

Enough Steadiness to Feel

Regulation in the Service of Experience

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Therapist companion to BKL's Self-Regulation pathway · 18 October 2026

A client returns after working through a regulation exercise and says, “I still got upset.” There is disappointment in the sentence, perhaps an apology. The exercise has become another place to discover that they are not doing themselves correctly. We may respond by explaining the technique again, recommending more practice, or reassuring them that improvement takes time. Before doing any of those things, it is worth asking what we have agreed improvement should mean.

Did the client notice their anger sooner? Could they remain in the conversation, ask for a pause, or return after leaving? Did they recognize that the demand was unreasonable? Were they able to feel disappointed without deciding that disappointment made them difficult to love? Any of these might matter, even if their heart continued to race.

In [You Don't Have to Be Calm to Have a Choice](#), I describe regulation as making more responses available while feeling remains possible. This therapist companion asks what it takes to support that capacity in another person, including when our own feelings begin narrowing what we can offer.

What are we trying to regulate?

Self-regulation is broader than reducing autonomic arousal. It includes attention, emotional awareness, inhibition of harmful action, recovery, and the ability to organize conduct around what matters. Emotion regulation is one part of that larger activity. Gratz and Roemer's influential formulation includes understanding and accepting emotions, access to strategies, and the ability to pursue goals and manage impulses while distressed. Emotional acceptance and behavioral responsibility belong together. [1]

Gross's process model widens the timing of intervention: a person may alter a situation, shift attention, reconsider meaning, or influence a response already underway. We should therefore look beyond techniques used after escalation. Clarifying an ambiguous instruction, reducing a punishing schedule, or arranging a difficult conversation differently can be consequential regulatory choices. [2]

A client can become outwardly quieter while becoming less present. Another can cry more freely while remaining able to hear us, disagree, and decide what happens next. Neither intensity nor

composure is sufficient evidence of capacity. Clinically, we need to ask about access: access to experience, the surrounding world, the other person, and meaningful choice.

This also changes how we hear “I lost it.” That phrase might describe an outburst, a painful but responsible disclosure, or a departure from a family rule against showing distress. These are different events. Our first task is to discover which one occurred.

A history of having to manage alone

Schore’s regulation theory directs attention to the early relational conditions in which affect becomes bearable. His 2022 synthesis emphasizes implicit communication through voice, face, gesture, timing, and the emotional bond. The therapist participates through how they receive experience as well as through what they explain. His more recent book, *The Right Brain and the Origin of Human Nature* (2025), continues this developmental account. [3, 4]

Its clinical invitation is to notice what happens beneath our polished language. A slight withdrawal when anger appears may matter more than the reassurance that anger is welcome. An interested silence may offer room; an unreadable silence may repeat abandonment. Schore’s hemispheric account is a theoretical synthesis, however, not permission to equate thinking with the left brain or every helpful encounter with a measured right-brain change.

A client may have learned that remaining acceptable meant showing very little need. Another may have discovered that distress had to become urgent before anyone responded. These are possible developmental formulations, not histories we can infer from presentation alone. A person’s current exhaustion, sensory environment, illness, discrimination, or unreliable relationships may explain more than our preferred attachment account.

The same caution applies to ourselves. Competence, soothing, interpretation, and emotional reserve can each be clinical resources. They can also become ways of avoiding helplessness. We need enough honesty to ask when a familiar strength has begun organizing the session around our comfort.

When the present carries the force of the past

Van der Kolk’s work brings the bodily immediacy of traumatic stress into view. In his 2006 clinical review, trauma reminders can evoke responses that interfere with orientation, modulation of arousal, and putting experience into words. He links recovery with tolerating sensations, regulating arousal, and restoring effective action. *The Body Keeps the Score* later develops this broader clinical perspective. [5, 6]

A client may know intellectually that a delayed reply is ordinary and still feel the urgency of being abandoned. Knowledge has not necessarily failed; it may simply be insufficient in that moment. More explanation can become another demand placed on someone already struggling to remain present.

Fight, flight, freezing, and appeasement can help people describe protective patterns. They are not tidy diagnoses of sympathetic or parasympathetic activity. Freezing can involve overlapping autonomic processes; appeasing another person is a relational behavior with several possible meanings. We cannot identify a specific vagal pathway from stillness, a smile, or a report of numbness.

Nor does a compelling bodily feeling establish that an interpretation or recovered image is historically accurate. We can take the experience seriously while leaving its explanation open. “Something feels frightening now” gives us a place to work without claiming to know everything that produced it.

Enough room for experience

Siegel’s *The Developing Mind* places regulation within a developmental and relational account of integration. The familiar window-of-tolerance formulation offers a useful clinical question: is there enough capacity to encounter what is happening while remaining oriented and responsive? It is a heuristic, not a biological threshold we can determine by watching someone. [7]

We might notice whether the client can follow the conversation, distinguish memory from present circumstance, move attention outward, and exercise a preference. We also ask. What looks like withdrawal could be reflection, fatigue, cultural reserve, or a wish for privacy. What appears intense may be fully manageable from inside.

The window metaphor becomes less helpful when it creates a narrow ideal of acceptable emotion. Some clients need support to approach feelings they habitually suppress. Others need less inward focus, shorter contact, movement, or practical action. Regulation may involve becoming more available to emotion rather than making it smaller.

In [Less Afraid to Be Yourself](#), I give acknowledgment and allowing time before inquiry. That pacing matters here too. Before asking what a response protects, we may need to discover whether the person can notice it without immediately feeling examined. Understanding should deepen contact rather than hurry past it.

Safety is something we help discover

Porges’s polyvagal framework has made clinicians more attentive to bodily state, social signals, and responses to perceived threat that occur without deliberate choice. His 2025 account emphasizes autonomic regulation and the proposed role of social engagement. A useful clinical consequence is to ask how our pace, distance, voice, and predictability are actually received. [8]

The framework’s specific neuroanatomical and evolutionary claims remain substantially contested. A 2026 expert critique led by Grossman challenges its foundational premises; Porges disputes that appraisal. The value of predictable, responsive care does not depend on presenting the contested physiology as established fact. [9]

For a person accustomed to intrusive attention, direct eye contact may feel exposing. A softened voice may feel patronizing. A breathing instruction may resemble being told to stop making trouble. We cannot announce safety into existence. We can offer an experience, ask about its effect, and alter our conduct when the answer surprises us.

That is also an ethical discipline. The client's unease may concern something we have actually done. Attunement includes hearing criticism and attending to power, rather than relocating every difficulty inside the client's nervous system.

Feeling has work to do

Panksepp's cross-species affective neuroscience describes primary emotional systems, including FEAR, RAGE, CARE, PANIC/GRIEF, SEEKING, and PLAY. His work situates emotion within motivation, attachment, survival, and engagement with life. These systems are not a complete classification of human experience, and an individual's story cannot be read directly from a proposed circuit. [10]

The clinical implication I draw is that regulating feeling should not mean erasing its purpose. Anger may help a client recognize an intrusion. Grief may register the significance of a loss. Interest and play may become available as protection loosens. The task is to help the person experience, understand, and respond to these movements without assuming that every impulse is wise or every strong emotion requires reduction.

Fosha offers a related clinical distinction between defenses, inhibitory affects such as anxiety and shame, and core affective experience. Within AEDP, dyadic regulation supports approaching experience that previously felt unbearable alone. Metatherapeutic processing then attends to what it is like to undergo and receive a helpful change. [11]

This suggests a different response when a client begins crying after feeling understood. We need not immediately restore the previous composure. We can ask whether they remain with us, whether the feeling is manageable, and whether they want company or a change of direction. We remain equally willing to stop. Depth is an opportunity, not a requirement.

Flexibility rather than a preferred technique

Bonanno and Burton's flexibility framework emphasizes sensitivity to context, a repertoire of responses, and attention to feedback. A strategy's usefulness depends on what is happening and what it makes possible. [12]

Lim, Nickerson, and Specker's experimental study, published online in 2024 and in a 2025 journal issue, offers a bounded example. Among 148 participants, those with probable PTSD who were instructed to match distraction and reappraisal to image intensity reported the lowest negative affect. This was a brief image-viewing experiment, not a trial of psychotherapy or evidence of durable recovery. It supports investigating fit rather than prescribing one strategy everywhere. [13]

The clinical translation remains a judgment. Redirecting attention may help someone regain enough orientation to return. Used automatically whenever sadness appears, it may maintain avoidance. Reappraisal may correct a mistaken assumption; offered too soon, it may communicate that the person's pain is inconvenient. We have to learn from the encounter rather than label strategies universally healthy or unhealthy.

Research on breathing deserves the same care. Balban and colleagues' 2023 randomized study compared daily five-minute breathing practices with mindfulness meditation over a month. Some breathing practices, especially exhalation-focused cyclic sighing, showed advantages for mood and respiratory rate. It did not establish a trauma treatment or validate every sighing variation. [14]

BKL's comfortable inhale and soft sigh are an optional practice, not the same protocol. Box breathing includes holds that some people dislike. If counting, depth, or breath attention produces dizziness, air hunger, panic, or disconnection, discontinue that exercise and reassess; ordinary breathing and external attention remain alternatives. Success is not obedience to a breathing instruction.

What clients may bring back from the five modules

The [Self-Regulation pathway](#) begins with **Recognize your early signals**. A client may return with a bodily cue, but also with a behavioral observation: rereading messages, becoming unusually brief, or losing the thread. We can help separate what occurred from what it seemed to mean. Noticing afterward is useful; demanding constant early detection can turn awareness into anxious surveillance.

Make room without surrendering choice invites a distinction between feeling, impulse, and action. A client might discover, "I was angry, but I did not have to send the message." Another may find that compassionate language feels false. We can explore what words were believable, what responsibility remained, and whether the practice allowed experience or merely concealed it.

In **Build a flexible regulation menu**, the client examines actual effects rather than collecting techniques. What helped them orient? What increased pressure? What depended on the other person's response? The report can start that inquiry, but it is an educational reflection, not a diagnosis or a validated measure of physiological regulation.

Create a pause for purposeful action brings learning into conduct. A pause may make a clear request possible. It may also become disappearance if there is no return to an important conversation. Ask what happened next, including whether the situation required protection, repair, or a practical decision. Agency includes commitments as well as boundaries.

Plan recovery and sustainable support widens the frame beyond the moment of activation. Sleep, workload, pain, isolation, material resources, and dependable help matter. A client who cannot recover between excessive demands may need a changed arrangement more than

another exercise. In [You Can Help Me Without Taking Charge of Me](#), I explore support that preserves the recipient's voice and the helper's limits.

The useful bridge back into therapy is one encounter the client chooses to discuss: what they expected, what they tried, what happened, and what they now understand differently. They need not show us everything they wrote. If a practice felt shaming or unhelpful, that is important information about its fit, not evidence that they resisted learning.

The second person whose regulation matters

Our reactions are part of the clinical situation. A client becomes angry and we feel an urgent wish to explain. They become quiet and we fill the silence. They describe repeated harm and we lose access to curiosity about the person who caused it. They improve and we feel relieved in a way that makes disappointment harder for them to disclose.

Siegel's *The Mindful Therapist* brings the clinician's awareness, presence, and response flexibility into the work. The invitation is to notice our inner activity while continuing to meet the person in front of us. We do not need to become untouched. We need enough room to distinguish what we feel from what the client requires. [15]

Gwertzman and Tishby's 2025 study examined 57 therapists treating 86 patients in short-term psychodynamic psychotherapy. Several therapist regulation capacities were associated with symptom improvement and alliance development, including acceptance of negative emotions and maintaining goal-directed behavior. Findings were not uniformly straightforward: greater reported awareness difficulties were unexpectedly associated with larger alliance improvements. This observational study cannot establish causation or a universal profile of the effective therapist. It does make therapist regulation an empirical question rather than merely an appealing ideal. [16]

Abargil and Tishby's 2024 study of 41 treatments likewise linked changes in therapists' relational wishes and countertransference awareness with aspects of alliance and outcome. Its scale and design limit inference. The clinical implication I draw is to examine what we want from the encounter, particularly when that wish begins determining the intervention. [17]

Our bodily response is information to investigate, not a privileged reading of the client. Tightness may reflect resonance, our own history, fatigue, a rushed lunch, or something occurring between us. Supervision helps us hold these possibilities without turning a strong feeling into certainty.

When helping becomes an urgency

Consider a fictional encounter. Mara says that her partner interrupted her and that she later sent several furious messages. The therapist feels a quick tightening in the chest and begins offering breathing exercises. Mara smiles, agrees, and becomes less expressive. The therapist initially experiences this as improvement.

On noticing their own relief, the therapist reconsiders. “I moved quickly toward helping you settle. What was that like?” Mara replies, “It felt as though the anger was the problem again.” That answer does not excuse the messages. It reveals that the intervention skipped the experience the therapist intended to help.

The therapist acknowledges the miss and offers a choice: “We can understand what you were angry about and also look at what the messages did. Where would it help to begin?” Mara speaks about being repeatedly interrupted. Her voice trembles. She remains oriented, corrects the therapist’s summary, and decides that she wants to make a direct request and repair one insulting sentence. She is still angry when the session ends.

The therapist’s regulation consisted partly in tolerating the discomfort of being corrected. The outcome was greater specificity and a chosen response. Whether that response helps outside the session remains to be seen. If Mara instead became overwhelmed or wanted distance, the next step would change. The example illustrates judgment; it does not demonstrate a treatment result.

Working within our own limits

Before a session, we might briefly notice fatigue, personal preoccupation, or an expectation about how this client should be doing. During a difficult moment, a small internal question can help: what am I feeling, what am I being pulled to do, and what have I stopped noticing?

Sometimes the response is physical: release an unnecessary muscular effort, feel the support of the chair, or allow an unforced breath. Sometimes it is relational: acknowledge a misunderstanding, ask a simpler question, or allow a pause. Regulation should return attention to the encounter, rather than become a private ritual that takes us away from it.

We can then check the intervention’s effect. Did the client become more able to participate, or merely more agreeable? Did our explanation clarify something, or replace their language? Did slowing down help, or make an already disconnected person feel more distant? Feedback can be verbal, behavioral, and relational; it needs the client’s account to become intelligible.

Afterward, choose one precise moment for reflection or supervision. What preceded our urgency? What did we intend? What did the client actually report? What alternative response could we rehearse? Where patterns recur, our own therapy and experiential work may help us encounter feelings we otherwise ask clients to manage for us. That is a commitment to professional development, not a demand for an imagined state of complete healing.

Regulation must not become a waiting room

Skills can support trauma recovery, but they should not become a blanket prerequisite for treatment. Van Vliet and colleagues’ randomized trial found no significant advantage for a preparatory STAIR phase followed by EMDR over immediate EMDR on the studied outcomes in adults with childhood-abuse-related PTSD. This does not mean preparation is never needed; it challenges requiring it for everyone. [18]

Conversely, the 2024 RESTORE pilot trial of ESTAIR in 56 veterans with complex PTSD found promising benefits relative to treatment as usual. ESTAIR addresses several domains, not emotion regulation alone, and the small pilot needs larger confirmatory trials. The two studies ask different questions. Together they support individualized planning rather than allegiance to a universal sequence. [19]

BKL is an educational companion, not either of these treatments. Its exercises cannot substitute for assessment, appropriate trauma care, or protection from ongoing harm. A client does not have to finish five modules or demonstrate composure before deserving deeper therapeutic attention.

A different measure of steadiness

The change we hope to support can be quiet: a client notices the familiar stomach drop, gives the feeling a little room, and asks what was meant. They remain hurt and acknowledge their own impact. They need help and can receive some of it. They stop an exercise that is not helping without turning the decision into another failure.

Therapists have parallel work. We feel helplessness and remain interested. We notice the wish to be useful without requiring immediate relief as proof of our usefulness. We can be moved, mistaken, and responsible enough to repair.

Enough steadiness to feel is a modest phrase for a substantial capacity: to remain in relationship with experience while retaining some freedom about what follows. The pathway offers opportunities to practice that capacity in ordinary life. Therapy can offer a place where the difficulty of doing so is met with company, clinical judgment, and a person willing to keep learning too.

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