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ARTICLES

From Armouring to Awareness: A Somatic Case Study of Emotional Neglect and Meeting the "Black Hole" Within

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This article presents a synthesised clinical and theoretical exploration of using touch-based somatic psychotherapy to address the embodied imprints of developmental trauma in adult clients. Specifically, it investigates the subtle, pervasive impact of early emotional neglect characterised by rejection, relinquishment, and abandonment. While overt abuse often commands clinical focus, this paper investigates the unique psychobiological survival strategies and symptoms arising from relational absence. It draws on three sessions with an adult female client, Monica (a pseudonym). Three critical axes of therapeutic focus emerged: the deepening awareness developed around long-standing, body-based protective patterns as she was introduced to the concept of yielding; the progressive integration between her interoceptive experience and psychological insight; and the encounter with a unique psychobiological phenomenon she referred to as a "black hole". With her written consent, I draw on Monica's lived experience, the therapeutic processes we engaged in and her responses to treatment—with deep appreciation for her courage and willingness to explore something new. The underlying framework of this synthesis is explicitly reparative in nature and primarily leverages around NeuroAffective Touch®. Ultimately, this paper argues that intentional, attuned physical touch is an essential catalyst for navigating the void of early developmental omission and in supporting the integration of fragmented, preverbal trauma narratives.

> When a child's emotions are not acknowledged or validated by her parents, she can grow up to be unable to do so for herself. As an adult, she may have little tolerance for intense feelings or for any feelings at all. She might bury them, and tend to blame herself for being angry, sad, nervous, frustrated, or even happy. The natural human experience of simply having feelings becomes a source of secret shame. "What is wrong with me?" is a question she may often ask herself. (Webb, 2012, p. 79)

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Emotional neglect describes "the absence of sufficient attention, responsiveness and protection appropriate to the age and needs of a child" (National Scientific Council on the Developing Child, 2012, as cited by Murray et al., 2022). It is as curious as it is concerning that, until recently, a clear distinction had not been made between trauma rooted in abuse and that arising from emotional neglect. While there are certainly overlaps in the adult presentation of these two grim experiences, there are also critical differences that require a nuanced therapeutic response. The failure to adequately distinguish between them has serious implications, with a staggering number of clients who describe a "reasonable kind of childhood"–where "nothing really bad happened"–possibly overlooked in their need for a highly attuned, trauma-informed treatment plan to address not what was done to them, but that which was missing (Stauffer, 2021, p. xi).

Further, there is strong evidence that the impact of early emotional neglect is as detrimental, if not more so, than that of overt abuse in terms of its ramifications on mental and physical health, social functioning, and attachment orientation later in life. Because "lower-level brain regions are starved for the type of sensory input inherent in positively valanced and safe physical and social interaction", its absence engenders a perpetual fear that our innate mammalian survival needs will not be met (Stauffer, 2021, p. xv). Because humans are intrinsically wired for and developmentally dependent on social engagement, attunement, and reciprocal interaction, the absence of acknowledgement or relational responsiveness significantly disrupts the formation of a coherent, integrated sense of self.

Sadly, in such a context, individuals may come to experience critical, punitive, or even abusive interactions as being less threatening than relational absence. The former at least confirms one's presence in the world whereas neglect, in contrast, communicates a form of non-recognition which, to the recipient, typically translates as an ongoing experience of having a diminished sense of existence, belonging, and mattering in the world. Compounding this further, Gabor Maté (2010) notes that neglect trauma often goes undetected until decades later, and that the greatest damage done in this scenario is not the immediate pain inflicted but the long-term distortions induced in the way a developing child will continue to interpret the world and her place in it (p. 350).

Kathryn Stauffer, author of *Emotional Neglect and the Adult in Therapy* (2021), calls survivors of childhood neglect "ignored children" in that their needs went unnoticed, and they were not made to feel welcome, loved, or safe by their caregivers (p. 7). She explains how survivors of neglect can prove challenging to work with therapeutically because their experience is founded on absence, and concerns that which did not happen as opposed to that which did. Further, as their experience of emotional neglect is rooted in preverbal stages of neurodevelopment, any associated memories are implicit, meaning they lack conscious awareness and verbal narrative to describe their embodied experience.

Typically, clients with a history of emotional neglect present with a vague description of an area of struggle in life, a high degree of well-managed anxiety, and a reduced capacity for affect regulation. They are often reserved, very polite, and motivated to do the work but require strong but carefully communicated direction from the therapist as to what the work might be (Stauffer, 2021). Required here is an exquisitely attuned response that never pathologises and holds a strong resource orientation as the client's survival techniques are acknowledged, celebrated, and, over time, broadened. Because history has shown others to be unreliable, unhelpful, and unavailable for adequate love and caring, the work of a therapist can feel threatening and intrusive and the risk of further misattunement untenable. For these reasons, working with this developmental deficit can prove to be slow work that demands long-term patience and, ultimately, "beautiful healers who can attend to matters of the heart" (LaPierre, 2021).

A Word About The Reparative Therapeutic Relationship

In attending to developmental trauma, I consciously work within a reparative therapeutic framework, one in which intentional provision is made "by the psychotherapist for a corrective, reparative or replenishing relationship action where the original parenting [was] deficient" (Clarkson, 2003, p. 113). While both the concept of a reparative therapeutic relationship and the use of touch in psychotherapy have historically generated strong debate–particularly regarding boundary violation, power dynamics, potential exploitation, and the risk of fostering client dependence–such critiques fall outside the scope of this study. Readers seeking a comprehensive analysis of these clinical and ethical complexities are referred to Hunter and Struve's (1997) seminal text, *The Ethical Use of Touch in Psychotherapy*, which provides an invaluable framework for safely navigating boundaries within touch-based interventions.

From both somatic and developmental perspectives, I regard reparative touch not as an optional adjunct, but as an essential intervention in restoring safety and self-connection following trauma. Like all mammals, human neurodevelopment and survival are shaped by attuned caregiving, somatic resonance, and ongoing reciprocal relational engagement (Kearney & Lanius, 2022). It is this understanding that underpins my decision to provide reparative touch for those wanting it in their therapeutic work (Pope & Vasquez, 2016; Zur, 2007).

Introducing Monica

Monica (a pseudonym)[1] is a 55-year-old Dutch immigrant who was referred to me by a colleague. Over the past decade she has engaged in talk therapy to process the profound impact of Postural Orthostatic Tachycardia Syndrome (POTS) on her life and her mental health. POTS, a form of dysautonomia and often autoimmune in nature, disrupts autonomic nervous system regulation, producing constellations of debilitating symptoms such as chest pain, dizziness, gastrointestinal distress, numbness, nausea, heart palpitations, visual disturbances, and orthostatic intolerance (Australian POTS Foundation, 2024; Standing Up to POTS, 2025). For Monica, the condition initially manifested through tachycardia-induced fainting upon standing. This prompted swift medical investigation that ultimately led to a recognition of her unresolved childhood trauma.

Despite the ongoing and invaluable support of her talk therapist, after reading Peter Levine's seminal text, *Waking the Tiger* (1997), Monica came to understand that trauma is as much a physiological response as it is a psychological one. This insight led her to seek a bottom-up approach–one that prioritised regulation of her body's physiological responses over the exclusive engagement of cognitive reasoning (van der Kolk, 2014). She also began to recognise how her "extreme workaholism" had functioned as a survival strategy–keeping her feelings buried and her body disconnected. Intuitively, she sensed and verbalised to me that touch was needed for her to move beyond her survival strategies, come out of her head into her body and start to truly feel. This was her expressed therapeutic goal. Despite her clarity and unwavering resolve to try something new, she was understandably nervous about engaging with this unfamiliar faculty of embodied intelligence and most uncertain about what the process might reveal. Before describing this, however, it is important to offer some background on her early years to illuminate the extent of her developmental emotional neglect and to contextualise the themes that emerged in our work together.

Monica's Story: The Early Years

Monica's mother fell pregnant in the late 1960s to a married man 15 years her senior, who, upon news of the pregnancy, insisted she have an abortion. Despite this and pressure from the strict Catholic nuns at the unwed mothers' institution to give Monica up for adoption, her mother chose to keep her. However, Monica was soon placed in the care of an unwilling maternal grandmother. At age four, during her grandmother's temporary hospitalisation, Monica was sent to live with her mother in the city and attended daycare which stands as one of her earliest memories of

1 The author obtained written, informed consent from the client discussed in this case study. The client was made fully aware of the nature and purpose of this academic work and agreed to the inclusion of anonymised details of their case for educational and publication purposes. All identifying information has been removed or altered to ensure confidentiality.

feeling "dumb, fearful, and the odd one out". Monica describes this young self as "intensely shy and dissociated, desperate to be invisible and perfect" for fear of being abandoned or returned to her mother. Tragically, at age eight, she was permanently moved to live with her mother and stepfather, a move marked by profound loss–of her grandmother, beloved dog, friends, and small village school–all primary attachments and sources of stability.

Despite being told how privileged she was to live with her parents in the city and that she should be happy, the move resulted in feelings of deep confusion, fear, and loneliness as little Monica was left unattended for entire days while her parents worked. Her words to describe this season are "locked up" and survival for the next several years required her to "keep [her] head down and look after [her]self". Understandably, this took its toll and by age 16, with her grades dropping, difficulty sleeping, issues with concentration, and an undeniable depression, the school suggested she see a therapist. Despite family therapy being recommended her parents were "too busy" and she was told instead to "go for a walk to lift [her] mood". Sadly, this season concluded with her admission to a mental health facility for a week at age 17.

Adult Years and POTS

The next phase of Monica's life involved moving away, graduating from university, starting a career, and marrying. She admits to crafting a life of "full-time distraction from feeling" through her demanding role as a financial controller, working 60-hour weeks. Her success in reorganising financial departments earned her compliments, rewards, and bonuses that bolstered her self-esteem and sense of belonging. Despite sleepless nights and chronic headaches, she maintained this intense work schedule for two decades until, at age 45, her life dramatically changed when she literally "came down" with POTS after fainting at work. This event changed everything. Such was the enormity of her POTS diagnosis and its life-altering implications that Monica once again required institutional support for her mental health. Ultimately, her debilitating symptoms and psychological decline marked the end of her career entirely–the very strategy she had relied on to keep her feelings buried. For the first time, at 45 years old, she was faced with "feeling it all".

Session One: The Initial Meeting

Prior to our first meeting, Monica sent me a bullet-point summary of her life from birth to the present day. Her story was poignant; both heartbreaking and a testament to human resilience. This format proved ideal as she had clearly expressed her preference not to engage further in talk therapy. Nevertheless, she agreed to attend an initial consultation to clarify her therapeutic goals, raise any concerns, ask questions, and identify potential resources–defined here as physical, emotional, social, or spiritual supports that have contributed to her resilience. This enquiry opened a rich exploration of not only her current resources but also those she had access to as a child and teenager. Each was gathered as a metaphorical "breadcrumb",

offering a path back to her innate capacity for health, vitality, and authentic expression. Resourcing remains central to our work together, as post-traumatic growth is most effectively supported by foregrounding the client's inherent strengths, capacities, and resilience (Heller & LaPierre, 2012; Tedeschi & Calhoun, 1996).

Equally important, the initial session offers an opportunity for quiet, phenomenological observation of the client's nervous system prior to the introduction of touch. This includes attunement to subtle indicators of autonomic regulation such as bracing patterns, vocal prosody, the depth and rhythm of the breath, and the client's relational capacity for eye contact. In recognising the interpersonal field as a source of valuable information, I also attend to any somatic resonances that arise within myself in response to the client's presence (Jensen, 2012).

Session Two: The Nurture Surround

NeuroAffective Touch® is "a polyvagal-informed, psychobiological approach that integrates the key elements of somatic psychotherapy, attachment and developmental theory, psychodynamic psychotherapy and affective and interpersonal neurobiology" (Totally Alive, 2020). As is customary in working psychotherapeutically on a massage table, Monica positioned herself in a supine presentation unsure of what to expect. In truth, neither did I but my focus in this session was to create a tangible sense of safety through optimising her comfort level. In NeuroAffective Touch® the creation of this "cocoon of comfort" is called a *nurture surround*, a highly collaborative, empowering process involving choice points for the client around optimal positioning, the receiving–or not–of soft and squishy, warmed velvet pillows on to their body, additional weight, pillow support or body covering, temperature consideration, and potentially the introduction of touch. In this way, "the therapy" has already begun with the five core principles of trauma-informed care–safety, trustworthiness, choice, collaboration, and empowerment–leading the way (Blue Knot Foundation, 2025).

Indeed, the very creation of this womb-like experience serves multiple therapeutic functions:

1. **Enhancing interoceptive awareness** by inviting the client to attune to their embodied preferences, cues, and impulses. For Monica this directly addressed her therapeutic goal of "coming more into [her] body".

2. **Fostering trust** and thereby **strengthening the therapeutic alliance**.

3. **Inviting the client to receptivity**–a potentially unfamiliar or dysregulating experience for those with histories of emotional neglect.

4. **Introducing the concept of yielding**–a foundational element that warrants further discussion.

Yielding

Bonnie Bainbridge Cohen, the founder of Body-Mind Centering®, describes yielding as "an active state of fully surrendering your weight into gravity" (Schwartz, 2026). Far from being passive, yielding is a relational exchange involving trust and is characterised by a relaxed alertness allowing for a full, conscious receptivity to available support. It represents the first of five basic neurological actions that reflect the intuitive developmental stages of the first two years of life: *yield, push, reach, grasp,* and *pull.* These fundamental movements are essential in establishing the relational matrix within the nervous system, providing a template for future attachment, self-organisation, regulation, and agency. Each action holds a psychological and emotional correlate, forming part of what has been named the *Satisfaction Cycle* (LaPierre, 2015, p. 90; Schwartz, 2026).

Indeed, yielding to a caregiver's sensed attunement provides the very foundation for experiences of safety in the world and capacity for connection. Sadly, in clients presenting with pre- and perinatal trauma, such as Monica, we invariably see bracing in place of yielding and herein lies a powerful entry point for working with early development trauma (White & Van der Wal, 2025). Through touch, the therapist offers this vital reparative experience by providing the attuned somatic support necessary to convey the sense of safety that has been missing. Furthermore, according to LaPierre (2024), by so doing, we directly address the three essential self-states that are foundational for secure attachment: I exist, I am protected and safe, and my needs matter (pp. 96 &114).

Introducing Touch

With Monica's system gradually introduced to relational safety through the creation of the nurture surround and with her permission given, I introduced touch by resting my hands on her feet–a gentle, non-invasive point of contact that allowed her nervous system to attune, recalibrate, and organise in the presence of another. After several moments, given her repeated mention of persistent neck and shoulder tension requiring ongoing physiotherapy, I then proceeded to inquire whether *this* area might be open to receiving touch to explore what the discomfort might be holding or attempting to express.

With her consent and growing curiosity, I moved to the head of the table to engage the cranial base–the place where body and mind intersect. Cradling her head, I could palpably sense the tension she described, particularly in the sternocleidomastoid, brachial plexus, and scalene muscles. Her bracing pattern was so pronounced that her head remained nearly immobile, her neck rigid and tightly held.

NeuroAffective Touch® highlights two fundamental movements as primal expressions of autonomy: the gestures of "yes" and "no". A "yes" involves a tilting manoeuvre–flexion and extension–of the atlas (C1) on the occipital bone at the base of the cranium. A "no" is accessed through the rotational movement of the axis (C2). Engaging these subtle micro-movements at the cranial base promotes a softening and release of deep bracing patterns, initiating a ripple effect down the entire spine, into the sacrum. As this central axis of the body–including the sympathetic chain embedded within it–begins to unwind, the system is gently invited towards physiological homeostasis. In turn, the back body and spine can yield more deeply into supported contact, facilitating a shift away from chronic hypervigilance and its associated somatic imprints (LaPierre, 2024).

Cradling Monica's head from beneath, I gently introduced micro-movements along her cervical spine. Initially, any attempt to engage these motions was met with sudden, unmistakable muscular gripping–a deeply ingrained bracing response. When I reflected this observation to Monica, she was unable to perceive it herself, a testament to how familiar and habituated the bracing had become. We slowed the process significantly, spending time oscillating between resting into the support of the cranial cradle before moving into gentle, incremental explorations of the "yes"/"no" movements. With time, Monica was able to discern a subtle shift in recognising the difference between bracing and yielding. As she began to somatically register and experiment with this new feeling of "letting go", I offered some minimal psychoeducation and languaging around the concepts in focus to better support integration between her cognitive understanding (mind) and her emerging somatic awareness (body). It is through such embodied mind/body dialogue that body-based psychotherapies reveal their unique capacity to foster deeper, more enduring healing beyond the reach of traditional talk therapies.

Meeting Monica's "Soldiers"

With the invitation to weigh in, Monica's mind described the feeling of her brace as being "a big protection" and landed on a metaphor of her neck having "soldiers standing guard". "That's their job," she explained, "and one they take very seriously!" Rather than challenging her insight, I responded with strong affirmation and explicit acknowledgement of how necessary and vital these "soldiers" had been–not only in helping her survive, but in allowing her to function as well as she had in life. I suggested they were heroes: resilient, fiercely loyal, and unwavering in their commitment to "keeping her safe" and "keeping her going". Monica agreed and, with her metaphor voiced and validated, and with her mind able to make meaning of old somatic patterning, she sighed deeply, yielding further into the support beneath her.

It is not uncommon for individuals to encounter vivid and meaningful imagery as they begin to connect with the sensations of their embodied narrative. In Monica's case, her spontaneous use of imagery–alongside her

growing sensory awareness and emerging meaning-making–reflects three of Peter Levine's (2010) five "SIBAM channels" in his Somatic Experiencing model: Sensation, Imagery, Behaviour, Affect, and Meaning. Each channel offers a potential portal through which individuals can process and integrate their lived experience, shaping perception and contributing to a more coherent sense of self in the world.

Interestingly, in response to my invitation at the end of the session to journal or create images of her "soldiers" for homework, Monica emailed me details of further insight gained. There were eight soldiers in total, organised in pairs for reasons of "safety and collaboration–each with distinct roles and responsibilities". Four of them she identified as "The Strong Ones"–"grim, powerful, always armoured and agenda-driven". Their role was to keep her constantly busy: "always doing, never thinking, and certainly not distracted by emotions or bodily sensations", to which they "close the boom gates". Two others she named "The Controllers"–"ever vigilant and stationed around the clock to observe, strategise, and sniff out danger". They worked to control the outcomes in life. Like The Strong Ones, "they trust[ed] no one and avoid[ed] emotional or sensory experience". The final pair she described as smaller, friendlier, and "fake". Their task was to "please everyone and maintain the pretence that all is well" but "beneath this performance they carr[ied] a deep sense of sadness that long[ed] to feel seen and heard".

It was heartening to witness the emerging integration between Monica's embodied experience and the metaphorical framework through which she had navigated the world. Her writing reflected clarity, courage, and self-compassion as she gave language to a previously unspoken orientation towards life.

Session Three

In session three, following a similar but shorter set-up, I noted slightly more receptivity in the musculature of Monica's neck as we revisited movements and themes previously introduced. As she shared further insight around the role of her soldiers, a new image emerged of herself as a two-month-old infant and, with it, a wave of panic followed by profound sadness. Tears fell as she named the feeling as "familiar but previously unacknowledged". With the arrival of such emotion, my sense was to shift focus to her "heartspace" and, with her consent, I repositioned myself by her left side, cocooning her heart by sliding one upturned hand gently beneath her thoracic cage, resting underneath the latissimus dorsi. At the same time, the other held a warmed pillow on her chest. In this way, her heart was supported from below, protected from the front, and her sadness met with an emotional attunement that communicated "You are not alone. You are seen, you are heard, you are safe, and your needs matter". I wanted to dignify her untold sadness and invite it to tell us more of its story if it so wished. While she felt "more contained", this posture proved additionally significant

in highlighting how difficult it was to receive "so much support". This she voiced by describing the feeling of a "block or resistance" emerging within that felt "scary" to be with.

The Black Hole

In Monica's naming of "the block", an intensely unpleasant sensation emerged in her upper body that she described as a "black hole"–another rich visceral metaphor capturing the magnitude of her inner experience. "It's very scary" she whispered as her body presented signs of heightened sympathetic arousal: her breath tightened, her spine braced, and restless, disorganised movements presented through her arms and hands which she described as "very anxious and fidgety". This rapid physiological shift into flight required careful pendulation in supporting her to remain within her therapeutic "window of tolerance" (Siegel, 2010). I invited her to scan her body for somewhere that felt more comfortable, warm, settled, or simply "less scary" that she might orient towards. She named her legs which felt "safe and good" and this reminded her of being at the beach, a favourite place of restoration for her. With resources sufficiently strengthened we were able to spend several moments gently pendulating between the sense of safety experienced in her legs to meeting the edge of this mysterious yet crucial psychobiological "black hole".

Such encounters can often arise in trauma recovery, particularly for those with early relational deficits. For survivors of early emotional neglect, it is not uncommon to hear of encounters with a "void", "abyss", or "black hole". These abstractions describe a psychic space of profound existential distress where one's sense of existence feels dislocated, unacknowledged, or under threat. It could, perhaps, be understood as a manifestation of what Bollas (1987) labelled "unthought known"–psychic material that remains unformulated yet deeply felt. Indeed, the experience is typically accompanied by sensations of falling, dangling, or feeling hollowed out, with each communicating a loss of grounding, connection, safety, or containment.

As someone with lived experience of early emotional neglect and encounters with my own "void", I can attest that it is every bit as terrifying as clients describe. The eerie visceral sense of impending doom or imminent annihilation defies language and feels as incomprehensible as it does disturbing. The experience can feel like one is losing a grip on reality or worse still, one's own mind. But perhaps, in a different light, the "black hole" could be understood as an expression of the psyche's adaptive intelligence–an implicit survival strategy that, when approached with attuned presence and relational safety, can serve as a profound portal to integration and healing–or in other words, post-traumatic growth.

It is well established that maladaptive "later-life" corticolimbic organisational patterns –that is, the connection and communication patterns between the executive functioning of the prefrontal cortex and the emotional limbic system–are rooted in the absence of attuned relational mirroring during early developmental periods (Schore, 2001). While these findings are

grounded in attachment theory and neurobiology, Waldon (2013) offers a more nuanced exploration of the specific phenomenology of the "void" and does so from an object relations paradigm. She explains that the necessary internalised imprint of the object–the caregiver–is missing in the psyche–or relational object space–and is replaced with a "black hole" in their stead. Sadly, the infant is drawn to this and trapped by it because of their intrinsic, instinctive need for a "real object"–an internalised caregiver. Waldon (2013) comments:

> It is only in the presence of a real object that one can generate the essential gravity necessary to draw the core of the self that is still in an undeveloped state from deep within the abyss. It is the moving towards a real object, a [caregiver], that relativizes the absolute power of the black hole and begins a reformation of its essence within the psyche. (p. 99)

There are two key points to highlight from this. Firstly, herein lies hope. Working within the framework of the reparative therapeutic relationship described earlier, the therapist can intentionally step into this role and offer themself as the previously absent "real object" sought by the client since infancy. This therapeutic positioning aligns with Miller's (1981) concept of being the "enlightened witness" whereby the therapist's attuned attendance to the inner child's original pain serves to break the cycle of silence and isolation. By providing this real-time relational counterpoint, the therapist creates or becomes the very "gravity" that Waldon (2013) describes, thus allowing the psyche and any suboptimal corticolimbic organisation to begin its reformation. In this unique context, the use of therapeutic touch is not only appropriate, but arguably essential given its potency in supporting the integration of fragmented preverbal trauma narratives and corresponding neurological responses.

Secondly, to protect against the perceived threat posed by this experiential "void", individuals invariably develop sophisticated psychobiological adaptations–protective patterns embedded in somatic memory–that serve to shield the self from direct contact with "black hole" encounters of the "missing other". Stated differently, the emergence of the "void" may become inevitable when long-held bracing begins to soften, creating space for new experience.

In Monica's case, I wonder if her sudden encounter with the "abyss" can be understood as a response to two concurrent shifts towards new possibility: (a) an invitation to somatic yielding and (b) a lowering of the internal guard–her eight "soldiers". I would argue that it can be and accordingly, underscore the importance of proceeding with great care when meeting this new, "scary" psychobiological terrain.

There is a profound, almost sacred intimacy to this kind of work. To navigate it, the therapist must extend and hold an unshakeable resonant field of safety and ongoing attunement, anchoring the space as the client, quite

literally, touches into their deepest layers of vulnerability. Accordingly, three core trauma-informed principles are held in steady focus to help prevent overwhelm or re-traumatisation:

1. **Titrated engagement** with the emerging phenomenology, ensuring that the process unfolds as incrementally as the client's system dictates.
2. **Pendulation of attention** in which the therapist gently ushers the client's focus between sensations or experiences that feel resourcing and life-affirming, before gradually approaching the *trauma vortex* symbolised here by the "void" (Levine, 1997, pp. 197–200).
3. **The introduction of dual awareness**, supporting the client to cultivate present-moment awareness while simultaneously remaining connected to the emerging traumatic material (Fisher, 2017; Ogden et al., 2006).

Rather than being delivered didactically, this psychoeducation is best woven into the therapeutic interaction in a way that feels organic, gentle, and invitational; for example, I may ask:

- As you notice the scary feeling inside, can you also feel the support of the table beneath you?
- Is there any part of you that might be curious about this strange experience you're having?
- There's a lot of scared showing up right now. Is it possible to feel the sensation of "the scary", without being scared of it? We don't want to get too close–but we also don't want to avoid it entirely.

Conclusion

Working with clients' experiences of a "void" caused from the trauma of emotional neglect requires the therapist to hold steady as a grounded, curious witness–offering their own nervous system as a co-regulatory presence while remaining deeply attuned to the phenomenological unfolding of the client's internal world. Rather than viewing the "black hole" as a phenomenon to be fixed or escaped, it is preferable to approach it with respect–potentially as a sacred space to be honoured as an internal refuge where the psyche survived by temporarily withdrawing in response to overwhelming experience. Healing in this context emerges through witnessing presence, paced engagement, and embodied connection–each necessary in facilitating integration of these preverbal survival states (Jung, 1969; LaPierre, 2021; Levine, 2010; van der Kolk, 2014).

Prior to training in body-based psychotherapy–namely Somatic Experiencing® and NeuroAffective Touch®–I was a clinical counsellor and may have been surprised by how swiftly touch-based interventions can access the raw, unintegrated states rooted in early childhood experiences. However, having now witnessed similar responses across a range of clients, I have come to understand that such depth of access is not anomalous, but rather a consistent and reliable outcome.

At the time of writing, Monica and I continue to meet to explore the themes outlined in this study and she continues to make steady progress in moving towards her goals. Essentially, our work centres around two core aims: 1. developing interoceptive awareness and 2. supporting her capacity to remain present with whatever sensations and emotions emerge without becoming alarmed and dysregulated. Ultimately, as her capacity to meet activation and sensation increases, that which was previously intolerable can start to be met with self-compassion, curiosity, and connection. In this way, Monica and other individuals have the opportunity to learn to hear, hold, and respond to the unmet needs of their own "tiny one within".

While these goals may appear straightforward in theory, they become significantly more complex in the context of the overwhelming terror associated with the "black hole". Navigating such existential terrain requires a gentle, incremental approach, firmly grounded in the principles of titration and informed by a nuanced understanding of working at the edges of the window of tolerance in a way that is both manageable and sustainable. This paper highlights the refined attunement and pacing required when working somatically with early emotional neglect and affirms the therapeutic potential of attuned, body-based interventions in facilitating lasting repair.

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