



## editorial

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PETER TYRER, KOFI KRAMO, KATERINA MILOŠEŠKA AND HELEN SEIVEWRIGHT

### The place for nidothrapy in psychiatric practice

The treatment called nidothrapy can be regarded as a novel approach to an old problem, a rebranding of old wine in new bottles, or a vicarious diversion from the important stuff of psychiatry. Readers of *Psychiatric Bulletin*, who are mainly clinicians, are in an excellent position to decide on which is right. This review, by practitioners who are all involved in administering nidothrapy, is intended to ensure that a fourth way of looking at nidothrapy, from a lofty position of supreme indifference, is not really a satisfactory option.

#### Background

Nidothrapy (named after the Latin *nidus* (nest)) is the 'collaborative systematic assessment and modification of the environment to minimise the impact of any form of mental disorder on the individual or on society' (Tyrer et al, 2003a). It is perfectly appropriate to ask, 'so what?' in response to this, as awareness of the environment is part of the comprehensive assessment of any psychiatric patient. There have also been dozens of environmental interventions in the past, ranging from rests in the country for the alleviation of stress to permanent incarceration in institutions, that have not been of particular benefit to psychiatric patients. Nevertheless, nidothrapy has good evolutionary theory behind its use. Too much of our work in psychiatry is designed to make people into unsuccessful clones of more competent individuals in society. Charles Darwin pointed out that an organism that is a disastrous fit in one environment can be an outstanding success in another; so why not make the changes in the environment rather than persistently attempt to change the person who is unchangeable?

Nidothrapy attempts to be a formalised planned method of achieving all forms of environmental change, from moving house to feeling at ease in the settings where you spend most of your time. It therefore covers physical, social and highly personal forms of environmental change (Tyrer & Bajaj, 2005). The potential of the treatment has yet to be established, but most of our experience has been with chronic, apparently intractable, psychiatric disorders in which therapeutic despair has become the norm and 'holding' the patient in an unsatisfactory equilibrium is the best that seems to be attainable. Many of these patients are under the care of

assertive outreach teams, have comorbidity including major psychoses, and have personality disorders and a propensity to violence (Ranger et al, 2004).

Nidothrapy was first used in the treatment of personality disorder (Tyrer, 2002), but can also be extended to all forms of chronic disorder, including the full range of non-psychotic disorders and learning disability. Active therapeutic endeavour for learning disability has more or less come to a halt, but considerable handicap remains (Tyrer & Kramo, 2007). One of the advantages of nidothrapy is that motivation to change, one of the requirements for success with most complex treatments, is not necessary, as there is no direct attempt to change the person, only the surroundings, to effect a better match. This is of great help in the treatment of those with personality disorders, most of whom are treatment-resisting (Type R) rather than treatment-seeking (Type S) (Tyrer et al, 2003b).

#### Benefits over normal person-centred care?

Nidothrapy is the treatment that, above all, 'goes the extra mile' on behalf of the patient, and differs from the person-centred approach (Reid et al, 1999) in concentrating only on the environment and its interaction with the patient. The different phases of nidothrapy are described elsewhere (Tyrer & Bajaj, 2005), but the essential component is to obtain a 'patient-eyed' view of the environment in all forms and then to work collaboratively to effect changes in this. With one exception (P.T.) the nidothrapists were not psychiatrists when they carried out this work. This is not a deliberate policy, but in our practice, and we accept that this should always be subject to review, the nidothrapist is independent of the rest of the clinical team (but liaises regularly with it) and is 'outside the box' of the conventional treatment system. Being less aware of the conventions of psychiatric practice can often help in harnessing patients' enthusiasm (many consider their nidothrapist far superior to their standard therapists) and also allows changes that might seem ludicrous, such as withholding antipsychotic drug treatment (yes, this is often perceived as an environmental assault at all levels) from patients with diagnoses within the schizophrenic spectrum. This involves going beyond evidence-based practice to patient-based



evidence (Tyrer, 2000), but needs care, special understanding and good awareness of risk assessment to do successfully. However, this lack of convention may sometimes help to break the cycle of non-cooperation among a minority of patients who not only value their independence, particularly their environmental independence, above all else (Priebe et al, 2005), but have the insight to recognise their relapses and take appropriate action.

### Nidotherapy in practice

Some professionals who have observed or heard about nidotherapy regard it as either a form of family therapy, a systems theory intervention, basic social casework, cognitive-behavioural therapy, or just plain common sense. We disagree, but perhaps the following vignette can serve as an example from which others can draw their own conclusions.

A woman with a long history of paranoid schizophrenia and disengagement from services was referred to an assertive outreach team. She had repeatedly failed to adhere to treatment once she left hospital but fooled the staff into thinking she was adhering until she became very unwell and highly disturbed, following which she was readmitted compulsorily. The general view, even after spending considerable time with the new team, was that there was no alternative to continuous treatment with depot antipsychotic medication and that without her cooperation there would be continual admissions under the Mental Health Act 1983.

Independent contact with a nidotherapist revealed that, even when apparently well, the patient did not regard any of her therapists as acting in her interests and had adopted a siege strategy of keeping them at bay and trying to maintain her home as her last redoubt of defence. The nidotherapist, who was soon welcomed to her home, a place which the rest of the team had avoided as it was considered too dangerous to see her there, realised after full assessment that there was a strong paranoid element to her personality independent of her schizophrenia and that it was only when feeling safe at home that she relaxed and no longer felt threatened. Progressive constructive disengagement from the team followed, with promotion of a set of environmental improvements and transfer of control of her life back to the patient. This also involved testing different oral antipsychotic drugs until she found one with no substantial adverse effects and which she recognised helped her when she was out in the community. Her care was transferred eventually to her general practitioner.

The main differences between the standard perspective with regard to the environment and the nidotherapy perspective are shown in Table 1. We accept that primary focus on the environment should not be the norm when the patient is in a state of flux that is very different from their normal functioning, but can be when a problem has become chronic and intractable. Common sense tells us that the experienced clinician is in a better position to decide on the environmental needs of a vulnerable individual with multiple problems, but nidotherapy never acts without the patient contributing, and agreeing, at least in significant part, to the environmental change.

The skills of a nidotherapist are considerable but are not taught in standard curricula. There is the need for empathy, acceptance of all kinds of behaviour (within certain boundaries), the ability to act independently (we find that the nidotherapist works best when less closely involved with others in a clinical team) and considerable flexibility in adjusting to the viewpoint of the individual. The most difficult part of management is to obtain an agreed plan of environmental targets and the timetable for their implementation. For a good assessment it is necessary to see the patient at home, for it is only in this setting that all important environmental factors can be evaluated. There is considerable debate about the value of home treatment in psychiatry at present (Burns et al, 2002, 2006), but this is considered mandatory in nidotherapy. Understanding the environmental problems of the individual involves 'collateral collocation' (Tyrer et al, 2003a), literally placing yourself in the exact position of the patient in relationship to the environment. This cannot be done at a distance from the most important environment of all, that of the home. It is only after several assessments in the most relevant environments of the patient that a plan for nidotherapy can be formulated. It may only be a rough one at first but when it is owned by the patient it can lead to a breakthrough in progress, as it promotes autonomy and self-esteem to a much greater extent than any externally directed plan, as the vignette indicates.

Nidotherapy is not yet an established intervention but we feel it needs serious attention. It is called niche therapy in the United States (P. Cohen, personal communication), where it is being studied in some depth at present. We have recently completed a randomised trial

**Table 1. Standard and nidotherapy perspectives of the environment for those with mental illness**

Standard perspective	Nidotherapy perspective
Environment is of secondary importance in psychiatric practice	Giving primary importance to the environment in nidotherapy allows for the possibility of change that would not otherwise be attained
Once people with mental illness get better their original environmental problems resolve	Environmental problems often become persistent precipitants of relapse in mental illness
The clinician is the best person to decide on the environmental needs of the patient	The properly informed patient is the best person to decide on their needs
Environmental intervention does not require any special clinical skills	Successful environmental intervention involves sensitive awareness and special skills in balancing the needs of the patient with those of others



of nidotherapy in people with chronic psychiatric disorders. So, please do keep abreast of developments with this new approach, and if you see a nidotherapist walking towards you along the therapeutic road, do not always cross to the other side. You may have something to learn by staying where you are.

## Declaration of interest

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**\*Peter Tyrer** Professor of Community Psychiatry, Department of Psychological Medicine, Imperial College, St Dunstan's Road, London W6 8RP and Honorary Consultant in Assertive Outreach, Central North West London and West London Mental Health NHS Trusts, email: p.tyrer@imperial.ac.uk, **Kofi Kramo** Research Assistant, Department of Psychological Medicine, Imperial College, London, **Katerina Milošeska** Nidotherapist, Community Outreach Rehabilitation Team, Central North West London Mental Health NHS Trust, London, **Helen Seivewright** Clinical Research Fellow, Department of Psychological Medicine, Imperial College, London