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OBM Integrative and Complementary Medicine

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Original Research

'It's Nice for My Body but I Don't Like It' – Experiences of Soothing Rhythm Breathing in Clients with Depression

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Academic Editor: Peta Stapleton

Special Issue: Mind-Body Approaches that are Revolutionizing the Health Field

OBM Integrative and Complementary Medicine
2023, volume 8, issue 4
doi:10.21926/obm.icm.2304041

Received: August 25, 2023
Accepted: October 08, 2023
Published: October 11, 2023

Abstract

Soothing-rhythm breathing (SRB) is a core component of compassion focused therapy (CFT). While integral to CFT, research has yet to explore personal experiences of SRB. This study aimed to explore the experiences of individuals with depression who had practiced SRB in NHS primary care services. Interpretative phenomenological analysis (IPA) was used to analyse data from individual semi-structured interviews. Three experiential themes were identified: 'mind-body connection and bodily needs', 'a new relationship with the mind', and 'slowing down: shifting to the new and challenging'. Results highlighted the benefits of connecting with the body and the challenges of practicing SRB. Clinical implications and suggestions for further research are discussed.

Keywords

Compassion focused therapy; soothing-rhythm breathing; depression; interpretative phenomenological analysis; qualitative

1. Introduction

1.1 Depression

Depression is the most prevalent mental health problem worldwide [1] and a leading cause of disability [2]. It is estimated that 24% of women and 13% of men in England will receive a diagnosis of depression in their lifetime [3].

Recommended treatments for depression include anti-depressant medication, cognitive behavioural therapy (CBT) and short-term psychodynamic therapy [4]. CBT has been well-researched in the treatment of depression [5, 6]. Although estimates vary, relapse rates may be as high as 49% for cognitive therapies [7], suggesting the need for existing and new therapies to address this.

Shame and self-criticism are reported risk factors for the development of depression [8]. Self-criticism is positively related to depressive symptoms [9] and may serve as both a precursor and maintaining factor in depression [10]. Similarly, shame is associated with depression [11], and is associated with maintaining factors in depression such as rumination [12].

1.2 Compassion Focussed Therapy

Compassion focused therapy (CFT) was developed for mental health problems linked to high shame and self-criticism [8, 13] and is a promising treatment for depression.

CFT involves compassionate mind training (CMT), an evidence-based programme that includes psychoeducation and experiential exercises to cultivate the skills and competencies associated with compassion for both self and others [14]. This includes psychoeducation about the evolution of the human brain which gives rise to a tendency for negativity bias, rumination, shame and self-criticism, referred to as the ‘tricky brain’ [15]. CMT also teaches individual practices for activating 'soothing' emotions and parasympathetic feeling states linked to the experiences of care and interpersonal safeness [16]. These include mindfulness, compassionate imagery, body-focusing, and breathing practices [17]. Cultivating compassion (for oneself or others) can be a challenging experience, particularly for those who are prone to shame and self-criticism or have limited or negative experience of receiving care [18]. Therefore, an integral feature of CFT involves working with fears, blocks, and resistances (FBR) [19].

Soothing-rhythm breathing (SRB) is an essential component of CFT practice. It is designed to slow and deepen the breath, and to encourage the individual to focus on the feeling of the mind and body slowing down. SRB practice also draws focus to bodily cues linked to care and soothing such as touch, voice tone, and friendly facial expression [15], which are associated with ventral vagal activation [20]. Aspects of SRB such as slowing the breath and making physical changes with the body are intended to stimulate the vagus nerve and assist parasympathetic regulation [21].

There is increasing evidence of CFT’s effectiveness A recent review exploring compassion-based interventions found moderate effect sizes for reducing symptoms of depression and anxiety, and showed improvements in levels of compassion, mindfulness, and well-being [22]. Group-based CFT is associated with reductions in depression, anxiety, self-hatred and fears of compassion, improved sleep, and self-compassion [23, 24]. There is also evidence that SRB has several physiological impacts thought to be beneficial for wellbeing, including reducing arousal, activating the parasympathetic nervous system and improving heart rate variability (HRV), which is a measure of vagal activity [17].

1.3 Breathing Practices

Breathing practices have a long history in psychotherapy [25]. Examples of breathing practices used in the treatment of depression include breathing meditations in mindfulness-based cognitive therapy (MBCT), where attention is anchored to the breath and experienced as a whole-body process [26]; coherent breathing, which entails breathing through the nose with equal duration of inhalation and exhalation at an average rate of five breaths per minute [27]; and heart-rate variability biofeedback which aims to increase heart rate oscillations (or variability) through slowing the breath while giving real time feedback on variability [28, 29].

The rationale for breathing practices in the treatment of mental health problems is often attributed to the role of breathing in autonomic function [21, 30]. Autonomic function refers to the dynamic shifting between sympathetic and parasympathetic nervous systems [31]. The ability to activate the parasympathetic system is associated with vagal activity, which relates to the body's ability to regulate emotions, self-soothe, connect with others, and perform higher order cognitive functions [31]. Parasympathetic activation is also associated with mentalisation [31], which may allow identification and interruption of ruminative thinking patterns in depression.

1.4 Current Study

Despite the central role SRB plays in CFT clinical practice, there has been no prior research exploring the subjective or lived experience of its application. Whilst CFT has some evidence in treatment for depression, it is not known which aspects of it are most effective. CFT is a process-driven approach and is tailored to the individual, suggesting the importance of research focussed on specific components and processes to understand their impact and reception. Process-focused research in CFT, focusing on specific methods, has already proved fruitful in clarifying what clients find important and helpful in chairwork, shaping future training [32]. Additionally, a salient aspect of CFT involves identifying and working with an individual's FBRs to compassion and experiences of soothing, safety and slowing down [33], which can be difficult for individuals with a history of trauma or inadequate care [19]. The current study aimed to explore client experiences of SRB, to provide valuable insight into the mechanisms or factors of the technique that facilitate change for an individual, and any challenges or barriers it may yield, forming part of CFT's understanding of the blocks and benefits to practising self-compassion.

2. Method

2.1 Design

The study employed a qualitative approach, using an interpretative phenomenological analysis (IPA) methodology. IPA seeks to develop an in-depth understanding of the experience and meaning-making of participants in relation to a given phenomenon, and is based on phenomenological, hermeneutic and idiographic principles [34]. The current study's focus on informing therapy through the experience and perspective of clients is in line with IPA's principle of 'giving voice' to participants [35].

2.2 Intervention & Recruitment

Recruitment of participants was aided by clinicians delivering CFT in primary care Improving Access to Psychological Therapies (IAPT) settings. Clinicians identified clients who met eligibility criteria then shared study information and asked about interest in participating. The researcher then contacted potential participants to offer further information about the study and obtain informed consent. Participants were given a 'cooling off' period of at least one week between signalling interest and being interviewed.

Prior to the recruitment of participants, the researchers developed an SRB protocol (informed by Gilbert (2010) [33]) and provided training to therapists delivering the intervention to ensure standardisation and fidelity, and to develop interest in the project and enhance participant recruitment. Therapists audio-recorded their delivery of the SRB intervention in-session and shared this with the researcher, the audio recording was checked to ensure that core components of the exercise took place.

2.3 Participants

Purposive sampling was used. This is a non-random method of sampling which involves recruiting participants who have experienced the phenomenon of interest, while considering pragmatic factors such as availability, willingness to participate, and the ability to communicate experiences [36]. Purposive sampling is a key feature of IPA, in which samples are often small and homogenous, allowing for exploration of a specific phenomenon in a specific context [34]. This aligned with the aims and focus of the current study: looking particularly at participants with depression in a primary care setting (specific context), receiving SRB (the phenomenon of interest) as part of their intervention.

Inclusion criteria included participants: meeting eligibility criteria for IAPT, in receipt of CFT and SRB as part of their routine care, and having a 'provisional diagnosis' of depression or low mood (as judged by the assessing clinician). The use of 'provisional diagnosis' is a routine part of IAPT assessment as outlined by the National IAPT Programme Team (2011) [37]. Participants were also required to score over nine on the Patient Health Questionnaire (PHQ9), which is considered the 'cut off' for clinical depression [38].

Eight participants (n = 8) were recruited from IAPT services. Sample sizes vary in IPA and smaller sample sizes are preferred to facilitate in-depth analysis [34]. Smith et al (2009) [34] recommends four to ten participants for studies of this kind (a doctoral thesis).

Participants were between 21 and 65 years old (mean = 37 years). Participants were recruited on a first come basis and no participants who met inclusion criteria were excluded. All participants had a provisional diagnosis of depression were undergoing CFT in an IAPT setting at the time of interview.

Participant demographic data are shown in Table 1.

Table 1 Participant demographic data.

Participant pseudonym	Age	Gender	Ethnicity
01. Jane	21	Female	White- British
02. Ali	41	Female	White- British
03. Lucy	38	Female	White- British

04. Marie	40	Female	White- British
05. Emma	36	Female	Asian/Asian British- Pakistani
06. Steph	33	Female	White- British
07. Sue	65	Female	White- British
08. Beth	22	Female	White- British

Several measures to describe characteristics of the sample were taken at the time of interview:

- PHQ-9: nine-item brief measure of depression severity. This measure was used as an indicator of level of depression.
- The Compassionate Engagement and Action Scale (CEAS) [39], comprised of three scales measuring self-compassion, ability to be compassionate to the distress of others and ability to receive compassion from others.
- Forms of Self-Criticising and Self-Reassuring Scale (FSCR) [40]. A 22-item measure of self-criticism and the ability to self-reassure.
- Other As Shamer Scale (OAS) [41], an 18-item measure of external shame (how others judge the self).

Participants scored a mean of 16.14 (SD = 5.11) on the PHQ-9 at interview, which is categorised within the moderately-severe depression range [38].

Whilst not based on statistical analysis, on the CEAS, participants scored higher on 'compassion for self', engagement scales (M = 34.13, SD = 7.18) and lower on action scales (M = 19.14, SD = 5.96) compared to a non-clinical sample (engagement, M = 24.80; action, M = 28.25) [39]. On 'compassion to others' scales, participants scored higher on engagement (M = 51.14, SD = 4.09) and action scales (M = 35.38, SD = 2.34), compared to a non-clinical sample (engagement, M = 43.48; action M = 31.67). On measures of 'compassion from others', participants scored slightly higher on engagement scales (M = 36.71, SD = 7.09) and lower on action scales (M = 27.75, SD = 4.47), compared to a non-clinical sample (engagement, M = 36.11; action, M = 31.67).

Participant FSCR scores were: on the 'inadequate self' (IS) (M = 28.57, SD = 4.03) and 'hated self' (HS) (M = 11.57, SD = 4.30) scales, (M = 12.57, SD = 5.63) for the 'reassured self' (RS) scales. Compared to previous research, participants scored higher than average on IS (M = 17.72) and HS (M = 3.88) scales, and below average on the RS measures (M = 20.27), compared to non-clinical samples [42].

Participant scores on OAS (M = 37.71, SD = 11.04) were higher than the average for a non-clinical sample (M = 20.0) [41].

2.4 Procedure

2.4.1 Data Collection

Data was gathered via semi-structured interviews with the first researcher. Interviews took place over video-call, keeping the camera on to aid communication. Examples of interview questions included:

- Please tell me about your overall experience of the (SRB) exercise?
- How did you find slowing down your breath and focusing on your breathing?
- What was it like to change your body in different ways: changing posture, facial expression, touch, and voice tone?

- Can you tell me about any emotions or feelings you noticed during that exercise?
- What will you take from the exercise? Is there anything important that you have learnt or will remember?

Interviews took place at least one-week after the introduction of SRB in therapy to allow for the exercise to be practiced independently. Interviews were audio-recorded and transcribed by the researcher. Once transcribed, audio-recordings were anonymised and deleted. Participants were asked to provide pseudonyms which were attached to their data.

2.4.2 Ethics

The study was approved by the University of Manchester Research Ethics Committee and the NHS Health Research Authority (IRAS 305061).

2.4.3 Analysis

Analysis of the data followed IPA's six-stage procedure [34]. Each participant's data was initially analysed individually, on a case-by-case basis. The first step of the analysis involved reading an individual's transcript multiple times to gain a sense of the salient phenomena described by participants and the meaning they ascribed to it. The second step involved noting of initial thoughts and impressions. In the third step, these initial impressions were converted into experiential statements or themes. The fourth step involved the grouping of experiential statements and themes into superordinate and subordinate themes and exploring the relationship between themes. This process was repeated for each participant in the fifth step. In the sixth step, a table of themes was produced to explore the repetition of themes across participants.

Throughout the research process, the researcher kept a reflective diary; this noted expectations, assumptions and thoughts that might influence the analysis process, helping them to reflect on, and manage, their own interpretative process. This was particularly useful for monitoring expectations prior to analysing new interviews, for example noting an expectation that participants may have struggled with slowing down, or had a sense of frustration around this, based on analysis of the previous participants' interviews. Once identified, the researcher was able to return to the raw data to explore contradictions of this. The reflective diary was also used in research supervision to explore alternative interpretations of the data.

To ensure that themes were grounded in the data, and that the analytic process was both systematic and transparent [34], the research supervisor independently analysed three transcripts to compare with the author's analysis. Differences in interpretations were discussed and integrated into the analysis.

3. Results

From an IPA analysis of the dataset, three interconnected but distinct themes were developed, shown in Table 2.

Table 2 Group experiential themes and subthemes.

Main theme	Sub theme	Number of participants
Mind-body connection and bodily needs	Strengthening the mind-body connection	8
	Accessing bodily and 'human' needs	8
A new relationship with the mind	Relating to mind and thoughts differently	8
Slowing down: shifting to the new and challenging	Shifting into a new way of being	8
	Feeling too slow and counter-intuitive	7

3.1 Mind-body Connection and Bodily Needs

3.1.1 Strengthening the Mind-body Connection

Most participants reported a greater sense of connection with their body from the practice of SRB. Participants reported a heightened sense of awareness of bodily sensations and an enhanced focus on their physical experience that felt somehow novel and strange. For Emma, this was experienced as form of re-connection to the body, and a sense of re-discovery:

It was the physicality of it, sort of being present with the physical. So you know sometimes, it sounds funny, sometimes I don't really feel very present with my body. Like I don't really think about how I'm using it, what I'm doing…I realized it was a bit disconnected from me, you know, so it's quite nice to sort of do the breathing, and feel a bit connected. (Emma)

For Emma, SRB re-connected her with her body in the present moment, whilst also highlighting how disconnected she was from her body during her daily life. Such increased awareness of the body appeared to foster a new relationship with it. A greater sense of connection between body-parts was felt, with some participants describing feeling the body as a whole or 'joined up' system, as described by Beth:

The feeling of breathing like in your lungs and in your stomach and stuff, and forcing yourself to breathe a bit more exaggerated almost, and feeling each part of the air going in and out. It kind of made me be connected as like a tube. (Beth)

As Beth explained, the breathing practice appeared to bring a specificity and rich granularity to people's experience of their body, with the focus on the movement in the stomach, and the air moving across the throat. Whilst Beth described the sense of connection as a tube linking body parts, Ali described it as a connective chain from head to toe:

Almost like there was a connective chain of, yeah. It was going up down my feet, back up my feet, up through my head and all the way back down. So literally grounded, like I'd been put in the garden in soil. (Ali)

Ali's description of being '*put in the garden in soil*' also captures the notion of feeling grounded or rootedness within the body, but also perhaps symbolized a sense of growth and regeneration. Ali continued to use natural imagery in her description of how it felt like '*a dam broke'* creating a rush of feeling, leading to a break-through between body and mind, and a sense of being '*full*' while taking in the breath.

Whilst most participants reported benefit in such connection, two participants had a contrasting view. Lucy reported the experiences was *'at times quite alien'*, suggesting such connection was foreign to her usual state of disconnection:

At times quite alien, depending how long you've been living up here [pointing to head]. So getting back into my body can feel quite odd. But ultimately it feels like I'm trying to do a good thing. (Lucy)

Although Lucy found elements of the SRB procedure challenging, she was ultimately assured of its benefits. Jane was more vocal in her discomfort with SRB practice. For Jane, focusing on her bodily sensations in a sustained way felt at odds with her understanding of herself as someone *'who is constantly moving'*:

It is useful then, but I really don't enjoy it, as someone who is constantly moving. And it is nice to calm down, but I don't like too, for my body to calm down. But that's, I don't like that, it's not something I actually like. It's nice for my body but I don't like it. (Jane)

This juxtaposition created a sense of dissonance, with Jane rationally acknowledging the benefit of calming and connecting with the body, although this conflicted with her intrinsic want for activity and external focus.

3.1.2 Accessing Bodily and Human Needs

Through the strengthening of the mind-body relationship, participants began to feel greater attunement to the body, which allowed them to identify bodily needs, a sense of common humanity and increased control of the body. The richness of this new relationship is best illustrated in the experiences of Lucy who found connecting with the breath broadened her sense of identity, as if expanding beyond just her thoughts:

To allocate time to consciously breathing is, reminds me that I am not just my thoughts, I am a creature with basic needs, that like needs to see daylight and be in my body. (Lucy)

This allowed Lucy to connect with her basic animal-like needs (*'I am a creature'*) in a way that she had previously overlooked. Such experiences fostered a more compassionate understanding of her needs and permission to prioritise and attend to these:

I break promises to my body .... I feel like I'm a bad parent to my body sometimes. So the breathing is, I guess, trying to sort of be present with that, instead of thinking about the times that I've, you know, broken a promise in the past. (Lucy)

There was an underlying sense of discovery, that the body and its needs could be connected to in real time, and a sense that the neglectful relationship could be repaired by a new parental attitude. Lucy further described wanting to care for her body, evident in her use of maternal imagery and nourishing the forgotten needs and parts of her body:

I guess it's about imagining that breath filling those parts of my body and nourishing it … I imagine it almost like a light, like a warm light, like I'm trying to send kindness to, through my breath, like saying 'I'm sorry I forgot you, but I'm aware of you now'… it feels almost like a maternal sensation of just, sort of like, I've not been looking after, taking care of the whole part. (Lucy)

Her conception of this process being like a warm light illuminating previously hidden elements of the mind-body connection suggested that the process was not one of establishing a connection but of repairing it. SRB brought a sense of immediacy to the relationship, the ability to be present with the body and actively communicate with its needs.

Connecting with the body and understanding its needs helped participants appreciate the humanness of their experience. Participants described being reminded of 'being human' by connecting with their body:

My body feels heavy, it grounds me… it reminds me like I have a body, I am a human (Jane)

For Lucy the process was *'reminding me that I'm a living organism'*, while Beth described feeling '*more like of a real person'* when connecting with her breath. This also allowed for a fresh perspective on difficulties, for example Jane feeling less overshadowed by depression:

I think the grounding feeling just, just reinstates that, I'm a human being, I have a body, I'm here. And for me that's what that does, it reminds me that, like I have a brain that has a chemical imbalance. It just reminds me, the facts I guess, that I forget sometimes when I overthink or when my mental illnesses overshadow all those facts (Jane)

The deeper connection or 'grounding' in their innate humanness added a redemptive quality, allowing a re-connection to a sense of common humanity, with Jane '*reinstating*' that she is a human being, facilitating a more compassionate understanding of depression as a human condition. A lessening of self-blame was similarly a key takeaway for Ali, who had generated a more compassionate understanding of her difficulties through SRB and identified that there had previously been '*missing connectivity*'.

I think probably a little bit more compassion that I'm thinking, instead of self-blame and of the 'I'm broken', that there's been an absence of something that I'm having to find for myself. No one's going, was gonna knock on the door and say 'hey here's this connectivity that you've been, you've been missing'. (Ali)

This marked a perspective shift, from previously understanding herself as '*broken*' to a realisation that there was viable connectivity with humanness and the body. However, there was also a sense of loss in acknowledging the time spent without such connection and a realisation that this was something she needed to do for herself.

3.2 A New Relationship with the Mind

3.2.1 Relating to Mind and Thoughts Differently

In connecting with, and focusing on, the body, participants experienced a shift in their relationship with their thoughts. The exercise became a means for participants to manage their depressive thinking. Ali described noticing fewer critical thoughts, and a difference in how she related to thoughts with '*less attachment'*. Marie went further in describing a newly discovered sense of mental clarity and calmness: '*it makes me feel, my brain just feels a bit more clearer or something'.* Similarly, Lucy spoke about the process of connecting with physical aspects of SRB to gain space from thoughts:

There is a moment where you're locked in the room with your thoughts and you're paying more attention to them. But then eventually it's like 'I'm aware of you, but please just give me a minute to like, you know'. And then it's just locking onto my breath, and it can be quite, take, require a lot of concentration to try and just sort of like stop all of the thoughts and just like focus on the physical process. But it's ultimately a massive relief. (Lucy)

This shift from being locked in with thoughts to locking onto her breath changed her sense of power and agency over her thinking. Her previous sense of being '*locked in a room'* with these thoughts had been replaced with a sense of hard-won freedom and relief.

Participants described using the body as an anchor to be present, rather than merely as a tool to distract them from thoughts. The ability to connect to the present moment led to slower or fewer thoughts and enabled a sense of mental clarity and spaciousness. For Marie, the ability to calm the body and mind helped her to detach from a cascade of negative thinking:

So, I think it just allows me to calm it down. Sort of slow everything down. And then any thoughts that do come, I'm like 'you're being silly' I could push, deal with them better … rather than just more and more negative thoughts keep coming in… It's much better when I'm in a calmer state, to be able to deal with thoughts that are coming in… And a more rationally instead of catastrophising. (Marie)

By slowing and detaching from the emotional qualities of her thoughts, Marie gained the ability to process and assess her thoughts with a calmer and more reflective perspective. Similarly, Emma was able to gain a different perspective on thoughts and realised that she did not need to be led by them, but rather she could show herself compassion and allow herself time to relax:

One of the times I was just in the kitchen and I just thought after it, was actually, well I don't really need to be that stressed out like the baby is asleep, yes, there's a lot to do in the kitchen, and I'd really love to but right now, I don't really need to be that stressed out (Emma)

Two participants reported that prior to the SRB they had managed their rumination with alcohol, which was seen by them as a means of coping or escape from a sense of spiralling. Marie discussed how SRB allowed her to slow down her thoughts, rationalise them, and use the breathing to prevent that spiralling as opposed to using alcohol for the same effect:

It was like 'oh I've figured out a way to not let them spiral.' … I'm hoping that this replaces that. That like the … need to like stop it with drinking or self-harm, or drugs or something like that… it doesn't need to stop it, it just needs to allow me to rationalize them, and actually think through what's happened calmly. Rather than it being a catastrophised and blown up in my own head (Marie)

The process had instilled a sense of hopefulness and empowerment that the spiral could be prevented by herself rather than relying on external measures she rationally knew were harmful. In a similar way, Ali was optimistic about the role of SRB in providing a replacement for substance use:

And that's that investment in me, we're now a point in my thinking, yeah 'I deserve it, I'm worth it'. This feeling is obtainable without having drugs or alcohol, or frying my brain up (Ali)

Ali's ability to step back from self-critical thoughts and connect with a sense of self-worth, perhaps tied to an increasing sense of agency over her body and mind from SRB, facilitated a realisation that she could dispute the power of such thoughts through the breathing practice.

3.3 Slowing Down

3.3.1 Shifting to a New Way of Being

SRB not only offered an alternate way to cope with negative cognitions, it also offered a means to shift into a different way of being, one that was in direct contrast to participants' past patterns. Lucy acknowledged the inherent difficulty of admitting to herself that her previous mechanisms of dealing with that were ineffective:

I'd say that slowing down is probably my ultimate goal. Particularly, those days when I'm feeling like I'm overwhelmed it can be, like I'd say, uncomfortable to sort of step through that barrier into taking care of, accepting that like your process isn't effective, you know, and stepping out of your thoughts into like your reality in that moment, is to say 'this isn't working'. (Lucy)

Participants described slowing down as calming and giving them an opportunity to pause and slow down more generally. Sue described a connection between slowing the breath and feeling calmer:

The slower breathing, you know, kind of helped sort of make me feel calmer and less anxious. As well as the actual physical, you know, in my head I felt less anxious and stressed. (Sue)

The newfound sense of calm that Sue identified was felt in both body and mind. Beth described the relaxing aftereffects of SRB, enabling her to feel grounded and in the 'flow':

I kind of did feel a bit more relaxed like after I had finished it as well. Like for kind of the next half hour after I felt a bit more like down to earth type of feeling, like just it's a bit flowy. (Beth)

For Beth, her description of 'flowy' conveyed a sense that she felt better at ease and lifted while simultaneously also feeling rooted in her body. For others, slowing down had a more rooted feeling, and was important in gaining a sense of control. For Lucy, slowing down allowed her to stage an intervention with her own mind, and access a different mindset or 'channel':

It just becomes like a, just, having two TV channels on in your head at once… And then at that point, it's you know staging an intervention with your own brain, we're just going to put the brakes on this. (Lucy)

SRB had disrupted normal routines and patterns of self-criticism both by reducing the amount of noise in her mind *('having two TV channels on'*) and enabling her to unhook from these cycles (*'putting the brakes on'*), in turn creating space for new ways of self-relating.

Some participants reported that slowing down through SRB offered an opportunity to reset and recalibrate, as described by Marie:

It helps reduce the thoughts and negative thoughts or feelings, or whatever, and just calms me down. To allows me to focus on a task that I might want to do that day, and just reset myself. (Marie)

This reset not only helped her manage thoughts and feelings but practically enabled her to connect with valued activities. Lucy found the ability to reset both renewing and tranquil:

It feels like sunrise. It feels like this recalibration of just like a warm safe place is the best way I can describe it. But where there's just like a moment of, yeah, of quiet. (Lucy)

Her poignant description of this moment of serenity, connection with a sense of warmth and safety, and metaphor of a sunrise alludes to an opportunity for new beginnings and a sense of optimism.

For Steph, slowing down gave her the opportunity to remind herself that she was able to cope:

To have something that I could give myself a moment to 'now you've got to do this, get in the car, and from the car to the hospital, now we've just got to wait' you know. … it was it, just relief, I think that's the main, that that you can do it. (Steph)

Slowing down allowed her to break tasks down and implement effective coping strategies, which in turn empowered her to have more self-belief that she could achieve her goals and cope more globally.

3.3.2 Feeling Too Slow and Counter-Intuitive

Whilst most participants spoke about the merits of slowing down and its practicability in day-to-day life, some did struggle with aspects of this. Jane found slowing down felt counter-intuitive in managing low mood:

If I'm anxious and I'm, my thoughts are going like, darting around, going very fast, and I'm overthinking, and there's a lot going on in my head, it's great. But if it's not like that and it's just low mood, then, then I don't like my body slowing down because… I just focus on those bad thoughts even more. It kind of does, just for me, it just like amplifies it even more… I always need something to do, always need something to think about (Jane)

The idea of slowing down and calmness in a period of low mood felt like it exacerbated feelings of depression for Jane. Slowing down meant that Jane connected with thoughts that she had previously distracted herself from through being busy. The process of slowing down was at odds with her previous coping strategies, which may have been a barrier to engaging with the practice.

Steph identified that slowing down helped her to break from cyclical thought patterns, but she felt it did not have a similar impact in managing low mood.

It don't help the low mood though, I can't explain it… I feel it works for bringing myself back down… So if I'm feeling like really anxious, and I'm going over and over things that don't matter. That's what it helps bring me out of. But not, I think the low mood is, the low mood to me is a personal thing. So like it's personal attack against myself. That's what my low mood is. (Steph)

Jane and Steph made comparisons with practicing SRB when anxious, which may have influenced their expectations of the practice. Their initial experience of feeling a reduction in anxiety may have given them a belief that this would transfer to an ability to reduce low mood and were perhaps disappointed when they felt it did not.

Some participants described a sense of strangeness with slowing down, occasionally accompanied with a fear of consequences of this:

It's just a weird feeling. It's not uncomfortable. It's just weird. The only thing that I think, like now I'm not worried as much, at first I was like, 'oh, why'. Part of me is always worried that I'm gonna open the floodgate. (Marie)

For Marie this was a fear of connecting with strongly felt emotions and subsequently how she would deal with these. Her imagery of '*floodgate'* conveyed both that feelings had been pent up for a long time and an underlying concern that it might be damaging to have them all released at once. The metaphor implied a sense of irreversibility that she was perhaps reluctant to engage with, for fear of worsening her mood or turning to harmful coping strategies.

For Ali her sense of fear was grounded in the idea that slowing down would leave her soft and vulnerable:

I think I was scared. Am I gonna be like Mr Soft at the end of all this? Is nothing gonna you know, am I gonna be like bendy all over the place, and nothing's gonna bother me? [Ali]

There was an association between being soft and weakness of character. She feared the result of slowing down and connecting to a more vulnerable position would render her weak, or unbothered by potential threats, and fundamentally unable to protect herself. Both Marie and Ali's reservations around SRB were rooted in the difficulties of trusting both the process and its outcome, and how in turn they would be able to deal with it.

4. Discussion

Three main themes were apparent across all participants. Firstly, connecting with the body allowed participants to nurture its needs, and to connect with 'human' experiences. Secondly SRB also helped participants to 'step out of the mind' allowing a different, and distanced, perspective on

their thoughts. Thirdly, the theme of slowing down (slowing the body and slowing the mind) provided a sense of empowerment to reset and choose effective actions. Challenges were also apparent when participants found slowing down counter-intuitive to manage low mood.

4.1 Mind-body Connection and Bodily Needs

Participants' previous disconnect from the body was highlighted by their engagement with SRB. Previous research has highlighted the relationship between the body and depression [43, 44]. Depression has been linked to different states of embodiment, sometimes conceptualised as 'hyper-embodiment' with the body experienced as heavy and rigid, or a sense of disconnect from the body [45]. Disturbances of embodiment in depression have been experienced as a loss of connection or agency over the body, with the body experienced more as an object or from a third-person point of view [46]. These experiences also have parallels with depersonalisation, a dissociative experience in which there is a sense of detachment from oneself [47], which can be a feature of depression [48].

For participants, greater connection to the body encouraged increased awareness of bodily sensations and present-moment experiences. Literature in the field of mindfulness suggests that mindful activity (mindful breathing) may reduce depressive symptoms, such as rumination [49]. Michalak et al. (2012) [43] also suggested that using the body as an anchor for present-moment awareness reduced rumination and depressive symptoms. Greater awareness and attunement with the body may allow detection of signals of worsening or returning depression, helping to stop a cascade of unhelpful responses (such as rumination) and allow helpful actions to take place [26]. Mindfulness may also serve as a valuable component in the treatment of depersonalisation and depression [50].

Increased mind-body integration offered participants contrasting experiences to those associated with depression. Intentional shifts in the body during the practice, such as changes in posture and facial expression, may impact on emotional states [51]. For example, Wilkes et al. (2017) [52] found that upright posture increased positive affect in participants with depressive symptoms.

As well as highlighting the contrast in experiences, directing attention to the body and the mind-body integration helped reveal previously unmet needs. This phenomenon has been described in mindfulness literature, allowing people to decide more consciously on meeting their needs while considering long term aims [43].

The importance of increasing awareness of the body and identifying its unmet needs is shown in the definition of compassion in CFT: to demonstrate sensitivity to suffering whilst committing to alleviate it [18]. In the context of tuning into the body, this could be seen as the first aspect of compassion, tuning in (rather than out) to find out what is painful and what, ultimately, is needed for its remedy [18].

Connecting with the body and its human needs helped participants to connect to a broader sense of humanity, potentially aiding compassion through developing a new relationship with the body. Neff (2021) [53] suggests that this sense of common humanity is inherent to self-compassion, and recognising life challenges are part of human experience, encountered by all. This implies a fundamental empathy in the experience of suffering, and it derives from the recognition that the human experience is imperfect [53]. Connecting with a sense of common humanity may have broadened participants' sense of identity and belonging, from a disconnected or isolated one to a more connected human perspective.

4.2 A New Relationship with the Mind

Connecting with the body offered a new way of relating to the mind, with a sense of moving down into the body to be able to relate back up to the thoughts from a different 'place'. This offered a sense of choice and agency, especially important in depression which is associated with lack of agency, entrapment, and powerlessness [54].

This phenomenon may be conceptualized as a form of 'de-centering' which has been a prominent focus for many second and third wave cognitive therapies, such as metacognitive therapy, mindfulness-based therapy, and acceptance and commitment therapy [55]. It has variously been referred to as a 'metacognitive' perspective [56], an observer or mindful perspective [57], or as cognitive defusion and experience of the self as context [58]. These approaches encourage a focus on present-moment experiences of the body, as a way of building cognitive capacity and 'de-centering'. The current findings add further support to this phenomenon and the benefit that participants may experience from 'de-centering'.

Agency, choice, and empowerment were interwoven throughout the main themes. Participants described slowing down as an opportunity to reflect on action, achieve a sense of soothing and connect with ideas learnt through therapy. Relating to thoughts differently allowed an alternative perspective on worries. Connecting with the body facilitated ideas around regulating emotions. For example, learned hopelessness, entrapment, subordination are seen as key factors in depression, and are linked to evolutionary conceptions of depression. Theories addressing this explore the adaptive function of depression, such as Gilbert's (2017) [59] social rank theory which highlights the association between depressive symptoms and loss of social status serving as a protective function for group inclusion. Similarly, shame and self-criticism are linked with subordination and loss of power from an evolutionary perspective [33] further illustrating the utility of interventions that build a sense of agency and freedom.

Participants reported using the body to support the mind, which links to CFT's aim to work on bottom up (body first) processes rather than using cognition to change mind and body (top down) [18]. Participants reported gaining space from thoughts, an ability to relate back to process rather than be caught in content, with greater clarity and perspective. This is perhaps linked to mindfulness qualities of SRB practice (body focus supporting these mindful qualities, with body used as an anchor) and greater control or awareness of attention [57]. This is in line with Park & Park's (2012) [60] findings, that paced breathing increased internal attention in participants, as well as increasing parasympathetic activity. Reduced cognitive fusion may have occurred from this new stepped-back position with thoughts, with participants reporting greater ability to mindfully notice thought patterns associated with depression, such as self-critical thought patterns [61]. This may also be shown in the relationship between mindfulness and ruminative thinking in depression [62]. Segal et al. (2002) [26] proposed that the ability to be mindfully aware of thought patterns can reduce patterns of ruminative thinking. The ability to break these patterns is important as ruminative thinking is thought to be a salient factor in the maintenance of depression [63] and a marked contributor to relapse [64].

This body first (bottom up) approach may provide a helpful alternative or adjunct to cognitive approaches, particularly for cognitions that are difficult to change, as supported by a recent meta-analysis by Sverre et al. (2022) [65]. Sverre et al. (2022) [65] found that mindfulness-based treatments and CBT were equally efficacious in treating depression, noting differences in these

approaches to working with cognitions (such as cognitive restructuring in CBT and taking an observational stance with cognitions in mindfulness-based approaches). The authors further suggested that this provided greater choice in first-line therapies for clients and therapists [65].

Breaking out of loops of self-critical thinking and catastrophising was reported by participants. These may be conceptualised as loops in the mind between old brain and new brain, sometimes labelled 'tricky brain' [33]. Mindfulness is often used in CFT to break from old-new brain looping [33]. Bringing a mindful awareness to thoughts appeared to aid a different relationship with these types of thoughts, give perspective and allow alternative action. Similarly, two participants discussed their use of SRB instead of destructive coping (such as alcohol) to deal with thought processes, breaking depressive spirals.

4.3 Slowing Down: Shifting to a Different Way of Being and Feeling Too Slow and Counterintuitive

Slowing down was likened by participants to switching channels or as a new sunrise. Such changes were not experienced by a change in cognition alone, but by a holistic whole-system change, both mind and body. Slowing down and calming the body are associated with stimulating the parasympathetic soothing system [66]. In mammals, the soothing system is associated with attachment and social connection, as well as having 'rest and digest' functions [66]. Slowing the breath and accessing the soothing system is physiologically connected to vagus nerve activity [22], supporting the inter-play of mind and body in accessing soothing [20]. The ability to access the soothing system is also important to balance this in relation to the other emotional systems, and an ability to move out of threat and drive-based affects, and to down-regulate negative emotional states, such as shame and depression [15]. It has also been suggested that integrating breathing practices into wider interventions may also enhance therapeutic sessions by balancing the autonomic system and reducing stress during sessions [67]. Erkkilä et al. (2021) explored this by integrating a paced breathing practice (resonance frequency breathing) into music therapy, which produced greater improvements in outcomes of depression than therapy alone [67].

The soothing system is also important in developing an internal sense of safeness [16]. Participants reported a sense of warmth, calmness and safeness associated with slowing down. Internal safeness is different from a more general sense of 'safety', as a general sense of safety may use physiological processes governed by threat-based responding (for example, in which attention may be focussed on the avoidance of threat or harm) [18]. SRB adds in social safeness cues, such as touch and inner voice tone [68].

Some participants described slowing down as 'alien' and were concerned about dropping hypervigilance. Slowing down also interrupted distraction or activity-based coping and put participants in contact with difficult or avoided feelings. This may suggest the presence of threat-based responses to SRB, for example in the use of safety-seeking behaviours such as distracting from or avoiding the practice. Some participants discussed working through FBRs by adapting the length of the practice, while others avoided it. This highlights the importance of working with FBRs with clients, particularly in the area of slowing down and connecting with the soothing system [19]. This suggests the importance of sensitivity to how people engage with the practice, allowing adaptations such as giving an external focus for attention, considering speed and pace of the practice, or offering a graded approach.

4.4 Limitations & Recommendations

One limitation of the sample was the lack of male participants. The purposive sampling method may have led to a sample of only people that therapists expected would respond well to SRB; further research might focus on adverse experiences or task refusal. Similarly, therapist personal practice may have influenced SRB practice as a broad range of therapists were involved in recruitment. Although a reasonable sample size for IPA was used, further research could check robustness of themes across bigger samples.

Whilst therapist facilitation of SRB was quality-checked by reviewing audio recordings, there was no control of when SRB took place within the course of therapy, and there was potential variation in what had already occurred within the course of therapy. Although a minimum length of practice was implemented (one week), the length of time participants practiced SRB may have varied, with the practice introduced at different points in therapy. It is therefore unclear when SRB is best applied.

The study is also limited by the lack of formal diagnosis for depression. However, the use of IAPT routine outcome measures (PHQ-9) and the 'provisional diagnosis' from the assessing clinician [37] replicates how clients would be selected for treatment within NHS primary care services.

The current study explored experiences of SRB in participants with depression as their main presenting problem. Participants were not excluded from the study if they had co-occurring problems (such as anxiety), it is therefore unclear if themes are particular to depression. Similarly, participants may have had varying therapy durations, co-occurring pharmacological treatments and medical comorbidities. Future research might explore this in other populations and presentations.

The variation in experiences of SRB emphasises the importance of careful exploration of difficulties arising during SRB practice (for example when slowing down). These difficulties may relate to client FBRs and highlight important mechanisms in the maintenance of depression (such as ruminative thinking, or an expectation that low mood can be eradicated completely). Participants offered accounts of ‘working through’ or adapting to these difficulties rather than stopping the practice or avoiding challenges, indicating that attending to such challenges in therapy is important. This also highlights the importance of a flexible approach to the practice, for example some participants found it helpful to complete the practice in a graded fashion, or using the parts they found most helpful at times they may have struggled to complete the entire practice.

These findings have implications for CFT training, suggesting that clinicians be trained to predict, normalise, and value the difficulties during SRB rather than expecting the method to generate a homogenous experience of soothing. This suggestion is in keeping with prior research on FRBs to compassion [19] which concluded that ‘understanding the wisdom in the client's FBRs, and validating and de-shaming the client's FBRs are crucial’ (p.850). Future training of clinicians might include an emphasis on the expectations that clients hold about CFT and the treatment of depression, and a focus on adapting core CFT exercises to idiosyncratic needs. Advanced and specialist training in CFT is also something that clinicians might consider from the Compassionate Mind Foundation (https://www.compassionatemind.co.uk/).

Abbreviations

SRB	soothing-rhythm breathing
CFT	compassion focused therapy
NHS	National Health Service
IPA	interpretative phenomenological analysis
CBT	cognitive behavioural therapy
CMT	compassionate mind training
FBR	fears, blocks, and resistances
HRV	heart rate variability
MBCT	mindfulness-based cognitive therapy
IAPT	Improving Access to Psychological Therapies
PHQ9	Patient Health Questionnaire
CEAS	The Compassionate Engagement and Action Scale
FSCR	Forms of Self-Criticising and Self-Reassuring Scale
OAS	Other As Shamer Scale
M	mean
SD	standard deviation

Author Contributions

All authors were involved in the planning and design of the project. The first author (Jasmine French) carried out all interviews, analysis and write-up of the paper. The second and third authors (Richard Brown and Tobyn Bell) were project supervisors, providing support, oversight and feedback during all stages of the project.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

Competing Interests

The authors have declared that no competing interests exist.

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