BREATHING PSYCHOANALYSIS

“...No presence is possible without air” - Luce Irigaray

ABSTRACT

Life begins in a sea of sensation, gradually giving way to a mental area (Ferrari 2004). Therapy begins in this mental realm, working with thoughts and feelings related to experience. Yet there are excluded realms of experience, either noted only somatically, or physicality pushed away or ignored. Theorists such as Aulagnier (2001), and Ferrari (2004), have recognized the importance of our “continuous encounter” throughout life with a “physico-psychical milieu” in developing a “felt” sense of experience (Aulagnier 2001). Neuroscientists as well, are looking beyond a primary focus on cognitive and affective processing to information coming from the body, which has contributed to a more complex understanding of emotional experience (Paulis, 2013). Specific breathing patterns associated with emotions, for instance, might not develop in children whose breathing is chronically more shallow, effecting their overall emotional development (Phillippot, 2002, Krause, 2000). I will use the important (and often overlooked in psychoanalysis) phenomenon of breathing to illustrate how the mind uses bodily experience to make conscious mental representations, or avoid them altogether by finding a somatic equivalent of the psychical. I will explore the role that breathing patterns play in psychological development, with clinical material and implications for technique.

INTRODUCTION

Kyla had a striking breathing pattern. An athletically, intellectually and artistically gifted fourteen-year old, she was poised, articulate and appeared calm, except that she sat on the edge of her chair and frequently gasped for breath. She shifted from one topic to another, seemingly unable to take in what I ventured to offer her in terms of understanding. I said, on a couple of these occasions, “It seems hard to catch your breath.” She would nod, and breathlessly move to the next topic. Although clearly eager to convey something of importance that she needed help with, she did not seem able to imagine help. She remained distant from me and from her emotional experience for many months. Before coming to see me she’d been feeling depressed, suicidal, was cutting, missing school and experiencing frequent panic attacks, and asked her parents if she could see a therapist after investigating her symptoms online.
Her respiratory struggle could have been a symptom of anxiety, resulting in rapid breathing and a feeling of a lack of air, but I had more of a sense of something inarticulate, desperate and from long ago. My sense with Kyla was a desperate – no help is possible walled off state - the kind of desperation, which I will describe, that leads to shallow breathing. And, the long ago was likely in infancy - Kyla’s mother was much of the time incapacitated with severe post-partum depression and migraines.

When faced with a mother who is “not there” in some important way, most infants turn away in emotional pain. Normally, the turning away, sucking a thumb perhaps, fails and the infant begins to cry, hopefully eliciting a maternal response. If the mother is depressed over a long enough period of time as Kyla’s mother was, the urge to cry (the wish to be in contact) begins to be excluded. “Affective contact” with her mother would be “associated with feelings of ....intolerable vulnerability” (Korbicher), resulting in a more permanent, depressive turning away, along with a pattern of constricted breathing. Kyla’s shallow breathing revealed a very early internal conflict between the urge to cry and the danger of more affective contact. A sad, tearful affect which would normally lead to communicating through crying, now results in turning away and inhibition. A therapeutic process involving affective movement toward allowing the sad affect, and eventual tearfulness (and the possibility of comfort and affective contact with me) would be crucial.

PRIMAL PROCESSES

As adults, the sense of our body, the sensations and emotions that emanate from it, functions primarily in the background, unless we are ill, injured, very stressed, or aroused. But when we are infants, sensations and emotions are all foreground, and our survival depends on deciphering them. Infants, of course, cannot think about the functioning of mind and body experiences, they “simply and directly experience them” (Ferrari, p. 37). We cannot remember what this was like, but neuroscientists have theorized that the experience could be close to that of an LSD trip, where sensation and emotions, are so much in the foreground, and where expansiveness and awe one minute can turn to despairing sadness the next (Neuroscience, April 2016). In other words, primal. Freud’s often quoted, “the ego is first and foremost a body ego”, refers

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1 Tronick (2002) also felt “that the conflict may be felt most keenly in the body.”
to an underlying premise that the “roots of the ego, the id are found to be in body sensations and feelings”, ...(and) that the core of the self might be found in primordial feelings (Sletvold, 2014). Freud did not pursue this realm more, but two theorists (Ferrari, 2004), (Aulagnier, 2001), who worked with psychotic experience, did2.

Central to their theories is that what arises from the body is a “something” that we have to do something with. And we do that something with our whole self; a mind that can perceive and register experience, and a physical body with its sensations (Ferrari, 2004, p.41). It may be hard to think about infants having the capacity to use “the silent ‘intelligence’ of biological life”, such as the nervous, digestive, respiratory and other systems, to assist in creating a mental area for containing experience and emotions, but they do (Miller, 2014). Ferrari and Aulagnier worked with psychotic patients, where experiences like the terror of being too alone or of massive confusion led to mind/body patterns in the patient that were impossible to understand without expanding Freudian theory to encompass earlier states of mind. Aulagnier used the idea of primal, before primary process, similar to Ogden’s (1989) conception of autistic contiguous position, and Ferrari (2004) developed the idea of a concrete original object, partly described as “a global feeling of existing in an environment” (Ferrari, p 39)3.

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2 Piera Aulangier’s (1923-1991) work is very well known in France, however, her book, The Violence of Interpretation: from Pictogram to Statement, published in 1968, was not translated into English until 2001. And until the recent publication of Patrick Miller’s book Driving Soma, she was still virtually unknown in the United States. Based on her sense of “dissociation between what the analyst experiences and psychoanalytical theory, she put forward the hypothesis of a split: analysts assume that their knowledge of mental life should make it possible to act on the phenomenon.” (Miller, 2014) She felt that “there exists a knowledge of the psychotic phenomenon which proves ineffective when confronted with the field of clinical experience”, and is the basis of much of her work (Aulagnier, 1975, p. xxvii).

Armando Ferrari’s (1922 - ? ) book, From the eclipse of the body to the dawn of thought, published in 2004, has had important implications for theory and technique. Several Italian analysts, especially Ricardo Lombardi, have recently begun to publish more about his work. Ferrari began analytic training after some time as an anthropologist studying the subject of death rites in Brazilian tribes. His work in psychiatric units and an intense psychoanalytic practice “enabled Ferrari to gain a vast and multifaceted experience in the clinical field”. “Ferrari’s most significant encounter was with W.R. Bion who became his mentor and with whom Ferrari worked for a long period of time, becoming one of his most assiduous and constant scholars and collaborators in South America. In the mid-seventies, Ferrari moved to Rome and began to elaborate on his main hypothesis ‘ “that the body has a fundamental role in the birth, development and realization of mental functions” (Ferrari, 2004, p. 16).

3 Winnicott (1965) expressed as well that “the True Self comes from “the aliveness of the body tissues and the working of body-functions, including the heart’s action and breathing” (p.148). Klein, as well, quotes Margaret Ribble, an infant researcher describing the importance of sensory experience, “The development of these sensory capacities has been mentioned by nearly all
Roiling and tumultuous sensations and emotions, threaten the infant’s need for “harmonious physical functioning” (nervous, respiratory, endocrine, digestive etc.) (Ferrari, 2004 p. 44). And, although the infant has considerable inherent ability to manage, he or she must have help. Without help, the infant is left preoccupied with maintaining physical homeostasis. It is with the presence of the mother’s attentive mind, biologically anticipated, that the infant begins to develop the capacity to register and contain experience (Ferrari, 2004 p. 44). Aulagnier proposed a primal representative capacity (Miller, 2014 p. 127). She proposed that bodily feeling becomes the first representative of the object. “Something felt in our body lies in the place that will later be occupied by the mother (Miller, 2014 p. 128). For Miller (2014), “the infant tries to find figurative resources within their own bodily sensations and physiological equivalents, which function as a kind of ersatz of an internal object”. A “primitive ‘grammar’” of the body is developed, protecting the infant from “unmetabolized excitations coming from soma”. As adults, when highly stressed we can feel tension in, say, our face – it feels tight. That is one of the first responses the body has to hold oneself together under stress. Miller felt that “tension and contraction lead to immobilization which prevents the infant/person from falling endlessly. It is a “physiological grammar” to help the infant survive. This is very different from Freud’s idea of construction of the mind via an experience of hallucinatory satisfaction (Miller, 2014).

Neuroscientists are in wide agreement that the primary function of the brain is to regulate the body in order to survive (Paulis, 2013). If so, then mental activity might originate around body sensations and emotions, and that idea would be an important shift from Klein, Winnicott and Bion, who theorized that thought primarily arises in relation to the maternal object. The maternal object is of critical importance, but if physical survival is primary, then the location of the psychic object (the primary object of the infant’s mind) would be different. This could be thought about in terms an infant waiting to be fed. For Klein (1975), the breast would be the psychic object and managing the feelings toward it fundamental to the development of mental activity (p.1). In Winnicott’s thinking (1953), the psychic object is the mother’s consistent enough responsiveness to the infant’s need, and mental activity results from her not too frustrating failure (p. 94). The absence of the breast is central in Bion’s thinking which, when not too absent, promotes the conditions for something to come to mind, and alpha observers of infantile behavior ... but their particular importance for the personal relation between mother and child has not been emphasized.”
function. But for Ferrari (2004), it is not an idea of the breast or the absence of the breast, or the experience with the mother per se, but it is what to do with hunger and the associated emotion, that creates the need for thinking. The child needs the mother’s reverie to help discern and recognize sensations and emotions, for the infant to learn to experience them, and to communicate them to others and to themselves (Ferrari, 2004). The shift in focus has very important implications for technique, which will be addressed in the short section on technique at the end of this paper.

Kyla’s mind used the bodily experience of breathing, to manage what must have been felt as life threatening situations - not enough help from her mother. Her case highlights the theme of this paper; that in the beginning of life, there is a very close connection between body, sensory perception and mind, almost “as if the mind prefigures and models the body and vice-versa” (de Toffoli, 1988). As well, the “neurophysiological happenings within subjects – like breathing – can receive and generate information”. (Sheets-Johnstone, M. 2003), and can also generate information for the therapist. It may be that our ability as therapists to see what is happening with something as simple as breathing may be critical, especially when the mind is “borrowing” from the body, or where the body “holds” what can’t be tolerated by the mind (Miller, 2014). With Kyla, an intense, life threatening sense of mother not there, her mind “borrows” from her body - restricting breathing will help avoid a too overwhelming emotional experience. An example where the danger is actually physical, may help illuminate what Miller and others are describing.

Twenty-five year old Madison’s bodily symptoms were so severe that she had to stop working. She felt an incredible tension in her body, as though her body tissue was crushing her chest or throat and that she might even stop breathing. The tension extended to her entire body, and she had to continually attempt to massage away this tension. Her chest would sometimes be bruised from the effort. She also experienced a lot of physical pain and severe headaches. The symptoms began when she finished college and faced starting a career and separating from her parents. Although she excelled at school, she had a very difficult childhood, with a lot of physical complaints, and parents who tended to react to them with upset or helpless anger. Several times, she was sent to psychological treatment programs (she was quite adept at her psychological understanding, and was extremely bright). She wasn’t very interested in talk therapy and desired to spend her resources on, understandably, somatic or energy

4 This would imply that there is such a thing as an infant, and, of course, without any maternal care, there would be an infant who is experiencing dying.
oriented therapies, but her parents insisted. Psychologically she felt she had no space to be herself, and no room to breath. What was not thought about when she was growing up, or in later extensive psychological evaluations was that she was born prematurely!

As is common with many premature infants, a tube was inserted through her ribs to keep her lungs from collapsing. She had several needles in her head to relieve pressure on her brain, and an IV in her arm, and spent several weeks in the NICU. She also had to have a surgery to correct a physical deformity (twenty-five years ago, preemies were not given anesthetics with surgery, and as well, people born prematurely remain more sensitive to pain throughout life). Today, even the most premature babies are given skin to skin contact with the mother, but then her mother could only slide her hands under her through a special sleeve. I could imagine, the pain and the intense sensations she must have experienced – massive, painful and terrifying. She would have had to create tenseness and contraction to keep from falling endlessly. And, her body would react to the foreign objects - histamine, immune, inflammatory responses would have occurred, and her experience of terror would be intricately tied to her physical state. Miller writes, “Who triggers this? No one, not an individual -as-subject, not a psychical agency, but, in my view, the powerful life instinct— that is, an organic instinct for the preservation of the self, not a drive”. The body “remembers” this union (soma and psychical), and in extreme distress, something engages. So when Madison encountered such extreme distress around separation, her emotional experience would have “remembered” her bodily experience in extreme distress. Just as Kyla constricted her breathing to avoid affective contact, Madison re-engaged in tremendous tension and contraction in order to not fall endlessly, which likely did engage bodily processes.

BREATHING, INTERNALIZATION AND OBJECT CONSTANCY

The respiratory system is central in helping mother and infant manage in the beginning, and breathing patterns between mother and infant lay the groundwork for internalizing, and object constancy. de Cesarei expresses the importance of breath in the mother/infant dyad:

I believe that breathing contains a fundamental psychological aspect connected to maternal investment, a nature that envelops, ... something impalpable and yet so essential because it reflects the internal space prepared for the infant, the ‘spirit’ of the parent. A close link exists between the mother’s capacity to establish profound resonance with her child and
the establishing of a vital inner rhythm, of which breathing is an important element. (de Cesarei, 2005).

Her thoughts are reminiscent of Winnicott’s idea of the holding and the environmental mother with an emphasis on breath. An infant waiting for mother to arrive after waking is aware of his or her own breathing (again, a sensation that is much more in the forefront in infancy), which is linked to the breathing space with mother and the comfort that it provides. The capacity to wait is not passive, but involves an idea similar to Freud’s of a “something” that makes a demand on the mind for work (Freud, 1915). One of the earliest signs of taking support from the respiratory system (and the beginnings of internalization and object constancy) is when the infant can “wait” upon awakening for mother to come. The infant’s breathing is linked with breathing with mother, and the infant’s breathing body can help remember mother. For object constancy to eventually develop, the child must “weave” together a sense of mother “always there”. Breathing, with its constant presence, helps tremendously with this complex task.

We can see traces of just how vital breathing is when something goes awry in the mother/infant dyad. If a maternal breathing space is not there enough, if the mother is too depressed or anxious (her own breathing constricted), or there are too many propped up bottles, or the infant is alone too much in the crib, or, more recently, checking social media too much, watching TV, the infant cannot use the bodily sense of the constant presence of breath to help with gaps in experience, because their breathing will be constricted, or avoided to bypass the terror of “not enough”, fears of dying or “falling forever” (Winnicott, 1965). Milner (1969) reflected on a patient’s “difficulties with acceptance of her own breathing.” She and the patient “slowly came to realize the strength of the patient’s resistance to becoming aware of her breathing at all. It seemed to be connected with the intolerability of being alone with her body...which was linked with her terror of dying”. Ogden (1989) cited an example of a desperate patient who had to try to take conscious control of her breathing because without that control, she might suffocate.

As clinicians, we tend to associate “taking-in”, or internalizing, with the physiological process involved in feeding experiences, but any metabolizing system can

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5 Caldwell, elaborating on Winnicott’s idea of holding, felt that the capacity to be alone involved “internalization of the environmental mother holding a situation in time” - different than internalizing mother as object which slowly evolves.
be involved, especially breathing or crying\(^6\). deToffoli indicated that,

> Psychoanalytic literature is full of reflections on the functions of eating and the alimentary canal. Nobody believes any longer that lactation only fulfills the physiological need for the consumption and assimilation of food: it is quite evident that the intake of food becomes an experience of a relational and communicational significance. It is however more rare to find the importance of other biological functions being recognized, for example respiration. (de Toffoli, 1988)\(^7\)

One reason for the neglect in psychoanalysis of respiration in “taking in”, de Toffoli surmises, is whereas feeding represents the infant’s dependence on the mother, a relationship of need; respiration alludes to the background of air, which both mother and infant depend. Although the importance of breath is clearly observable in infant observations, little has been elaborated in the literature. “Breathing-in” mother (internalization), is part of infant’s experience of breathing in all sorts of things; light, color, sound and especially emotion. In infancy, our brain has an “initial proliferation of anatomical connectivity”, which results in normal, developmental infant synesthesia\(^8\) (an experience close to amodal perception), Wagner, 2011. Except for some, including many poets, musicians and artists, this sense falls into the background as neural connectivity becomes more established. But good experience is generally associated with “breathing-in”, love, joy, excitement, and surprise (think of mother’s short intake of breath to engage the infant in excited attention)\(^9\). And bad experience is “breath expelled”, we cry out in despair or in anger, or we are sad and sigh or cry.

Two studies in 2002 investigated the relationship between emotions and breathing patterns. In the first, participants were asked to produce an emotion of joy, anger, fear or sadness and describe the breathing pattern. The descriptions were comparable to patterns recorded in prior psychophysiological experiments. In the second study,

\(^6\) It is also easy for us to grasp how the mind utilizes processes of physical holding and how that relates to the “holding together of the infantile body-ego” (Bick, 1986, p. 299). We can also observe infants who are lacking adequate holding, hold things with their sight or hearing, or even their breathing.

\(^7\) Breathing also represents the first assumption of an autonomous rhythm at birth. (de Toffoli (1998)

\(^8\) Infant synesthesia is likely the physiological basis for our ability to develop symbolic capacity – being able to link one thing to another.

\(^9\) In fact, in all the “still face” videos by Tronick (you tube), every mother does this intake of breath repeatedly and naturally, and it is something the infant does not imitate. It is universal and yet I don’t think we understand the phenomena, but it certainly reflects the mother’s investment in the infant.
participants were asked to breathe using the descriptions of breathing patterns from the first study (participants did not know the purpose of the study) and report the emotions they experienced. The emotions reported “were significantly differentiated according to the type of breathing pattern” associated with joy, anger, fear or sadness. It is likely, then, that the mother is receiving information about the infant’s state by being subconsciously attuned to breathing patterns in herself and her infant.

Keeping one’s breath somewhat constricted, as well, impacts being able to experience different emotions (Krause, 2000). It is not just love that is registered; it is love and a particular kind of breathing that are forever intertwined (albeit in the background as adults). If the holding/feeding/breathing experience is not infused with love enough of the time, there is no space to breath into, and no sense of “holding” even if the child is physically held. Ogden (1989), thought that “in a psychological field in which the individual has little if any sense of internal space, the concept of internalization becomes virtually meaningless”. We must be able to “breathe-in” the experience of the mother/infant space.

PROBLEMS WITH BREATHING, INTERNALIZING AND OBJECT CONSTANCY

When the individual has restricted access to emotional experience because of shallow breathing, internalizing and the later development of object constancy are compromised. However, the need for a sense of continuous presence of mother still remains. If the mind is unable to “borrow” from a physical system such as respiration to fill in gaps, the mind must do so itself using defense mechanisms10. Parents of adolescents like Kyla, often report that they were very easy or good babies, not recognizing the absence of distress as a problem. Rather telling was Kyla’s mother’s description Kyla’s weaning, and her brother’s birth at eighteen months – that neither seemed to matter to Kyla. Her mother was puzzled, but couldn’t recognize the absence of protest as a problem. And so her surprise, when Kyla was twelve and “freaking out”, crying and panicking on a family vacation. And, my surprise when mother attempted to frame Kyla’s behavior as, “in many ways, normal teen angst”, despite the the serious symptoms of cutting, social withdrawal and suicidality. If the help the breath provides in tolerating mother’s absences is not available, cordonning off unbearable (mother not

10 Akhtar noted the individuals need for defense mechanisms when lacking object constancy, including “denial, projective identification, idealization, devaluation...”. I would include omnipotence as a way to create an illusion of self-constancy.
there) feelings using one’s mind is an option. Idealization may help create a mental constant “good” mother (unfortunately subject to breakdown). Kyla’s mother, in fact, seemed off limits in her Kyla’s discussions. Only after a year of intensive therapy was Kyla was able to access, bear and express angry feelings toward her mother. In the idealization, she avoided direct access to her despair, as she could imagine her mother’s “constant” goodness. As a child, Kyla not only inhibited expressions of distress, but it was as if there were no distress. In fact, her overwhelmed mother saw her as a “happy-go-lucky kid”, perhaps colluding with the emergence of her child’s psychic defenses. Kyla “too good”. In an odd way, this was repeated initially in the treatment with me; the gasping for breath like a neon sign pointing to desperation that she could not feel, in sharp contrast to her outward poise. Obsessive-compulsive defenses too, help create a something there – in rituals, compulsive exercise etc. Ogden mentioned the ubiquitous nature of obsessive compulsive defenses in cases where there are early traumatic gaps.

Defenses of idealization, obsessive-compulsive problems or resistance to being aware of breathing, or being overly aware of breathing, help exclude experiences that are overwhelmingly painful. It is a tremendous challenge for the therapist to find avenues back to these experiences, so that they can be felt and processed. For Kyla, breathing adequately with emotion, would bring her closer to feelings of wishing to cry, and feelings of despair. How does the therapist facilitate gaining access to excluded experiences that are now represented in bodily form? Ogden (2014) touches on the need to experience the “primitive agony” that was originally “foreclosed from psychical elaboration”, so that it can be successfully put in the past. In Kyla, this would mean getting closer to the primitive agony initially experienced but which not adequately represented in the mind. An adequate space for learning would be important.

BREATHING AND LEARNING

We breathe in a unique pattern when learning. Mother, when she is trying to grasp what is causing a stressful emotional state in her infant usually breathes with focus. When the infant’s distress is relieved, there is a space for the infant to similarly focus. With an infant who is crying in fright; mother picks her up, and not only is her distress relieved, but she now displays the kind of focused breathing associated with trying to understand something - a “what just happened” focus. Understanding emotional distress is critical for survival. Mother and infant do a lot of figuring which involves, the same kind of breathing we experience when with a distressed patient, or that is involved
in “evenly suspended attention” or a state of reverie. Breathing facilitates learning.

Bollas, and others have grasped the patient’s need for this kind for space for understanding. Bollas, when treating patients in breakdown commented that when patients are silent for long periods of time,

These are not introjective moments; I do not think they are fundamentally taking something in from the analyst. Rather, I think something known but not thought (the unthought known) is released by the analyst’s comment. It is very important, therefore, for the analyst to disappear as an interpretive presence ...(Bollas, 2013, pg. 65)

Miller alludes to something similar.

In my view, this kind of occurrence (patient being silent in the analyst’s presence) during a session is deeply conducive to some form of processing. This might not be the case were they to occur outside of the context and process of analytical treatment (which, in any case, facilitates their occurrence), without the presence of the analyst during the session and the analyst’s mental work that accompanies them. In that context, I see such phenomena moving in the direction of the infant's capacity to be alone in the presence of his/her mother, rather than as some kind of psychotic withdrawal that urgently demands an interpretation ...(Miller 2014, p. 207).

Neither writer mentions breathing, but I imagine it as the silent protagonist in these kinds of sessions, acting as “a transformer of somatic and emotional experiences into mental representations...”(de Toffoli, 1989, p. 723). Winnicott (1967) described a patient entering a “temporary phase in which the breathing of her body was all”. He felt he was “keeping a continuity by (his) own breathing”.

Towards the end of the first year of treatment, after having to miss two sessions, Kyla reported that while she’d been very ill with a fever, she grasped, in a rather poignant way, how hard her body was working to keep her alive. “I realized that my body wanted me to live” became a helpful metaphor for when she fell into dark, suicidal moods. A fever increases rates of respiration, and perhaps though alone and sick, noticing her body breathing was connected with the breathing space we’d both come to inhabit, so that being with her own breathing body was now tolerable.

**IMPLICATIONS FOR TECHNIQUE**

If the primary object of the mind is the body and the sensations and emotions that emanate from it, then the space the mother creates for the infant’s sensations and emotions to emerge and be understood is critical. The focus in treatment is less on the transference and more on creating links between sensations and emotions and thinking.
Transference could be viewed as the therapist initially becoming a kind of “mental area” for the patient, and as a kind of negotiator between the conflicts of the patient (Ferrari, 2004).

Kyla’s conflict over affective contact was reflected in her poem of a young woman’s cruel imprisonment and the painful sense of the rest of humanity eternally out of reach. She eventually recognized her own cruel imprisonment – keeping herself away from emotional contact with herself. This recognition made it easier for her to relax into her chair and feel sad, an avenue to foreclosed experience.

In normal development, intense sensations and emotions tend to fall into the background, eclipsed by the mind as a mental area develops. This process can be observed in cases like Madison where so much was pure sensation. Her initial obsession with massaging her body shifted when she began to express intense feeling - crying or angry protest (involving a lot of breath). The desperate massaging fell away, her bodily experience eclipsed by her mind providing help - by allowing her to feel.

CONCLUSION

I hope I’ve conveyed the intricate connection between mind and body. Breathing sets the stage for internalizing, object constancy and learning, and we do forget it, despite its constant presence, it being a fundamental requirement.

The movement from bodily sensation to thinking is possible partly because our minds can make use of the support that bodily processes provide. Hunger propels us to communicate distress. Our experience of hunger also helps us understand a sad feeling of something missing. Sad has a particular pattern of breathing. A sensation that requires us “do something” paves the way for grasping emotion (with help), having a feeling and eventually being able to think and communicate. I’ve come to think of breath as the unseen conductor, who mediates what we need to weave together of experience, via “taking-in” or internalizing, differentiating our feelings or developing a focus essential for learning and developing.

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