

When Regulation Is Not the End

By Gili Cook

Opening in the Room

Some people arrive in my office after therapy has already helped them understand themselves better. They can tell when they are becoming overwhelmed, and they know how to breathe, ground, and slow down. They carry the demands of work, relationships, and family, managing life as they understand it. And still, something stays slightly outside, on the periphery of their own life. A person may know they love someone yet feel at a distance from the love itself.

Sometimes, when I ask what makes them happy, they begin to list. They know the answers, but listing what brings happiness is not the same as feeling it while speaking. Others say it more plainly: life is happening, but it feels as if they are standing just beside it.

I have come to think of this as being present enough to function but not present enough to live.

That gap shaped the question I began to organize my work around: not only how we help a nervous system move out of overwhelm, but how more of life becomes accessible, and how freely a person can participate in it without losing themselves.

Regulation is not a small achievement, and I do not treat it as a preliminary stage before something more important. It is much of what makes any of this possible. But it is not always the end of the work.

What Becomes Accessible

Protection is not an error to be removed, nor a shell with truth waiting behind it. When protective organization becomes less dominant, experiences that were less accessible may become more available. What appears is not known in advance. It may be anger, fear, grief, pleasure, longing, curiosity, creativity, a boundary, an impulse to move closer or further away. Sometimes it is eros.

This still does not tell us what it means, so one of my central questions has become: what is becoming accessible now? That is a different question from what is supposed to emerge. It is followed immediately by a second: what else might it be? What other possibility is there?

The body can respond vividly while remaining remarkably ambiguous in meaning. Warmth, pleasure, contraction, genital response, gaze, or an impulse toward another person may provide information, but none establishes what an experience means or whether eros is present. Even within sexual responding, physiology and subjective arousal do not necessarily move together. In a meta-analysis, Chivers et al. (2010) compared subjective (self-reported) and physiological (genital) sexual arousal. They found substantially greater agreement in men ($r = .66$) than in women ($r = .26$), with variation across study conditions; even in men, the measures were far from identical. Clinically, this is one reason I keep physiological arousal, attraction, desire, wanting, and consent conceptually distinct. A bodily response does not, in itself, establish any of them. It also does not establish their absence.

Therapists inevitably form hypotheses. The discipline is to hold a hypothesis as a hypothesis. In body-oriented work, "the body knows" can easily slide into "the therapist knows what your body is saying." I try not to make that move.

A Clinical Illustration

The following clinical illustrations are based on my recollections of therapeutic encounters. Dialogue is paraphrased rather than transcribed, and nonessential details have been omitted. Neither involves sexual or erotic touch. Where touch is used, it is explicitly agreed and can be changed or stopped at any time.

One man described a sexual encounter in which he had felt aroused and frightened by his body's response. In our session, we spoke about that experience, without touch.

Rather than assuming the experience was still present, I asked whether he would like to explore what, if anything, from that encounter felt accessible now. He agreed. As he turned his attention toward his present experience, he noticed both arousal and fear arising again.

I did not yet know what the arousal meant. I had hypotheses, but I did not want to mistake a hypothesis for the experience itself. When I asked what he noticed in his body, he began, 'I feel that ...' I heard a shift from sensing toward explaining and invited him to notice what was there without deciding what it meant just yet.

I asked how much of the fear and how much of the arousal he wanted to approach. He wanted to meet both. As we explored them, he became able to observe these experiences rather than only being caught up in them. This gave him more room to breathe and begin processing what had happened. The fear and arousal did not have to disappear or be assigned a single meaning for his relationship to them to change.

Another man had asked whether we could include touch that day. I was offering steady, grounding contact to the back of his body when I noticed his gaze drifting and his presence seeming to recede.

I stopped the touch and gave him time to gather himself and check what felt right for him. Rather than treating continuing as the default, I invited him to consider several possibilities: slowing down, stopping, or continuing. He said he wanted to continue. Something in him, he said, was afraid, and meeting that fear was part of why he had come. Even so, I did not take his yes alone as sufficient evidence that choice was fully available.





I asked whether he wanted anything about the touch to change. He requested that I place my hands on his lower back. I did so, resting them there with steady contact. He said the contact felt supportive and noticed how much strain he was experiencing in that area.

The shift was not from one touch technique to another in pursuit of greater intensity. It was the pause, the exploration of options, and the opportunity for his preference to shape what happened next. His request

expressed a choice in that moment, not proof of greater overall capacity.

These moments changed how I understand an invitation that once sounded benign: *stay with it*. Today I leave more room around it: Can you stay with this for another moment? Would it be better to slow down, move away, or return to something more stable?

Emergence Is Not Capacity

These moments point to a distinction that has become central in my work: emergence is not capacity.

This sits alongside titration in Somatic Experiencing (Levine, 2010) and the window of tolerance (Siegel, 1999). A person can be well within their window of tolerance and still have little freedom: staying because they think they should, because I invited it, or because stopping feels like failure. My focus is on what freedom remains once experience becomes accessible, what it may mean, and whether we know enough to decide where the work should go.

An experience can appear before a person can remain in meaningful contact with it. Pleasure, fear, anger, longing, or arousal may become available after years of being muted. In body-oriented work, it is tempting to read that as permission to keep going in the same direction. I used to read it that way. I no longer think it follows.

I have stopped using capacity to mean how much intensity someone can tolerate or how long they can stay with a sensation. Here, capacity is the degree of freedom that remains in relation to what has become accessible. More capacity is not more intensity. Presence, access to boundaries, and choice are ways that freedom may show up.

Sometimes freedom looks like staying. Sometimes it looks like slowing down, moving away, changing direction, saying no, stopping, or saying, "I don't know." These are not signs that the work has failed. They may mean a person no longer has to abandon themselves to stay in contact.

This has also changed how I understand movement away from experience. A request to stop is always honored first. Other movements away, such as returning to thinking or joking, may be avoidance, but they may also be adaptive organization creating distance from something too much, too fast, or too uncertain. They should be neither overridden nor automatically followed. They should first be understood.

It has also made me look more closely at my own interventions. The therapist's invitation is not neutral. "Stay with it." "Go deeper." "See what happens if you remain there." They can be appropriate, but each carries direction and may imply that staying is preferable to leaving, that more sensation is better, or that continuing is progress.

The clinical aim is not endurance. It is the widening freedom to be in relationship with what has become accessible without losing presence, boundaries, or choice.



Eros as One Possibility

Not every charged experience is erotic. In work where body, pleasure, intimacy and relationship are close to the surface, eros may be present but should not be presumed simply because experience becomes vivid or the body responds.

Every charged experience calls for differentiation and pacing. When eros enters, even more care is needed because it is easy to assign meaning too quickly, and because sexual or relational meaning sharpens questions of boundary, consent, power, and responsibility.

I understand vitality as the broader field. Within it, eros is one possible charged movement: sensory, vulnerable, and sometimes sexual, moving toward encounter, connection, closeness, or creation. Eros is not reducible to sexuality. It may carry sexual meaning and it may not; it may appear with or without touch.

Nor is eros the life force hidden beneath protection or evidence that treatment is succeeding. It is not a required stage or goal. If it emerges, it enters the same differential process as any charged experience: one hypothesis among several, never inferred from a single bodily sign. The person's own meaning-making remains primary.

This keeps us from sexualizing experience too quickly without treating erotic meaning as inherently dangerous when the person brings it into the room.

Non-Enactment Without Relational Retreat

Charged experience becomes more complex when it takes on meaning in relation to the therapist. Desire, attraction, longing, or erotic charge may arise there. Relational and psychoanalytic traditions have long treated such material as clinically meaningful. Jody Messler Davies (1994) wrote about desire and dread in countertransference; Nancy A. Bridges (1998) addressed supervision around sexual and loving feelings in psychotherapy.



The ethical requirement for non-enactment is clear. But non-enactment and relational withdrawal are not the same. A firm boundary does not require disappearing emotionally. The work I describe here does not include sexual or erotic touch, or erotic reciprocity.

When charged meaning enters the room, a therapist may retreat into neutrality, change the subject, lean on rules, or create distance. Nothing has been crossed, and yet the room goes cold.

Sometimes distance is exactly what responsibility requires. If I cannot hold the frame, or if arousal or attraction is becoming hard to contain, I need to narrow the work, stop touch if it is being used, and seek supervision. Presence at any cost would create a dangerous ideal. But when the frame can be held, an unexplained relational retreat also becomes part of the person's experience. I can decline an action without shaming it. I can say no to something without saying no to the person.

This is where practitioner capacity enters. Charged material touches me too: anxiety, shame, attraction, arousal, protectiveness, the wish to rescue or get away, the need for the process to succeed. If I do not notice these, they can organize the session through pace, tone, and intervention. That is one way boundary failures begin: not as a single decision, but as a gradual narrowing of my freedom, until my own state is choosing for me.

At the same moment, I ask myself: Am I still here? Am I choosing my intervention, or are fear, attraction, or avoidance choosing for me?

My capacity is therefore part of the intervention, but the responsibility is not shared. The person in front of me is not responsible for holding the frame. I am. My attraction, arousal, fear, or wish to withdraw belongs first to reflection and supervision. Countertransference may be informative, but it is never evidence that the person's experience means what I imagine.

Consent belongs here too. Where touch is used within the practitioner's training, scope and law, the question is not only whether consent was given beforehand, but whether choice remains available. Can the person stop, change their mind, ask for something else, or say no without wondering how I will take it? Consent is a living relationship with the possibility of choice. This is consistent with body psychotherapy ethics guidance on ongoing informed consent and attention to spoken and unspoken cues (United States Association for Body Psychotherapy [USABP], n.d.).

The broader transference and countertransference meanings of erotic experience deserve fuller treatment than this article can provide.

Field Positioning

Trauma-oriented somatic approaches treat bodily experience as clinically relevant. Sensorimotor Psychotherapy, for example, works with bodily, emotional, and cognitive experience in trauma and attachment work (Ogden et al., 2006).

Relational body psychotherapy adds another dimension. Patrick Nolan (2014) describes psychotherapy as embodied and reciprocal, with therapist and client influencing one another moment to moment. What becomes available in the body may therefore also be shaped by what happens between them.

Eugene Gendlin's work on experiencing and Focusing shaped how I think about what is felt before it is known: felt experience can carry meaning before it becomes explicit or verbal (Gendlin, 1969).

SPIRALAYA is a developing somatic-relational clinical model growing from these influences and my clinical observations. It is not a validated treatment, and I do not present regulation, titration, boundaries, choice, agency, or attention to therapist responses as its inventions; they belong to many traditions. SPIRALAYA is not a touch method. It may work through conversation, breath, movement, voice, distance, gaze and, where ethically and professionally appropriate, touch. Its central clinical focus is the freedom available in relation to what becomes accessible and charged. Its broader aim is to expand a person's capacity for life.

When something becomes accessible and charged, three questions organize the work:

What is becoming accessible now?

What else might it be? What other possibility is there?

How much freedom remains in relation to it?

We neither deepen nor name experience quickly. We hold more than one possibility about its meaning and check how much freedom remains in the person and, asymmetrically, in the practitioner responsible for the professional frame.

Back to the Room

I think again of the man who felt aroused and frightened, and of the moment when presence began to recede during touch. In both cases, the temptation was to decide quickly what was happening and what should happen next. I am less interested in doing that now.

The task is to choose an intervention appropriate and proportionate to what is happening, the clinical aim, and the freedom available. Sometimes that means not deepening an experience but making more room around it, so the person can move toward it, away from it, or nowhere at all.

What matters to me now is not whether we stayed with it.

It is whether there was still a choice about where to go next.



Gili Cook is based in Israel and works at the intersection of emotional, somatic, and relational practice. She has 23 years of experience in therapeutic and emotional work, including 12 years of body-based work and touch. She holds a BA in psychology, completed three years of training in couples and family therapy and two years of training in Focusing, and has studied Somatic Experiencing and Nonviolent Communication. She is the developer of SPIRALAYA, a developing somatic-relational clinical model, and is currently completing a Hebrew book presenting it. More information about the model is available at www.spiralaya.com.

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