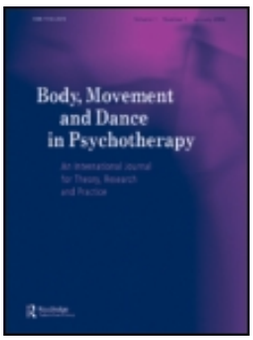

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Breathwork in body psychotherapy: Clinical applications

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The use of conscious breathing practices for the purpose of physical, psychological, emotional and spiritual healing has a long and extremely varied history, yet little work has been done to bring these practices into a coherent and unified form that contributes to the field of body psychotherapy (BP). This article focuses on translating theoretical themes developed in a previous publication (Caldwell & Victoria, 2011. *Body, Movement and Dance in Psychotherapy*, *6*(2), 89–101) into practical applications in the BP profession. The authors propose six clinical themes for the use of breath in BP, a balanced breathing exercise, and four clinical models for integration into BP practice. Recommendations are made for future research and training in this crucial area of BP.

Keywords: breath; breathwork; body psychotherapy; conscious breathing; breath therapy

Introduction

Conscious breathing practices have been used as a healing strategy in body psychotherapy (BP) since its inception, being seen by some as a kind of royal road to physical, emotional, psychological and spiritual health and well-being (Conger, 1988; Farhi, 1996; Hendricks, 1995; Hendricks & Hendricks, 1991; Middendorf & Roffler, 1994). However, the theories and practices of using breath in BP have often been vague and at odds. In a previous article, we began the task of unifying the theoretical basis for the use of breathwork in BP (Caldwell & Victoria, 2011). In brief, we operationally define 'good' breathing, in the normal circumstances of daily life, as a balance of the inhale with the exhale, an easy and mobile flow through the body and an ability to adapt quickly and effectively to the changing internal and external events (Fried & Grimaldi, 1993; Gilbert, 2002; Keleman, 1985; White, 1997). In this paper, we attempt to report and then synthesise various breath-oriented BP clinical practices so that breathwork in our field (as well as in other fields) can be used judiciously, efficiently and effectively.

Though beyond the scope of this paper to discuss, the physical benefits of good breathing have been well and thoroughly documented (Chaitow, Bradley, & Gilbert, 2002; Farhi, 1996; Fried & Grimaldi, 1993; Gilbert, 1999; Lowry, 1967; McKeown, 2004). Briefly, they can be summarised as improving immune function; regulating arousal; decreasing sinus problems; balancing hormones, enzymes and

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neurotransmitters; stabilising blood gases; increasing vitality; promoting digestion, circulation and proper organ function; facilitating waste metabolism, aligning posture, decreasing muscle tension; and increasing motility, mobility and movement efficiency (Bartenieff & Lewis, 1980/2002; Boerstler & Kornfeld, 1995; Farhi, 1996; Gilbert, 2002; Keleman, 1985; Lowen, 1975; Lowry, 1967; McKeown, 2004). These physical effects can in turn be seen as having a profound influence on psychological well-being, particularly in the areas of mood, the reduction of negative emotion and an increase in positive emotion, emotional regulation and the capacity for social engagement (Aposhyan, 1999; Chaitow et al., 2002; Conger, 1988; Hendricks, 1995; Levine & Macnaughton, 2004; Lowen & Lowen, 1977; Lowry, 1967; McKeown, 2004; Middendorf & Roffler, 1994).

As would be expected, BP has focused intensely on the psychological issues surrounding therapeutic breathing (Gilbert, 2002; Keleman, 1985; Masaoka & Homma, 2001; Minnett, 1994; Williams & Burdakov, 2008). Many theorists and clinicians agree, for instance, that breathing is affected by conscious and unconscious attempts to stave off strong emotion or uncomfortable states (Aposhyan, 1999; Gilbert, 2002, 1998; Hendricks, 1995; Lowen, 1975; Totton, 2003; Van Diest et al., 2001). It is believed that we dampen our perceptual sensing when we restrict our breathing, which is said to result in feelings of anxiety, fear or numbness (Aposhyan, 1999; White, 1997).

Empirical research has begun to weigh in on this topic. Neuroscience researchers have found that the brain's primary emotional centre, the limbic system, plays an important role in breathing patterns. Fried and Grimaldi (1993) report that respiratory functions exist throughout the limbic system, olfactory area and Broca's area, linking breathing to emotions, sensations and speech. Masaoka and Homma (1997) found that 'unpleasant emotions caused by mental stress altered the breathing pattern' (p. 153). For instance, negative emotions may influence children with asthma to assume their airways are constricting when they are not (Rietveld & Prins, 1998). 'Respiratory patterns are influenced by cortical and limbic factors and generated by a complex interaction between metabolic requirements and their behavioral effects' (Masaoka & Homma, 2001, p. 171). In other words, the body's metabolic need may not match up with the brain's arousal, which, in turn, affects the breathing rate and physiological arousal.

Gilbert (2002) states that a person in crisis or under stress will not consciously choose how to breathe, but, 'The mode of breathing seems to be selected automatically depending on what is anticipated in the next few seconds: breath holding may do for indecision or freezing; a deep gasp might prepare for major exertion or crying out; a sharp exhale might accompany anger, frustration, or aggression' (Gilbert, 2002, p. 119). Similarly, Boiten (1998) has found that emotional stimuli affect breath regularity and breath holding. For instance, this researcher explains that positive emotions, specifically laughter, decrease inspiratory time and tidal volume, and negative emotions, particularly disgust, induce both breath holding and prolonged inspiratory pauses. He concludes that breathing patterns correspond with coping attitudes.

The relationship of breathing to emotional experience and sensing is seen as critical to emotional 'fluency' and intelligence (Critchley, Wiens, Rotshtein, Öhman, & Dolan, 2004). White (1997) asserts that if the breath is not allowed to

move in a relaxed, open flow or 'wave', then we get stuck emotionally and mentally. Poor breathing habits and unbalanced breathing can decrease our ability to sense our emotional states and can arise from many causes, including stress, improper exercise, strong emotion, disease, allergies, trauma, chronic startle reflex, surgery, tight abdominal muscles, learned habit or prenatal/post-natal imprinting (Farhi, 1996; Gilbert, 2002; Mckenna, Mosko, Dungy, & McAninch, 1990; McKeown, 2004; White, 1997). Gilbert (2002) states that 'Regardless the presence or absence of disease, transience or permanence, functional or organic, there is a person experiencing it all, and a person in distress can disrupt his breathing so much that other interventions are thwarted' (p. 111). Heller (2012) goes so far as to say that 'an emotion is, among other things, a breathing pattern' (p. 35).

Thus, breath is a powerful agent in creating regulation or dysregulation in the body/mind system. It may be important to determine when emotional processing should be used as a way to regulate breathing (and therefore physiology) and when conscious breathing should be used to balance emotional states.

A review of therapeutic breathing practices in BP

A number of body psychotherapists maintain that using the breath consciously can help to alleviate symptoms of illness (mental, emotional and physical) through raising body energy levels, increasing the breath's adaptability and activating the body's natural flow (Aposhyan, 1999; Conger, 1988; Farhi, 1996; Hendricks, 1995; Lowen, 1975; Miller, 2000; Minnett, 1994). However, the techniques used in order to accomplish this may be in contention.

Wilhelm Reich was one of the first clinicians to be interested in the relationship between the breath and the psyche. He believed that a person creates bodily tension and breath holding as a defensive coping mechanism (called body armour) against threatening emotions (Sharaf, 1994; Totton, 2002). He put emphasis on recognising where clients were blocked in breathing and at times utilised breathing practices that focused on allowing deep breathing through the open mouth with and without sound through the vocal chords to achieve catharsis and energy charged sensation throughout the body (Hendricks, 1995; Sharaf, 1994).

This idea of using increased breath volume and rate in order to release chronic contraction and increase energy may contrast with views held by others. Heller (2012) cautions that a body psychotherapist should *calibrate* breathing practices to patient peculiarities. According to Hendricks (1995), the body-activating practice of deep rapid breathing may be dangerous and can induce psychological distress and crisis, likely precipitating anxiety attacks due to hyperventilation in some clients. Farhi (1996) agrees that we must 'reveal' the natural breath through attention and patience. She feels that breath must be 'untied' or gently coaxed out of hiding. Trying to alter breathing through mechanical, forced exercises may have little effect on the breathing patterns because these temporary methods do not change the fundamental patterns that have taken time to develop (Boerstler & Kornfeld, 1995). Totton (2002) comments:

> ... when one tries to allow the breath to happen freely *while attending to it consciously*, consciousness and spontaneity begin to interfere with each other: resistance emerges, corresponding to repression and embodied in the breath. Breathing

> is on the interface between voluntary and autonomic function: any attempt to 'control ourselves' – which is largely what repression is … emerges in the breath. (p. 23)

Many therapists agree that we use control of the breath to control ourselves and through releasing our control on breath, we release psychic material that we have been working to suppress, manage or avoid (Lowen, 1975; Middendorf & Roffler, 1994; Reich, 1949; Rhinewhine & Williams, 2007; Rosenberg, Rand, & Asay, 1985; Sharaf, 1994; Totton, 2002). Opposing this idea of releasing control on breathing to release suppressed psychological material, Rhinewine and Williams (2007) state that increasing control on breathing through voluntary hyperventilation used in Holotropic Breathwork, created by Stanislav Grof, produces altered brain states and could assist those with 'disinhibition of previously avoided or "suppressed" internal stimuli' (p. 775).

Hendricks (1995) states, 'one should always deal with feelings and correct the breathing before attempting to solve any problem on the cognitive level' (p. 184). Ogden, Minton, and Pain (2006) tend to agree that breathing signifies important emotional information and believe that breathing becomes most usable in stabilising the pendulum of arousal, grounding clients inside their window of tolerance, or tolerable amount of arousal, when breath is balanced, deep and relaxed. BP can benefit from more research that investigates the efficacy of 'set' breathing practices that are taught as a specific strategy for clients during and between sessions. Perhaps there are clinical settings where they can be useful, as well as useless, or harmful.

Breathwork is an essential component of integrative BP, a method founded by Jack Lee Rosenberg to balance the activation in the autonomic nervous system and regulate emotions (Rosenberg, Rand, & Asay, 1985). Hendricks and Hendricks (1991) developed a breathing practice called Radiance Breathwork through which clients vacillate from big, deep breaths to small, subtle breaths in conjunction with specific body movements typically in the neck, throat, chest, abdomen and pelvis in order to increase body energy and integrate positive sensation throughout the body. Similarly, Rubenfeld (2000) developed the Rubenfeld Synergy Method of healing through resonating touch and body integration. Rubenfeld feels that breathing signals the synchronisation of the body/mind/soul system and supports this system to release pain, heal and reintegrate painful life experiences. Ilse Middendorf developed a form of breath education called *The Experience of Breath* (Middendorf & Roffler, 1994). Her technique blends attentional focusing, sensing and breathing, as they are interrelated processes. These processes are followed by a series of spontaneous movement exercises that use stretching/expansion, pressure points, vowel breath spaces and movements determined by breath.

The literature seems to point to the existence of two distinct 'camps' in BP, one that advocates for conscious breathing that energises, activates and breaks through psychological blocks, and another that calms, allows and restores. Both camps value mobilisation and vitality, though they might operationalise those terms differently. On the surface, they seem contrasting and even contradictory. But these two paradigms also sound a lot like the arousing physiology of the inhale in contrast to the relaxing physiology of the exhale (Caldwell & Victoria, 2011). Perhaps BP can develop a unified paradigm that uses and balances both in application.

Distillation of six themes and a balanced breathing practice

Taken from the literature reviewed so far, the authors postulate six possible themes that can be used to construct a comprehensive methodology of conscious breathing practices in body psychology:

1. *Describe the patterns*. Clinicians should descriptively assess breath patterns in a client both in calm and stressed states. This means that the physical pattern is described rather than analysed for meaning so that a kind of observable 'before and after' view can be constructed. The assessment should likely include the three dimensionality of the breath, the flow of movement through various body parts (especially the torso), the balance of the inhale to the exhale, the patterns of effort, the respiratory rate and the pairing of breath patterns to emotional and arousal states, checking to see whether the breath may be supporting or dysregulating that state.
2. *Cooperate with natural oscillations*. Breath oscillates. Getting in alignment with this biological truth may help clinicians to assist clients in re-establishing healthy breath oscillations and to let those healthy oscillatory breaths regulate and harmonise with other body oscillations, such as can be found in the digestive, cardiovascular, endocrine and nervous systems.
3. *Teach the client how to regulate himself/herself*. Clients will likely benefit from being taught balanced, conscious breathing practices in the beginning of treatment, as a stabilising and re-patterning resource that can be called upon outside the session and during stressful moments within the session (as explained later). Encouraging clients to practice balanced breathing throughout the day might go a long way towards self-directed dissolving of dysfunctional breathing patterns over time and an empowerment of the client to self-regulate. In this way, more challenging and psychologically revealing breathing practices might be more safely used in psychotherapy sessions themselves.
4. *Use one's own breathing as a conscious intervention*. Therapists need to become good breathers themselves, as clients will attune to and match therapist's respiratory self-regulation. This modelling effect can exert its own healing momentum. As well, being a good breather may be related to good therapist self-care and the ability to avoid somatic counter-transference or vicarious retraumatisation.
5. *Learn to breathe with feelings*. Since emotion and breath co-regulate each other, conscious breathing should be used as a resource during emotional processing. It is important for the client to engage with how she *really* feels, rather than *how much* she can feel. In this way, the breath pattern itself can be used to support adaptive emotional processing, rather than exaggerating emotionality or pulling the client into more extreme states than are warranted or authentic or advisable.
6. *Use breath as a resource for both up-regulation and down-regulation*. Therapists can learn conscious breathing practices (and teach them to clients) that can be used together for both activation and calming, like an inhale and exhale that naturally occur together. In this way, we recreate the natural biological imperatives of the healthy body, and the therapist can adaptively

alternate between breathing practices that reveal and process difficult feelings, with breathing practices that help the client return to calm and restorative states.

7. *Conscious respiratory change takes time*. Therapists can advise their clients to be patient with their breathing patterns. Because breathing is mostly regulated by the autonomic nervous system, it takes time as well as conscious practice to change long-standing breathing imprints. It is the authors' experience that sustainable changes in autonomic breathing patterns can take as much as 3 months of conscious practice to generate increased and sustainable balance in autonomic breathing.

The balanced breathing practice

Given the above clinical themes, what breathing practices can we teach ourselves and our clients? The authors would like to postulate what we call a *balanced breath practice.* It is hoped that this practice will make use of all six themes. It could be taught to the client in the beginning of therapy so that he/she might practice it on his/her own, first in more neutral states and then under stress. As well, the practice can then be easily invoked in a session, when the client can use it to regulate his/her state so that it is clinically useful. It is listed here in an abbreviated form, noting that different clients need different metaphors:

1. Educate the client as to why and how this type of breathing might be important. It should be practiced when the client feels inclined, rather than dogmatised into certain time frames. The practice is effective when done for a few minutes after waking up, as a way to vitalise, and for a few minutes before going to sleep, as a way to calm and release. Ultimately, it is also best used as a moment-to-moment practice in the midst of ongoing events.
2. When teaching the practice, begin by just focusing on one aspect at a time. Start with the inhale. The inhale, as was noted before (Caldwell & Victoria, 2011), takes effort. The task of this phase of breath is to make the muscular contractions as efficient as possible, neither under- nor overworking. In order to facilitate the easiest contraction of the diaphragm, what might be called *belly breathing* is advised. This involves allowing breath to be felt all the way down into the floor of the pelvis. This also avoids the upper chest breathing pattern that is associated with unregulated arousal and anxiety.
3. Then, teach the exhale, noting that exhaling is an act of letting go (except during vigorous activity). Many clients associate letting go with collapse or helplessness, so it is important to help them experience the difference between an active yielding into gravity and a passive, helpless giving up. The authors often describe this as 'each individual rib resting closer together' on the exhale (a phrase used by Judith Aston of Aston-Patterning) and feeling the sense of one's weight being supported by the chair or floor. Over time, this can give the autonomic nervous system a direct experience that it is safe to rest.
4. Then, put the inhale and exhale together as an integrated practice, alternating between pooching out the belly slightly and then releasing into a feeling of one's weight being supported by the ground. Just practicing the efficient

activation of the inhale and the pleasant release of the exhale can be enough for many clients. This can first be practiced as a stand-alone exercise (in order to get the hang of it), and over time can be invoked as a way to make one's current state accessible, manageable and productive.

5. If the client wishes, he/she can learn the advanced practice of balanced breathing, which involves working with the transitional moments between inhaling and exhaling. First, work with the transition from the inhale to the exhale. Restricted inhaling often squeezes the torso into a narrowed and elevated shape, making the breather feel that his breath is going straight up and down. The authors have found that 'rounding out' the transition from inhale to exhale can help keep the body three dimensionally flowing with the breath wave rather than restricting it. Then, work with the end of the exhale. When we experience ourselves as safe, there tends to be a natural, slight pause at the end of the exhale, where the body waits to be 'inspired' to inhale again. The advanced exhale practice takes advantage of this and simply allows this natural pause to emerge on its own. Simply coach the client to 'watch for and greet' the pause if it shows up, and to watch as the body organises itself to inhale again on its own physiological authority.

The above practice represents a possible clinical strategy for the use of conscious breathing in BP, using the six themes developed by the authors. It is not meant to be *the* definitive practice, but more one that can serve as a home base from which other breathing strategies can be explored. It is meant to be in the middle of the breathing spectrum, following the assumption that BP needs to work with both down-regulation and up- regulation, and that this practice can integrate these two differing clinical needs along a continuum of available breath interventions. In addition, the more challenging and up-regulating breathing practices may only be safely accomplished in the midst of a psychotherapy session, and the client needs a breathing strategy that can be invoked in daily life, one that promotes physiological as well as psychological balance.

Breathing in psychotherapy: four models for viewing breathing

The following is an attempt to distil clinical and theoretical lenses into four possible models for breathwork pedagogy – a relational model, energy model, regulation model and consciousness model. All four models would use the balanced breathing practice as a reference point and tailor more challenging practices from there. It is hoped that these models can be used interchangeably in clinical applications, according to the needs and goals of particular clients rather than the habits or previous training of the therapist.

Relational model

Breathing is a social and communal process as well as an individual process. Our breathing patterns are influenced by what others are doing, beginning in the womb and persisting throughout the lifespan. In early development, the neonate and infant's autonomic nervous system 'listens' to the breath patterns of those around her and harmonises her patterns to those of her caregivers, habituating to their breath

signatures (Schore, 1994). In adult relationships, one's breathing is continuously affected by the quality of interaction with others, whether it be calm, stressful, sexually aroused, happy or fearful. Non-verbal communication research, for example, notes that when people who like each other interact, they tend to breathe at the same rate and tend to hold their breath or sigh at the same moments, creating a respiratory *pas de deux* that mimics movement-based synchrony (Bullowa, 1975; Lemke, 2004).

Often breathing becomes tied up in defensive relational strategies to break connection and relationship, especially when strong emotion is present (Porges, 2001; Totton, 2003). Totton (2002) notes that in order to stay in relationship with another, one must breathe and maintain contact at the same time, and that this might be difficult when the relationship is uncomfortable. For instance, autonomic breathing patterns play a role in relational defence strategies, according to Porges (2001). In his Polyvagal theory, there are three vagal nerve branches: ventral vagal, spinal sympathetic and dorsal vagal that coordinate conscious social engagement and interaction as well as more primitive fight, flight, freeze and faint responses. It is not known whether or not conscious breathing practices that attempt to recruit and sustain the social engagement (ventral vagal) system could help people to navigate conflicts without resorting to the more primitive mobilising or immobilising defences (Porges, 2001). Perhaps one person in an interactional system who is breathing in a way that supports calm engagement could influence others in the system to do so as well.

This research would be extremely contributive to couples and family therapy, as well as informing the therapeutic dyad. In the meantime, it may be advisable for therapists to experiment with the role of being a good breather as a relational and 'respirational' repair strategy, and to use their own regulated breathing as a direct intervention.

Energy model

Lowen (1975) maintained that conscious breathing can facilitate recovery from depression, noting that it increases energy, which is essential for treating the symptoms of depression.

The energy model uses conscious breathing to re-establish waves or pulsations of fluids and gases in the body that support a natural state of vitality and energy (Keleman, 1985). One example of this type of technique might be the Hendricks' 'charged breathing' practice, which alternates more energetic breathing with calming and integrating breathing (Hendricks & Hendricks, 1991). In this model, breathing practices can generate more 'energy', though the term energy has often been loosely and vaguely defined. This model is often associated with feeling and expressing emotions, particularly those that allow one to experience them more intensely. It is also frequently associated with specific strategies and body positions for breathing that support this intensification. Both conscious breathing and emotional expression are seen as resources for unblocking physical and psychological tensions and allowing a flow of natural and pleasurable experience.

The regulation model

Body psychotherapists look at breathing as a way to regulate physiological state as well as emotional and psychological state. Breathing is intimately tied up in the physical regulation of metabolic functioning as well as a regulation of emotional state (Bloch, Lemeignan, & Aquilera, 1991; Gilbert, 1998, 2002; Lowen, 1975; Masaoka & Homma, 2001). Emotions are themselves a temporary change in the intensity of feeling (LeDoux, 1996). From a biological standpoint, emotions are designed to come and go as a way to form adaptive responses to changes in the internal and external environments. Trouble arises when they do not come (repression or suppression) or they do not go (over-identification), or they become mismatched to the current situation. In these instances, we can say that emotional and psychological dysregulation occurs.

The regulation model of breathwork uses conscious breathing as a way to help a client stay within her/his 'window of tolerance' both on an emotional level and a physiological level (Ogden, Minton, & Pain, 2006), and be neither too aroused nor too depressed to be able to function in the session. In this model, breath is paired to a state in which the client is able to pay good attention to his/her current state and to stay mobilised and empowered within it.

Consciousness model

Throughout the ages, conscious breathing has been seen as eliciting mindfulness, expanded awareness and spiritual connection. According to Hendricks (1995), every spiritual tradition has breathing practices that support developing consciousness and enlightenment. Many of these practices have been influenced by Eastern philosophy, which holds that breath and aliveness are inextricably bound together. In many cases, this breathing involves a slowing down of and close attention to the nuance of the inhale and exhale. For instance, Boerstler and Kornfeld (1995) mention, 'This slower breathing rate indicates a deep meditative level, which will allow the person to experience that special point between self-consciousness and universal consciousness' (pp. 58–59).

Breathwork can also be linked to transpersonal states. 'The breath of life is our connection to the Divine Spirit that touches us all across the planet and relates us beyond ego to all living things' states Conger (1988, p. 187). 'The ancient view held that the soul was essentially the life of the body, the life-breath, or a kind of life force which assumed spatial and corporeal form at the moment of conception, or during pregnancy, or at birth, and left the dying body again after the final breath' (Jung, 1933, pp. 180–181). Jung added that the concept of ether or elemental breath is a widespread idea that connects the breath with life force.

In a current application of this model, Kabat-Zinn (1991) makes conscious breathing a cornerstone of his therapeutic system, called mindfulness-based stress reduction (MBSR). Developed out of his work with chronic pain sufferers, MBSR uses slow, even, conscious breathing as a means to lessen fear and anxiety, as well as to train one's attention to track but not identify with one's current state.

BP has also been influenced by the yogic traditions, especially in the arena of conscious breathing (Brown & Gerbarg, 2005; Heller, 2012; Sarang & Telles, 2006). Different yogic breathing practices are employed to cleanse toxins, calm stress,

promote relaxation, support the vigorous actions of some yoga poses and clear the mind and the heart.

In the consciousness model, set practices tend to dominate, though different practices promote different goals (such as meditative states, cleansing and energising). A common denominator is the search for a clear mind and body so that higher states of consciousness may emerge.

Conclusion

Attempting to meta-analyse the huge topic of the conscious use of breath in BP, this article began by describing the connection of breath with psychological well-being. Six clinical themes and four theoretical models were postulated, along with a balanced breathing exercise, allowing the authors to advocate for body psychotherapists to engage in specific training in breathwork practices and their nuanced application to individual cases.

Specific recommendations for the use of breathwork in BP include the following:

1. Teaching each client balanced breathing in the beginning of treatment as a crucial resource.
2. Taking a history that includes finding out about any illnesses that could have influenced breath patterns, as well as intense events that may have challenged breathing (birth trauma, drowning, choking, smothering, etc.).
3. Knowing what the contraindications of breathwork are, and being careful not to cause harm because of them. Classic contraindications of breathwork taken from the literature are as follows: (a) whenever physical or psychological symptoms develop, such as dizziness, pain or dissociation, (b) incipient migraine, (c) epilepsy, (d) hypoglycaemia, (e) heart problems, (f) diabetes, (g) obsessive compulsive disorder and (g) low impulse control.
4. Knowing a client's breathing patterns under stress, and how he/she/zi[1] uses breathing to regulate both positive and negative states.
5. Tolerating increments of consciously identifying an unbalanced breathing pattern and alternating it with balanced breathing as a way to gradually unwind the imbalance.
6. Finding the emotional and psychological associations with various breath patterns, and pairing the processing of one with the support of the other.
7. Facilitating the client to support positive affect with balanced breath (using breath not to just bring up negative emotions nor to calm from them).

Some overarching recommendations from the authors are for body psychotherapists to become better breathers, for body-centred therapists to have specific training in a variety of breathing practices and their clinical applications, for breathwork to match the client and his or her particular physiology and psychology and for a clinical capacity to engage with all four treatment models so that the therapist can switch between multiple approaches and methods in conscious breathing therapy.

Note

1. A gender neutral pronoun used to refer to a person that identifies outside of male/female gender norms.

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