurately with patients, colleagues, referrers, and researchers.

Formalise Founder Knowledge Transfer

The founder's demonstrations contain important procedural knowledge. A structured knowledge-transfer programme could include:

1. Annotated exemplar sessions;
2. Commentary on clinical decision points;
3. Trainer calibration;
4. Treatment-fidelity instruments;
5. Examiner training;
6. And independent observation of practical assessments.

The purpose should not be to reproduce the founder's personality. It should be to identify the essential competencies expressed in her work: observation, timing, pacing, affective responsiveness, protection of participant autonomy, and movement between regulation and learning.

Develop an Independent Research Program

Future research should examine both outcome and mechanism. Priorities include:

1. Independent randomised trials;
2. Longer follow-up;
3. Fidelity measurement;
4. Adverse-event monitoring;
5. Comparison with established interventions;
6. Mediation analysis;
7. And dismantling studies.

The complete ReAttach protocol, W.A.R.A., the Forgive and

Forget Hood, New Mind Creation, and Sensory Override should each have clear operational definitions and should not share one undifferentiated evidence base. For remote work and FND, research should examine feasibility, safety, engagement, self-control, symptom trajectories, and the difference between remote self-regulation and face-to-face co-regulation. For persistent post-concussion symptoms, later research should examine whether changes in regulation are associated with changes in activity tolerance, occupational performance, and participation. The completed Reitsma pilot provides an appropriate starting point, but larger controlled studies will be needed before conclusions can be generalised.

Conclusion

The purpose of this analysis was to create a coherent account of the development and fundamental concept of ReAttach so that future implementation, training, research, and succession can remain faithful to the method while allowing responsible innovation. ReAttach can be defined as a state-dependent, relational, multisensory, associative, and developmentally ordered learning intervention. It begins by creating the conditions in which processing is possible. The practitioner regulates arousal, sensory input, affect, attention, and relational contact. Social cognition, perspective-taking, and adaptive identifications are then introduced. Active learning and Cognitive Bias Modification follow only after these foundations have been established. The individual components occupy different positions within this architecture. W.A.R.A. is a focused negative-affect regulation technique. The Forgive and Forget Hood helps reposition persistent mental and sensory material. Part 1 of the ReAttach protocol provides the social-cognitive and identificational foundation. Part 2 introduces active learning and Cognitive Bias Modification. New Mind Creation extends the intervention toward secure exploration, optimism, adaptive schemas, and continuing developmental possibility. The Sensory Override Technique is an emerging acute-regulation method that requires further operationalisation and research. M.I.S.T. is the current formulation framework for tailoring ReAttach across ten transdiagnostic factors and for examining systemic co-regulation. The current international training pathway reflects the same order. Professionals first learn accessible remote self-regulation through the ReAttach Affect Coach Online Program. They then learn and demonstrate the complete face-to-face core protocol during practical training. After obtaining Practitioner competence, they learn M.I.S.T. and progress toward advanced New Mind Creation work and the full ReAttach Affect Coach diploma. The development of trained practical instructors, including Sieto Reitsma for paramedical and allied health professionals, is an important part of transferring founder knowledge beyond one person. The research and scholarly environment around ReAttach is also becoming broader. JRTDD formed an early open-access publishing phase. The *ReAttach Affect Coach Journal* now provides a wider interdisciplinary platform under the editorial

leadership of Professor Dr. Aida Mehrad. NeuroLog brings patient-originated FND data into research. The Global ReAttach Summit includes ReAttach specialists, FND researchers, people with lived experience, allied health professionals, and clinicians working with other treatment models. Dr. Bitá's studies add university-based controlled research. Reitsma's completed persistent post-concussion pilot adds occupational therapy, follow-up measurement, and functional participation to the developing research programme. Because the manuscript remains under peer review, the present synthesis recognises the study without reporting its unpublished findings. These developments should not obscure the core.

The clearest consensus is expressed in the order of ReAttach:

self-control before complexity; state before content; co-regulation before advanced self-regulation; sensory and affective integration before cognitive modification; identification before active learning; and secure developmental conditions before New Mind Creation.

This order is the most important element to preserve. The current literature provides promising findings, but the empirical evidence remains uneven and requires further independent research. A coherent internal consensus about what ReAttach is has become possible. A wider scientific consensus about effectiveness, mechanisms, indications, contraindications, and comparative value remains a task for the next phase of research. Defining this distinction strengthens ReAttach. It protects treatment integrity, supports honest professional training, honours the work of the developer and her collaborators, and provides a stable foundation from which future practitioners and researchers can continue to improve accessible and affordable care.

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