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Evaluating Diaphragmatic Breathing as a Brief Stress Intervention: A Pre-to-Post Experimental Study

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Stress contributes to psychological and physiological strain, yet established interventions (e.g., CBT, mindfulness, peer support) can be costly or impractical at scale. Diaphragmatic breathing may offer a brief, low-cost alternative. This study tested whether a short, self-guided diaphragmatic breathing intervention reduces stress, anxiety, and depressive symptoms. Ninety-nine participants (83.8% female; $M = 24.34$, $SD = 10.56$) were recruited via social media and the University of Chichester participation scheme and randomly assigned to an active breathing group or waitlist control. The active group completed five minutes of self-guided diaphragmatic breathing daily for seven days. Participants completed pre- and post-intervention measures (PSS, GAD-7, PHQ-9). One-way ANOVAs on pre–post difference scores showed no significant group differences in stress, anxiety, or depression. Participants reported moderate motivation and perceived usefulness. Findings suggest brief self-guided breathing may be insufficient without longer duration or instructor support; further mixed-methods research is recommended.

Keywords: Diaphragmatic breathing; Stress; Intervention; Mental health

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Stress is a common response to perceived challenges or threats, often resulting in psychological distress and physiological strain (World Health Organization, 2023). In the UK, approximately 74% of adults reported feeling unable to cope with stress within the past year, underscoring the need for accessible and effective stress-management strategies (Mental Health Foundation, 2018).

Selye's (1950) General Adaptation Syndrome conceptualises stress as a three-stage physiological response: an initial alarm phase (fight-or-flight activation), a resistance phase where heightened arousal is sustained, and an exhaustion phase marked by physiological and psychological deterioration. This system has been associated with cardiovascular and immune dysfunction as well as anxiety and depression (Dhabhar, 2014; Maddock & Pariante, 2011). Interventions that regulate this physiological arousal early in the stress response may therefore prevent progression to these adverse outcomes.

Although Selye's (1950) research relied on animal models and thus raises questions about generalisability to humans, his framework remains influential, particularly regarding the exhaustion stage that has been linked to numerous adverse physiological and psychological effects (Öhman et al., 2007). This suggests that effective stress-management interventions should aim to regulate arousal early, ideally during the alarm stage, to mitigate the risk of long-term stress-related conditions.

Stress Intervention

Evidence-based interventions such as cognitive behavioural therapy (CBT), mindfulness meditation and peer-support programmes are among the most extensively researched and widely recommended approaches to stress management and have demonstrated effectiveness in reducing stress and improving well-being (Hofmann et al., 2014; Khoury et al., 2015; Peterson et al., 2008). However, these approaches often require substantial time commitments, trained facilitators, or financial burdens, making them impractical for many individuals seeking immediate relief (Cavanagh et al., 2014; Kazdin & Blase, 2011; NHS, 2022). This has prompted growing interest in brief, low-cost interventions that can be self-administered without professional supervision.

Mindfulness-based interventions are among the most widely researched stress-reduction techniques and have consistently been shown to decrease stress and anxiety (Goldberg et al., 2018; Khoury et al., 2015; Peterson & Pbert, 1992; Roth & Creaser, 1997). However, such programmes typically require eight weeks of structured practice, which may limit feasibility for individuals seeking more immediate outcomes. Moreover, mindfulness-based self-help interventions report high attrition rates, with Cavanagh et al. (2014) identifying a mean dropout rate of 37%, raising questions about their suitability for unsupervised use.

Peer-support interventions, where individuals experiencing similar stressors provide mutual support, have also shown promise in reducing occupational stress and burnout (Agarwal et al., 2020; Crisp et al., 2020; Peterson et al., 2008). However, these programmes often rely on supervised group meetings and trained facilitators, making them difficult to implement outside structured settings or for individuals without access to appropriate peer networks.

While CBT, mindfulness, and peer-support interventions demonstrate effectiveness, their reliance on extended timeframes, professional input, or social resources limits their accessibility for the general population. These constraints highlight the need for a simple, brief, and affordable approach to stress reduction. Diaphragmatic breathing may offer a viable solution that meets these criteria.

Diaphragmatic Breathing

Diaphragmatic breathing, also known as deep or belly breathing, involves slow, controlled respiration that engages the diaphragm rather than the chest muscles (Hopper, Murray et al., 2019). This technique stimulates the parasympathetic nervous system, lowering heart rate and blood pressure, and counteracting sympathetic arousal associated with stress (Janet & Gowri, 2017). As a mindfulness-aligned "third-wave" approach, it also encourages present-moment awareness and may reduce cognitive rumination (Merwin et al., 2019). Despite its theoretical promise, research on diaphragmatic breathing as a stress intervention remains limited and methodologically inconsistent. Definitions vary widely, with related terms such as yogic breathing or deep muscle relaxation often used interchangeably (Kantziari et al., 2019; Raghuraj et al., 1998; Shahriari et al., 2017; Zope & Zope, 2013). Moreover, many studies have examined specific populations—such as nursing students, individuals with anxiety, or pregnant women—making it difficult to generalise findings to the wider public (Chen et al., 2017; Consolo et al., 2008; Kantziari et al., 2019).

A systematic review by Hopper et al. (2019) identified only three methodologically robust studies of diaphragmatic breathing and psychological stress (Joshi et al., 2016; Ma et al., 2017; Sundram et al., 2014) out of an initial 766 papers. Although each reported reductions in stress, the studies differed substantially in design, duration, and participant type, limiting comparability and generalisability. For instance, Ma et al. (2017) implemented an eight-week protocol and Sundram et al. (2014) a nine-month programme, raising questions about whether shorter interventions might also be effective. Both Ma et al. (2017) and Sundram et al. (2014) required long-term participation within specific workplace settings and did not assess adherence or engagement, increasing the risk of social-desirability bias. Their restricted sampling, IT employees and automotive plant workers, also introduced potential contextual confounds, and group assignments further limited internal validity (e.g., entire plants assigned to conditions). Joshi et al. (2016), while recruiting from several universities, assessed only physiological indicators such as blood pressure and did not re-measure perceived stress post-intervention.

Some evidence also contradicts these positive findings. Consolo et al. (2008) reported no significant change in stress or anxiety among nursing students, though because their study coincided with an academic exam period, the stable stress levels observed may still indicate a buffering effect. Methodological heterogeneity further complicates interpretation. Only Ma et al. (2017) standardised breathing rates at six breaths per minute under instructor supervision, while other studies offered minimal procedural detail. Later work by Conlon et al. (2022), investigating performance under pressure, used a similar six-breath, five-minute protocol, suggesting potential for briefer, structured applications.

Collectively, these inconsistencies highlight a substantial gap in the literature regarding brief, self-guided applications of diaphragmatic breathing for stress management. Further research is needed to determine whether the technique can be both effective and practical when delivered without instructor supervision.

Current Study

The present study sought to identify a brief, accessible, and cost-effective stress intervention suitable for use in the general population. Diaphragmatic breathing was selected as a promising candidate based on its simplicity, low resource demands, and emerging evidence for physiological and psychological benefits (Hopper et al., 2019; Ma et al., 2017). Previous research into diaphragmatic breathing has primarily focused on narrow participant groups, limiting generalisability to the wider population. Studies often lacked control for confounding variables and showed little standardisation in breathing rates or intervention protocols. Moreover, all identified studies involved instructor-led sessions, leaving uncertainty over whether the technique could be effective when self-guided.

To address these limitations, the present study examined the effectiveness of diaphragmatic breathing in reducing stress within a general population sample. The intervention was delivered entirely online without instructor support, allowing assessment of whether self-guided breathing exercises can produce measurable changes in well-being. The study also included engagement measures to evaluate participant adherence and used self-report questionnaires to assess outcomes after a short, one-week intervention period. In addition to stress, the study assessed anxiety and depression, which are closely linked to stress and have been included as secondary outcomes in previous diaphragmatic breathing research (Chaby et al., 2015; Sundram et al., 2014; Van Praag, 2004). Because the literature provides stronger evidence for stress reduction than for changes in anxiety or depression, a directional hypothesis was specified for stress and non-directional hypotheses for the latter two variables.

H_1 Participants in the diaphragmatic breathing (active) group will report a significantly decreased stress score than those in the waitlist group.

H_2 There will be a significant difference in the anxiety and depression scores with those in the active group rather than the waitlist group.

Method

Participants

A total of 162 participants were recruited through online advertisements posted on social media (Twitter, Facebook, Reddit) and via the University of Chichester's Research Participation Scheme. Ethical approval for this study was granted in accordance with the University of Chichester's Research Ethics Policy. All participants provided informed consent prior to participation. Consent was obtained electronically after participants had read an information sheet outlining the study aims, procedures, confidentiality and their right to withdraw at any time without penalty. Participants were informed that the study involved minimal risk and were encouraged to contact the research team if any issues arose. Inclusion criteria required participants to be aged 18 or older and to have no history of mental health crisis or long-term illness (Appendix A). Ninety-nine participants completed both stages of the study and were included in the analysis. Of these, 83.8 % identified as female (n = 83), 14.1 % as male (n = 14), and 2.0 % as non-binary (n = 2). Ages ranged from 18 to 64 years (M = 24.34, SD = 10.56). Most participants identified as White (84.8 %), followed by Asian/Asian-British (8.1 %), mixed or multiple ethnic backgrounds (6.1 %), and other ethnicities (1.0 %). Just over half (54.5 %) were students. The attrition rate of approximately 39 % aligns with previous findings that self-help interventions often experience high dropout rates (Cavanagh et al., 2014).

Design

The study employed a between-subjects experimental design. Participants were randomly assigned to one of two conditions: an active diaphragmatic breathing group or a waitlist control group. The independent variable was group assignment, and the dependent variables were post-intervention scores for perceived stress, anxiety, and depression.

Procedure

Data collection was conducted entirely online using Qualtrics. After providing informed consent, participants completed baseline measures of perceived stress, anxiety, and depression, along with demographic information. Within 24 hours, they were randomly assigned, using a computer-generated random-number sequence, to either the active diaphragmatic breathing condition or a waitlist control group. Those assigned to the active group received email instructions for a self-guided breathing intervention adapted from Conlon et al. (2022), whose protocol was selected because it provided precise breathing-rate guidance (approximately six breaths per minute) and demonstrated psychological benefits in prior research, addressing inconsistencies identified by Hopper et al. (2019). The full set of participant instructions is provided in Appendix B. Participants were instructed to take deep inhalations

through the nose, fill their lungs as fully as possible, and then exhale slowly through the mouth for approximately five minutes per session. They were asked to perform the exercise at least once daily for seven consecutive days, setting a timer to ensure consistency across sessions. Participants in the waitlist group received no intervention during this period. After one week, all participants were emailed a follow-up questionnaire identical to the baseline measures. Any participant who did not complete the follow-up within seven days was excluded from analysis to maintain a consistent pre–post measurement interval and protect internal validity.

Measures

Participants provided demographic information including age, gender, employment status, ethnicity, marital status, number of children, and highest level of education.

Perceived stress was measured using the Perceived Stress Scale (PSS-10; Cohen et al., 1983), a 10-item self-report instrument that assesses how unpredictable, uncontrollable, and overloaded respondents find their lives. The timeframe was shortened from "the past month" to "the past week" to align with the current study's duration (e.g., "In the past week, how often have you felt nervous and stressed?"). Items were rated on a 5-point scale from 0 = *never* to 4 = *very often*, with four items reverse-scored. Total scores ranged from 0 to 40, with higher values indicating greater perceived stress. Previous research has demonstrated strong reliability (Andreou et al., 2011), and internal consistency in the current sample was similar (α = .81).

Anxiety symptoms were assessed using the Generalised Anxiety Disorder Assessment-7 (GAD-7; Spitzer et al., 2006). This seven-item scale measures the frequency of anxiety-related problems over the past week rather than the standard two-week period (e.g., "Worrying too much about different things"). Each item was scored on a 4-point scale from 0 = *not at all* to 3 = *nearly every day*, producing total scores from 0 to 21, where higher scores indicate greater anxiety severity. Scores above 15 were classified as severe anxiety. The GAD-7 has previously shown excellent reliability (Ahmad et al., 2017), which was supported in this study (α = .86).

Depression symptoms were measured using the Patient Health Questionnaire-9 (PHQ-9; Kroenke & Spitzer, 2002), a nine-item measure of depressive symptom frequency. The reference period was similarly reduced to one week (e.g., "Trouble falling or staying asleep, or sleeping too much?"). Items were scored from 0 = *not at all* to 4 = *nearly every day*, producing totals from 0 to 27, with scores above 20 indicating severe depressive symptoms. Previous research has reported excellent internal reliability (Kroenke et al., 2001); the present study found comparable reliability (α = .87).

Engagement with the diaphragmatic breathing exercises was measured using an adapted version of Banerjee et al.'s (2018) engagement scale, comprising two subscales: physical and psychological engagement. The physical subscale consisted of two items asking participants how many days per week they practised and how many times per day they completed the breathing exercise; these values were multiplied to yield a physical engagement score. The psychological subscale contained four items measuring motivation, intent, commitment, and belief (e.g., "Over the past week, how motivated were you to set time aside for the breathing exercises?"), each rated on a 5-point scale from 1 = *not at all* to 5 = *completely*. References to mindfulness were replaced with "diaphragmatic breathing," and the item assessing frequency was removed to avoid redundancy with the physical scale. Total psychological engagement scores ranged from 0 to 15. Banerjee et al. (2018) reported strong internal consistency, which was mirrored in the present data (α = .81).

Data Analyses

All analyses were conducted in SPSS (version 23.0, Windows). Descriptive statistics were calculated for participant demographics, and independent-samples t-tests and chi-square tests compared demographic characteristics between the active and waitlist groups to confirm group equivalence. Total scores were computed for each measure after reverse-scoring relevant PSS items. Change scores were then derived by subtracting post-intervention totals from baseline scores, with positive values representing improvement. One-way between-subjects analyses of variance (ANOVAs) were conducted separately for the PSS, GAD-7, and PHQ-9 to test for significant differences between conditions. Multiple regression analyses were subsequently run within the active condition to examine whether physical and psychological engagement predicted post-intervention stress, anxiety, and depression scores.

Results

Of the 162 individuals who initially participated, 62 % (n = 100) completed both questionnaires. Three participants withdrew from the study because they did not complete the second questionnaire within the required one-week window, and one additional participant was excluded from analysis due to a physical engagement score of zero, leaving a final sample of 99 participants included in all subsequent analyses. The participant flow is summarised in the CONSORT diagram (Figure 1). Independent-samples *t*-tests and chi-square analyses were conducted to examine potential baseline demographic differences between the active and waitlist groups; no significant differences were identified, confirming that randomisation resulted in

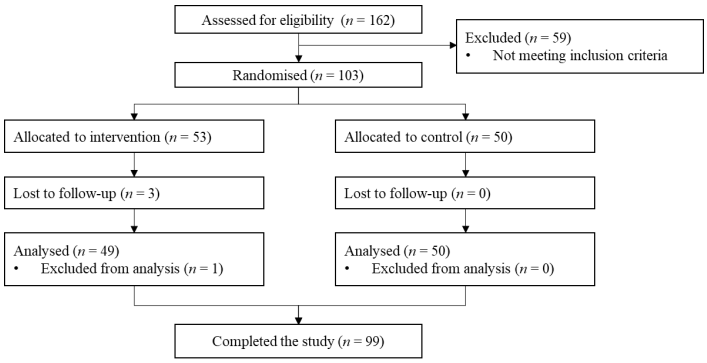

Figure 1. Consort diagram of participant flow.

Table 1. Means and standard deviations of difference scores on each scale by group.

Scale	Active		Waitlist	
	M	*SD*	*M*	*SD*
PSS	2.88	6.09	2.12	4.72
GAD-7	1.65	4.99	1.68	3.81
PHQ-9	1.84	5.04	.94	3.71

Note. Higher difference scores indicate greater improvement.

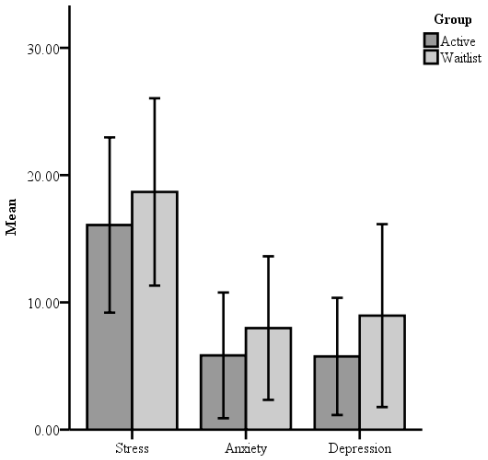

Figure 2. Post-intervention PSS, GAD-7, and PHQ-9 scores by group.

demographically comparable groups.

Difference scores were calculated for perceived stress, anxiety, and depression by subtracting post-intervention scores from baseline values, with higher difference scores reflecting greater improvement. Descriptive statistics for these variables are reported in Table 1, and the group means are illustrated in Figure 2. A Pearson correlation analysis indicated significant positive relationships among all measures: perceived stress and anxiety ($r(99) = .66$, $p < .001$), perceived stress and depression ($r(99) = .44$, $p < .001$), and anxiety and depression ($r(99) = .57$, $p < .001$). These associations suggest considerable overlap between the constructs of stress, anxiety, and depression within the present sample.

Engagement data were analysed for participants in the active group. Physical engagement scores ranged from 1 to 30 ($M = 7.98$, $SD = 5.55$), and psychological engagement scores ranged from 4 to 15 ($M = 8.92$, $SD = 2.39$). Overall, 30.6 % of participants reported completing the intervention at least once per day, whereas 30.6 % completed it on four days or fewer. Participants reported being moderately motivated to set time aside for the breathing exercise ($M = 2.88$, $SD = 0.75$), moderately likely to continue using the exercise in the future ($M = 2.92$, $SD = 1.08$), and moderately confident that it was effective in reducing stress ($M = 3.12$, $SD = 0.95$).

Assumption checks indicated that the data met the requirements for parametric testing. Histograms for all outcome variables approximated a normal distribution for both groups, and boxplot inspection confirmed the absence of outliers. Levene's tests demonstrated homogeneity of variance for stress ($F(1,97) = 2.48$, $p = .119$), anxiety ($F(1,97) = 1.01$, $p = .317$), and depression ($F(1,97) = 1.86$, $p = .176$).

A series of one-way between-subjects analyses of variance (ANOVAs) were conducted to compare post-intervention outcomes between the diaphragmatic breathing and waitlist control groups. No statistically significant differences were found for perceived stress ($F(1,97) = 0.48$, $p = .490$, $\eta^2 = .005$), anxiety ($F(1,97) = 0.001$, $p = .976$, $\eta^2 < .001$), or depression ($F(1,97) = 1.02$, $p = .315$, $\eta^2 = .010$). These findings indicate that participation in the diaphragmatic breathing condition did not result in measurable reductions in stress, anxiety, or depression relative to the control condition.

Multiple linear regressions were then conducted within the active group to examine whether engagement predicted psychological outcomes. Neither physical engagement ($F(3,45) = 0.29$, $p = .836$, $R^2 = .019$) nor psychological engagement ($F(3,45) = 1.10$, $p = .357$, $R^2 = .069$) significantly predicted post-intervention stress, anxiety, or depression scores, suggesting that frequency or self-reported investment in the breathing exercises did not meaningfully influence outcomes.

Discussion

The present study aimed to evaluate whether diaphragmatic breathing functions as a brief, accessible intervention for reducing stress, anxiety, and depression among the general population. Contrary to the hypotheses, analyses revealed no significant differences between participants who completed the diaphragmatic breathing intervention and those in the waitlist control group across any of the three psychological outcomes. Engagement levels were also lower than expected, with few participants adhering to the requested daily practice schedule. Nevertheless, participants in the active condition reported moderate psychological engagement and expressed moderate motivation to continue using the intervention in future, suggesting perceived value even in the absence of measurable effects.

Comparison with Prior Literature

The non-significant findings contrast with previous research reporting significant stress reduction following diaphragmatic breathing interventions (Hopper et al., 2019; Joshi et al., 2016; Ma et al., 2017; Sundram et al., 2014). Several methodological differences may explain this discrepancy. Notably, all prior studies incorporated instructor-led sessions, where trained facilitators demonstrated the breathing technique, corrected errors, and maintained adherence (Joshi et al., 2016; Ma et al., 2017; Sundram et al., 2014). In contrast, the current study employed a fully self-guided protocol delivered online (see Appendix B). Without live supervision, participants may have misapplied the technique,

particularly if they struggled to engage the diaphragm effectively. The lack of real-time feedback may therefore have limited the intervention's physiological efficacy and psychological credibility.

Cultural variation also represents a likely contributing factor. The existing high-quality studies were all conducted in Asian contexts where breathing-based and meditative practices are more culturally integrated into daily life (Du & Ning, 2024). Stress appraisal and coping have been shown to differ substantially across cultural contexts (Lee et al., 2022; Moreno Fortes et al., 2020; Pourmand et al., 2021). It is therefore plausible that UK participants, who may be less familiar or comfortable with body-focused mindfulness practices, engaged less effectively or found the technique less intuitive. Replicating the study within diverse cultural contexts would clarify whether diaphragmatic breathing's effectiveness is culturally moderated or universally applicable.

Methodological Considerations

Another key difference from previous studies was the shorter intervention period. Whereas Ma et al. (2017) and Sundram et al. (2014) implemented programmes lasting eight to nine months, the present study condensed the intervention to one week to test its short-term applicability. Selye's (1950) general adaptation syndrome suggests that sustained physiological regulation may be required to prevent progression from acute stress to chronic strain. More contemporary frameworks, such as McEwen's (1998) allostatic load model and the psychophysiological perseveration model proposed by Brosschot et al. (2010) similarly emphasise that meaningful psychophysiological adaptation requires repeated and sustained regulatory effort over time. Thus, a one-week intervention may have been insufficient for participants to form a consistent habit or experience meaningful psychophysiological adaptation. Low engagement levels further support this interpretation, with only a third of participants practising daily as instructed. Longer interventions, potentially with gradual reinforcement and behavioural support, may yield stronger adherence and outcomes.

Measurement differences may also have contributed to the null findings. Previous studies often used physiological measures such as blood pressure and heart rate variability rather than relying solely on self-report instruments. The present study used self-report measures adapted to a one-week timeframe, which, while practical, may have reduced reliability and sensitivity to subtle changes in stress. Furthermore, the engagement scale adapted from Banerjee et al. (2018) has not been extensively validated for brief interventions, raising questions about its precision in capturing adherence and commitment. Interestingly, 63% of participants reported being at least moderately likely to continue using diaphragmatic breathing in future. While this does not necessarily indicate the intervention perceived symptom improvement, it does suggest the intervention was broadly acceptable and feasible for continued independent use. Future studies incorporating qualitative interviews or mixed-methods designs could help reconcile these perceptual discrepancies.

Strenghts and Limitations

Despite these limitations, the study contributes to the limited body of research on diaphragmatic breathing by testing its short-term, self-guided application in a Western population. Several methodological strengths warrant recognition. First, this study uniquely incorporated engagement measures, offering insight into adherence and motivation-variables often overlooked in prior research. Second, the intervention instructions were standardised and replicable, allowing future studies to use a uniform, accessible protocol that does not require professional facilitation. Together, these features enhance reproducibility and highlight practical challenges in implementing self-help breathing interventions at scale.

The study's limitations should also be acknowledged. Reliance on self-report measures increases susceptibility to social desirability bias and response exaggeration, while the absence of physiological outcomes precludes direct assessment of autonomic regulation. The modification of recall periods across all three measures, necessary given the one-week study duration, may also affect the constructs being measured and the interpretability of scores relative to established norms. This is particularly relevant for the PSS-10, where the change may shift the measure toward current affective state rather than the stable stress appraisal it was designed to capture. Related to this, variability in when participants completed the follow-up questionnaire may have introduced a further confound, as earlier completers were likely reporting on experiences during the intervention while later completers may have been reflecting on a period after it had ended.

The sample was also demographically skewed, comprising predominantly female and student participants. Gender differences in stress reactivity have been documented (Graves et al., 2021; Peyer et al., 2020; Redondo-Flórez et al., 2020), and the timing of data collection, coinciding with university deadlines, may have heightened stress among student participants, limiting generalisability. The absence of fidelity monitoring is a further consideration; without verification that participants correctly implemented the breathing technique, it is difficult to determine whether the null findings reflect limited intervention efficacy or variability in its execution. Finally, the inclusion criteria did not assess whether participants already practised mindfulness or breathing exercises, which may have influenced baseline stress and intervention engagement.

Future Research Directions

Future research should build on these findings by replicating the present study with a longer intervention duration, supervised instruction, and additional physiological outcome measures. Comparing instructor-led and self-guided formats could clarify the role of guidance in sustaining engagement and achieving benefits. Cross-cultural replications would also determine whether cultural familiarity with meditative or breathing practices moderates outcomes. Incorporating post-intervention interviews or open-ended feedback would provide richer data on subjective

experiences, barriers to adherence, and perceived mechanisms of benefit.

Conclusion

In conclusion, this study investigated the short-term effects of a self-guided diaphragmatic breathing intervention on stress, anxiety, and depression in the general UK population. While the findings did not support the intervention's short-term efficacy, they highlight important methodological and contextual factors that may influence outcomes. The results underscore the need for longer-term, culturally sensitive, and potentially guided approaches to better understand the therapeutic potential of diaphragmatic breathing as a simple, low-cost stress-management tool.

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Appendix A

Inclusion Questions

1) Have you ever experienced a mental health crisis?

   A mental health crisis here refers to a moment of such intense distress that you required a rapid mental health assessment. A diagnosis of a mental illness does not necessarily qualify as having experienced a mental health crisis

2) Do you have a disability, long-term illness or health condition?

   The Equality Act (2010) defines a person as disabled if they have a physical or mental impairment, which has a substantial and long-term (i.e. has lasted or is expected to last at least 12 months) and adverse effect on the person's ability to carry out normal day-to-day activities.

Appendix B

Intervention Instructions

For the next 7 days, you have been randomly assigned into the diaphragmatic breathing group.

This means that we would like you to perform this brief and simple task at least once a day, for the next 7 days. Ideally, you should try to complete the task during a moment of stress during each of the days. However, if you think you may not remember to do this, you could set a reminder on your phone to complete the brief task once per day.

Below are the instructions for the task:

1. Take a deep breath in through your nose, with your hand on your stomach, taking in as much air as you can. This exercise focuses on using your diaphragm, which is located just below your lungs, so you should feel your stomach start to expand whilst you're breathing in.
2. Breathe out through your mouth, and feel your stomach start to contract. This may take a bit of practice to ensure that your diaphragm is being engaged with each breath.
3. Once you're confident that you're able to do this, set a timer for 5 minutes on your phone.
4. For the next 5 minutes, repeat this breathing technique and aim for approximately 6 breaths per minute (1 breath every 10 seconds). It's recommended that you keep your hand on your stomach during this time to ensure your diaphragm is still engaged.

As was previously mentioned, ideally, try and complete this task during a stressful moment during your day. However, if this isn't feasible, or you're likely to forget, completing it once per day will suffice.

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