Psychotherapy & Lifestyle in Psychiatric Practice

A practical toolkit for everyday clinical encounters

Dr Alina Vaida · Consultant Psychiatrist & Medical Psychotherapist · InDepth Psychiatry

A teaching resource for psychiatrists and other clinicians. It is not a substitute for individual assessment or treatment.

Why this matters

Under time pressure, psychiatric appointments can easily narrow to symptom review and medication. Yet every appointment is also a relationship, and that relationship can be used therapeutically — even in 20 minutes. The aim is not to turn psychiatrists into therapists, but to build on the therapeutic work that is already part of good psychiatry.

- Many patients have psychosocial needs that medication alone does not address.
- NICE guidance on depression (NG222) places psychological therapies alongside medication as first-line options.
- Personality difficulties are common in psychiatric clinics, so relational skill is needed in routine work, not only in specialist services.
- A targeted psychotherapy-informed intervention can take 3–5 minutes within a standard review.

Your position as a psychiatrist

The diagnosis	You hold the formulation, the context and the long view of the illness.
The relationship	Even brief, infrequent encounters are relational — patients remember how they were treated.
Prescribing	Medication offered with psychological framing (meaning, expectations, agency) can be more effective than medication offered alone.
Pattern recognition	You can see transference, splitting and avoidance as they happen in the room.
The systemic view	You can intervene with the patient, the family and the team.

Before you begin: the self-check

> *Is this intervention for my benefit or my patient's?*
> *Is there anything in my knowledge and experience I can use for their benefit today?*

- **Your reaction is data.** Notice how you feel before and during the appointment — it often tells you something about the patient's inner world.
- **Curiosity, not urgency.** Patients notice when they feel genuinely heard.
- **The one thing rule.** Choose one psychotherapy-informed intervention per appointment. Small and consistent beats ambitious and rare.

SECTION 1

CBT-informed tools

Anxiety, breathing, behavioural activation, sleep and grounding.

Breathing — a simple, often underused tool

Offer breathing first to every anxious patient, and practise it together in the session — three minutes is enough. Explain the rationale briefly: slowing the breath, especially the out-breath, activates the parasympathetic nervous system and settles the body's alarm response. Encourage practice when calm, so the skill is available when distressed.

TECHNIQUE	HOW	BEST FOR
Box breathing	In 4 → hold 4 → out 4 → hold 4	Acute anxiety, pre-panic, ward assessments
Extended exhale	In 4 → out slowly 7–8; repeat 4–6 times	Generalised anxiety, tension, before difficult conversations
Paced breathing	5–6 breaths per minute (in 5, out 5); a timer or app helps	Chronic anxiety, panic disorder, hypervigilance
Audible sigh	Deep breath in through the nose, long audible exhale through the mouth; 3–4 times	When the patient is visibly tense in the session

If breathing exercises make a patient more anxious (common in panic and some trauma presentations), shift the focus outward — to grounding or to simply lengthening the exhale without counting.

Behavioural activation — action comes before mood

Depression pulls people into withdrawal, which removes sources of pleasure and achievement, which deepens the low mood. Behavioural activation breaks this loop by scheduling small, meaningful activity regardless of how the patient feels. Mix activities that bring pleasure with ones that bring a sense of achievement, and grade them so the first step is easy.

> *Low mood → withdrawal and avoidance → less pleasure and achievement → deeper low mood*

Identify one activity	“What did you used to enjoy before you became unwell?”
Make it specific	Not “exercise more” but “a 10-minute walk around the block on Tuesday morning”.
Predict the mood lag	“Your mood may not motivate you — do it anyway, and notice what happens after.”
Keep a record	A simple diary: activity done, mood rating before and after.
Review together	Check at the next appointment and build on what worked.

Sleep — a treatment in its own right

Sleep difficulties are reported by most psychiatric patients and worsen almost every condition. Offer sleep advice routinely, and treat it as an intervention rather than an afterthought.

Fixed wake time	The single most powerful regulator — good sleep starts in the morning.
Caffeine	None after early afternoon; its effects last many hours.
Alcohol	Earlier in the evening or not at all — it fragments sleep in the second half of the night.
Environment	Dark, cool and quiet; a drop in body temperature helps sleep onset.
Stimulus control	Bed for sleep and sex only. If awake for a long time, get up, do something calm, and return when sleepy.
Screens	Stop 30–60 minutes before bed — both the light and the content are arousing.
Routine	A predictable wind-down ritual becomes a physiological cue for sleep.
Meals	Avoid large meals within two hours of bed.

Grounding and distress tolerance — regulate first, then talk

When a patient is dysregulated, flooded or dissociating, it is very hard to think or reflect. Bring arousal down first; the conversation can follow. Offer the technique rather than impose it, and do it alongside the patient.

TOOL	STEPS	USE FOR
5-4-3-2-1	Name 5 things you can see, 4 you can touch, 3 you can hear, 2 you can smell, 1 you can taste.	Dissociation, flashbacks, panic, overwhelm — works in ED, on wards and in clinic.
TIP (DBT)	**T**emperature (cold water on the face), **I**ntense brief exercise, **P**aced breathing.	Acute crisis, urges to self-harm. Check for cardiac conditions or an eating disorder before advising cold water or intense exercise.
STOP (DBT)	**S**top; **T**ake a step back and breathe; **O**bserve inside and outside; **P**roceed mindfully.	Impulsive urges, interpersonal conflict, self-harm urges in session.
Safe place	Eyes closed, breathe, imagine a place — real or imagined — of complete safety; notice what you see, hear and feel; stay two minutes.	Trauma, anxiety, before or after difficult disclosures.

SECTION 2

Psychodynamic and relational tools

Formulation, validation, narrative and countertransference.

Building a psychodynamic understanding

A formulation does not need a long session. In about ten minutes, three questions can sketch an understanding that changes how you treat. Share it tentatively ("I wonder whether…") and include a sentence of it in your letter — it helps the next clinician as much as the patient.

What are they defending against?	Which feeling, memory or truth is too painful to hold? What do they avoid, minimise or deny?
What pattern repeats across relationships?	How do they relate to parents, partners, children — and to you?
What is the function of the symptom?	Does it communicate need, avoid something, or regulate emotion?

Validation

Validation is not agreement. It communicates that the patient's experience makes sense given their history and situation. It reduces distress immediately and builds the alliance, which carries everything else. Linehan describes levels that deepen progressively: attentive listening; accurate reflection; putting unspoken feelings into words; making sense of the response in light of the past; recognising it as understandable in the present; and treating the person as an equal (radical genuineness).

> *“Given everything you’ve described, it makes complete sense that you feel this way.”*
> *“Of course you feel angry — anyone would.”*

Narrative linking

Link the present difficulty to the past without explaining it away — the aim is to make sense of it together. One brief linking comment can shift a patient’s relationship to their symptoms, from “something is wrong with me” to “this makes sense”.

> *“This anxiety about getting things right — does it have a longer history?”*
> *“You’ve learned that relationships end without warning. So of course you’re watchful now.”*

Countertransference — your reaction is clinical data

If you feel something unusual in an appointment, ask: what might this patient be communicating through my reaction? Some of what we feel comes from our own history, and some reflects the patient’s experience; supervision and reflective practice help to tell the two apart.

YOU FEEL	IT MAY MEAN	WHAT TO DO
Helpless	The patient’s own hopelessness, projected outward.	Name it carefully: “I wonder if you feel completely stuck right now?”
Irritated	May reflect a long-standing expectation that help will be withdrawn or relationships will fail.	Don’t withdraw. Stay curious — the feeling tells you about the relational pattern.
Special or chosen	Intense hope invested in you, often after many disappointing relationships.	Warmth with consistency; avoid becoming the only source of help.
Unusually anxious	Unspoken risk, or the patient’s anxiety carried by you.	Ask directly about risk, and slow down — your calm is the intervention.
Bored or detached	Possibly a defence against painful feelings — but first consider depression, negative symptoms or medication effects.	Notice the feeling behind the absence and gently invite it.
Wanting to rescue	May reflect how unsafe the patient feels — and your own discomfort with their distress.	Ask what they think would help. Support their agency.

SECTION 3

Trauma-informed practice

Assume trauma may be present, and work in a way that does not add to it.

Many people who use psychiatric services have experienced trauma — often repeated, and often within relationships. Trauma-informed care does not require a disclosure or a trauma diagnosis. It is a way of working that recognises how common trauma is and avoids repeating it.

> *Alongside "What difficulties bring you here?", ask "What has happened to you — and how did you learn to survive it?"*

Symptoms often make sense as adaptations. Hypervigilance, mistrust, dissociation or self-harm may have developed as ways to stay safe or survive something unbearable.

Six principles (adapted from SAMHSA)

Safety	Physical and emotional safety. Explain what will happen in the appointment and why.
Trustworthiness and transparency	Be clear about confidentiality, risk decisions and next steps. Do what you say you will do.
Peer support	Signpost to lived-experience groups and peer workers where available.
Collaboration	Make decisions with the person, not for them.
Choice and empowerment	Offer options — including the choice not to talk about the past.
Culture and identity	Consider how gender, culture, migration and discrimination shape both the trauma and the experience of care.

In the appointment

- **Disclosure is not required.** *"You don't need to tell me the details. It's enough for me to know that something difficult happened."*
- **Window of tolerance.** Watch for signs of hyperarousal (panic, anger, agitation) or hypoarousal (shutdown, numbness, dissociation). If the person moves outside it, pause and ground first (Section 1), then continue.
- **Pace and permission.** *"Would it be okay to talk about this a little — and we can stop whenever you want?"*
- **Services can re-traumatise.** Restraint, not being believed, sudden discharge and frequent changes of clinician can echo earlier experiences. Notice these risks and, where possible, name them with the person.

Your own response

Hearing about trauma affects clinicians too. Vicarious trauma is real; supervision and reflective practice protect both you and the people you care for.

SECTION 4

DBT tools in clinic

You don’t need to be a DBT therapist. You need five concepts.

Biosocial model	Emotional sensitivity (biological) plus an invalidating environment leads to difficulty learning to regulate emotion. This is about learning and environment, not character.
Dialectics	Opposites can both be true: the patient is doing the best they can *and* can do better; wants to live *and* wants to die. Hold the tension rather than resolve it. This stance also helps teams who disagree.
Validation	Acknowledging that a response makes sense reduces shame and is a prerequisite for change.
Skills	Four modules — mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness. A single skill can be taught in minutes.
Chain analysis	Map together the sequence of events leading to a crisis, to understand it and find where things could go differently.

Chain analysis in practice

> *Instead of “Why did you do that?” try “Let’s understand together what happened.”*

CHAIN LINK	EXAMPLES	INTERVENE WITH — PICK ONE
Vulnerability	Poor sleep, alcohol, illness, recent stress, missed medication	Lifestyle, routines, adherence
Prompting event	The specific trigger: a row, a rejection, a loss, a memory	Problem solving; anticipating triggers
Links	Thoughts, feelings, body sensations, urges, small behaviours	Distress tolerance, emotion regulation, thought challenging
Crisis behaviour	Self-harm, overdose, an outburst	Safety planning, formulation, a shared crisis plan
Consequences	Short-term relief, long-term cost — what keeps it going	Strengthen other ways of getting needs met

SECTION 5

EUPD in psychiatric clinics

Before technique comes understanding. The frame you hold shapes every interaction.

A note on language. Many people dislike the diagnosis of emotionally unstable (borderline) personality disorder, and some prefer terms such as *complex emotional needs* or *complex trauma*. EUPD is used here because it is the diagnostic term clinicians will recognise. Many people given this diagnosis have experienced trauma, and many improve significantly over time.

> *People with this diagnosis are doing the best they can and are in genuine pain. Crisis behaviour is communication — often the only language available when words have not been safe or have not been heard.*

Crisis as communication	Crisis behaviours are attempts to convey pain, regulate overwhelming emotion, or find out whether a relationship is safe.
The invalidation wound	Many people with this diagnosis grew up with their emotions treated as wrong or dangerous. Each time we minimise, we re-enact the original injury.
Abandonment fear is real	Cancellations, handovers and discharge can feel catastrophic. Flag transitions, give notice, explain what will happen.
Safety and consistency first	In outpatient care, a consistent and safe relationship comes first; steady progress builds from there.

Splitting in the team

Splitting is not intentional, and it is not something the patient does *to* the team. It reflects the patient's pain and the team's own dynamics: intense, opposing feelings get distributed between staff. It happens to every team.

Signs	Staff strongly disagree about how unwell the patient is or what they need; some feel protective, others frustrated; different staff hear different accounts; "good" and "bad" staff or wards emerge.
Your response	Name it without blame ("I wonder if we're being split?"); keep communication transparent and consistent; contain the team's feelings as well as the patient's; use reflective practice.
With the patient	"We make decisions together as a team." "What I say to you I also say to my colleagues." "I notice you've said something different to Dr X — can we talk about that?"

Holding risk together

The central challenge is staying engaged and helpful while supporting the patient's own ways of coping. Decisions about admission should be collaborative and individual — sometimes admission is needed. Longer term, the aim is to build ways of managing distress outside hospital, never to withhold care.

- **An explicit crisis plan,** co-produced in advance: what the patient will do first, second and third; who to call; when to attend ED.
- **Consistent, not reactive.** Warm and reliable every time, so that care does not depend on being in crisis.
- **Separate care from crisis.** Regular, predictable contact — not only when in crisis — is itself therapeutic.
- **Keep long-term goals alive.** "What does a good life look like for you?"
- **Manage your own reaction.** Helplessness, anger or over-responsibility are all informative; take them to supervision.
- **Team reflective practice** helps staff stay compassionate, and reduces burnout and unhelpful re-enactment. Essential, not optional.

What to say in the appointment

SITUATION	SAY	AVOID
Has self-harmed	"I'm really glad you came in. Let's make sure you're safe, then I want to understand what happened."	Jumping to risk assessment without acknowledgment
"You're the only one who understands me"	"I'm glad our conversations feel helpful. I also want us to build your connections with other people."	Becoming their only source of support
Says they will kill themselves if discharged	"I hear that you're terrified about what happens next. Let's talk about that fear and plan carefully together."	Dismissing what they said, or deferring discharge to avoid the conversation
Unhappy about a nurse	"That sounds like a difficult interaction. Can you tell me more? I'll also speak with the team."	Agreeing without exploring the full picture
Misses appointments, then crisis	"I'd like to understand what got in the way. And I'm glad you're here now."	Automatic discharge without exploring what got in the way
You feel pulled to do more	To yourself: "Am I responding to their need, or to my discomfort with their distress?"	Acting on the pull without reflection

SECTION 6

Lifestyle as treatment

Exercise, nutrition, nature and routines — alongside medication and therapy, not instead of them.

Lifestyle approaches are offered as additional tools, never as blame. Mental illness is not caused by a lack of effort, and changes should fit what the person can realistically manage, including their circumstances and resources.

Exercise	Trials (e.g. Blumenthal et al.) show effects comparable to antidepressants for mild–moderate depression. Likely mechanisms include effects on stress hormones, neuroplasticity and sleep. Offer it as a prescription: specific, time-bound, achievable.
Nutrition	Mediterranean-style diets are associated with lower depression risk. Keep advice practical: more vegetables, a varied diet, less ultra-processed food — one change at a time.
Nature and light	Time outdoors and morning daylight support circadian rhythm and mood. A low-barrier option for almost anyone.
Routines	Predictable wake, meal and activity times stabilise mood — especially in bipolar disorder, EUPD and ADHD. Help the patient build one routine before adding more.

The 1–2 change rule

The most common error is ambition. Small, specific, agreed changes accumulate. Motivational interviewing helps: ask permission before advising, let the patient choose the change, and use scaling questions — “On a scale of 0 to 10, how important is this to you? How confident are you?” — then ask what would move it one point higher.

> *“I just want to feel better first, then I’ll start exercising.” An understandable wish — but mood often follows action rather than leading it. Name this gently, and start very small.*

- **Start impossibly small:** “Not a gym membership — ten minutes’ walking tomorrow morning.”
- **Predict setbacks:** “Some weeks you won’t manage it. That’s fine — we come back to it.”
- **Celebrate small wins:** “You did it three times this week. That matters.”

THE LIFESTYLE PRESCRIPTION

What?	One specific activity — not a category
When?	A specific day and time, not “when I feel like it”
How long?	Achievable, not aspirational — 10 minutes is better than none
If it doesn’t happen?	Agree the response in advance: no shame, try again next week
Review	At the next appointment; notice mood before and after

SECTION 7

ACT, IFS and existential tools

Values, meaning, purpose and parts work.

Acceptance and Commitment Therapy

ACT aims to reduce the struggle with symptoms and increase movement toward what matters. It rests on six processes: acceptance, defusion, present-moment awareness, self-as-context, values and committed action. Several can be used in five minutes.

Values	“If anxiety weren’t so loud, what would you be doing with your life?” Values are how someone wants to live, not goals to achieve.
Defusion	“I’m having the thought that I’m worthless” instead of “I am worthless” — separates the person from the thought.
Acceptance	Not resignation, but willingness to feel difficult emotions in the service of what matters.
Committed action	One small behaviour toward a value today, regardless of how they feel.
Multiple baskets	Help patients hold three or four sources of meaning — relationships, work, creativity, faith — so the loss of one is bearable.
In liaison settings	After a serious diagnosis or a major change in health or role: “What still matters to you?”

Internal Family Systems — working with parts

IFS (Schwartz) sees the mind as made of parts with different roles: protective parts that manage daily life or act in emergencies, and vulnerable parts carrying old pain. The aim is not to eliminate parts but to understand them from a curious, calm and compassionate stance. A single parts question can change the tone of a risk assessment.

SCENARIO	ASK	WHY IT HELPS
Suicidal patient	“Is there a part of you that wants to stay alive?”	Accesses ambivalence without confrontation; often opens the therapeutic work.
Recovery feels stuck	“Is there a part of you worried about what happens if you feel well?”	Getting better can bring real losses or fears. Curiosity instead of confrontation.
Change feels hard	“What part of you is cautious about things changing? What is it protecting you from?”	Treats hesitation as protective, and reduces shame.
Urges to self-harm	“What does the part of you that wants to hurt yourself need right now?”	Separates the behaviour from the whole person; creates room to reflect.

SECTION 8

Putting it together

The 20-minute appointment — a reminder of what is possible, not a rigid structure.

TIME	PHASE	WHAT HAPPENS
0–3 min	Connect	Something human before the clinical agenda: “How have you been since we last met?” Notice body language, affect and what is not said. Self-check: how do I feel entering this room?
3–10 min	Assess and formulate	The standard review — risk, medication, symptoms — plus one question about the narrative or pattern behind the presentation. Hold both the structure and the person.
10–17 min	Intervene	Choose one thing: breathing, psychoeducation, validation, a linking comment or a lifestyle goal. “I’d like to try something with you — is that okay?”
17–20 min	Agree and close	Summarise. One agreed action, owned by the patient: specific, achievable, meaningful. Name the next contact. Record the intervention in your letter.

If you remember nothing else

1. Breathe first. Offer breathing to every anxious patient and practise it in session.

2. Validate before you fix. The experience makes sense given the history.

3. Your reaction is data — countertransference is an underused clinical tool.

4. Hold the dialectic: doing the best they can *and* able to do better.

5. Small lifestyle prescriptions compound. One change, agreed together, reviewed next time.

6. EUPD: consistent, warm and reliable, with clear boundaries. The steadiness is part of the treatment.

7. Ask about values and meaning, even in three minutes. A life worth living is the goal.

Resources

For clinicians	Balint and reflective practice groups; RCPsych CPD eLearning; British Society of Lifestyle Medicine; DBT and MBT awareness training.
For patients	Recovery Colleges; NHS Talking Therapies self-referral; Calm Harm app; Headspace or Insight Timer.
Reading	Linehan, *DBT Skills Training Manual* (2nd ed.); Hayes et al., *Acceptance and Commitment Therapy*; Gabbard, *Psychodynamic Psychiatry in Clinical Practice*; Schwartz, *No Bad Parts*; Herman, *Trauma and Recovery*. NICE NG222 (depression), CG185 (bipolar disorder), CG78 (borderline personality disorder).