

SAMPLE CHAPTER FROM:

Nidotherapy

Harmonising the Environment with the Patient

By Peter Tyrer

ISBN: 978-1-904671-74-9

Year: 2009

Published by RCPsych Publications (via Turpin Distribution for the trade)

www.rcpsych.ac.uk/publications



General introduction and principles

Nidotherapy (the 'i' is long) is a treatment born of despair and desperation. It has been used to date mainly for a group of people with chronic mental illness who have been in the long-term care of psychiatric services in the UK. In describing this population it is necessary to put it into context. Before 1970 mental healthcare was generally split into two groups: a large group of patients in mental hospitals (asylums; it reached a maximum of 150 000 in 1964) who had major mental illness (psychoses, dementias and learning (intellectual) disability), many of whom stayed for many years, and another, larger group who were often characterised unfairly as the 'worried well' – as they were neither particularly worried nor particularly well – who lived in the community and were not generally stigmatised as being mentally ill, possibly because the full nature of their troubles was rarely admitted overtly. Most active psychiatric care was given to the second group, many of whom were classified as having either depression or neurotic or stress-related problems, and as much was given in public (National Health Service) as in private care. Of course treatment for the other group was also given, and there was some crossover between the two, but the treatment for the more severe psychoses was mainly pharmacological and given for those in psychiatric hospitals. Most of the new drug treatments had been introduced between 1950 and 1970 and for a time they were regarded with such high hopes that other treatments were lost in their shade (Sargant, 1966). Gradually, from about 1972 onwards, but only partly as a result of this new therapeutic optimism, the deinstitutionalisation of the mental hospital began, and those in the first hospital group (I will call it thus for short) were returned to the community in one form or another. Large institutions were regarded as bad and counter-therapeutic, and good community services, with a small institutional base linked to a clear geographical catchment area (Thornicroft & Tansella, 2004) were the new form of care for these patients. Oddly enough, the optimism behind this was so great that before long the term 'recovery' replaced 'rehabilitation' and 'long-term care' (see chapter 8) and the notion that no one with a mental illness should be regarded as immune from recovery became almost a politically correct mantra.

This pervasive optimism developed its own momentum. People were not allowed to rest under the label of any form of chronic mental illness. As Berrios has noted, a whole new vocabulary developed to fit this new attitude, which he summarised as psychiatric mercantilism:

In the 'developed' Western world, 'treatment' and 'cure' are embedded in 'medical acts' which are being increasingly re-defined as scientific and mercantile transactions ('health' has become a 'commodity', patients 'clients', clinicians 'purveyors of health'). This new approach demands that the medical act be measured and priced and rendered economically efficient. Like the selling of faulty goods, 'lack of response' to treatment is increasingly being considered as a violation of a putative trade descriptions act. Courts need 'operational criteria' to decide on whether a breach of trust has occurred, and these are being provided by the so-called treatment guidelines which bodies of experts are increasingly compiling. Non-response to treatment can only be called 'treatment-resistance' if the guidelines have been complied with, and this lets the therapist off the hook. In social and legal terms, the notion of 'treatment resistance' can thus be used as an alibi as it transfers the responsibility for the lack of response from the therapist to the disease or the patient [Berrios, 2008: pp. 18–19].

So with this philosophy of care it is very difficult to admit to failure. In both the USA and the UK assertive community or outreach teams were introduced to cope with those who had not responded to conventional care, now rebranded as evidence-based psychiatry, to acknowledge that most standard interventions had been tested and had showed evidence of effectiveness, preferably in randomised trials.

This was the rocky terrain in which nidotherapy was developed. In the teams where it was practised there was no new therapy, only an enthusiastic model of care that involved teams from different disciplines and good collaborative working (Stein & Santos, 1998). But this was not always enough, and when the key purpose behind the introduction of these teams, a saving in the use of psychiatric beds, was not achieved (Burns *et al*, 1999; Harrison-Read *et al*, 2002; Killaspy *et al*, 2006) there was an urgent need to find something new. But when time after time each new therapy was thrown back as unacceptable or ineffective some radical changes in both approach and attitude were indicated.

This change was simple but dramatic. Instead of repeatedly trying to change people so that they fitted in better to their environments, we chose to change the environment so it made a better fit for the person. The adjustment of the environment is well exemplified by a bird's nest, a simple structure that adjusts to whatever is placed within it, and has the capacity to accommodate both large and small, multifaceted and round, sharp and blunt objects, and whether there are five fledglings or only one squawking within does not matter – it is equally suited to them all. We hypothesised that many people with the apparently intractable forms of mental illness seen in assertive outreach practice were out of harmony with their environment in all its forms, and it did not take too much to realise that many of them had pretty harsh and unforgiving surroundings that had never shown much

degree of flexibility. This was the starting point of an approach which has developed considerably since the early days in 1988 when this therapy began, and which has moved far beyond its original context.

Theoretical basis of nidotherapy

We are all conscious of the importance of the environment in shaping our responses to the world. But although we stress the environment almost to excess during the phase of development when putting nature and nurture in head-to-head competitions with each other, we often forget about it when development has run its course and we have metamorphosed adults in a world where choice and control of the environment are taken for granted. So we seem as one with Shakespeare's Hamlet: 'What a piece of work is a man, how noble in reason, how infinite in faculties' (*Hamlet*, Act II, Scene II), a person who should have the capacity to fit the environment to his lofty aims without much in the way of assistance. But of course, we all tend to compete for the same things, and as Darwin demonstrated so convincingly in *The Origin of Species*, the struggle for dominance of the environment in competition with others is constant throughout life and across generations, and success comes to those who are best fitted for the environment. As he wrote: 'no country can be named in which all the native inhabitants are now so perfectly adapted to each other and to the physical conditions in which they live, that none of them could be still better adapted or improved' (p. 83) and consequently, 'the slightest advantage in certain individuals, at any age or during any season, over those with which they come into competition, or better adaptation in however slight a degree to the surrounding physical conditions (italics mine), will, in the long run, turn the balance' (Darwin 1859, reprinted 1970: p. 444). Nidotherapy is introduced, to rephrase Darwin's words again, to change the environment to create 'better adaptation in however slight a degree to the mental state conditions'. Thus with those who are persistently mentally ill, we should abandon the strategy of getting them to compete with others who are conventionally more fortunate and better able to compete, and instead attempt to match their special strengths with environments that suit them and which are not troubled by their weaknesses. So instead of having a large number of individuals competing for a limited space in the Sun we are creating a set of mini-environments, each fashioned to suit the person it is accommodating, not in competition with anyone else and which allows everyone to succeed. In a civilised world in which everyone is judged to have a place it is not appropriate to have everyone struggling for the same one, but in our pursuit of perfect health we recapitulate this stupidity. Darwin's principle of natural selection can be supplemented with the principle of nidotherapy, or 'informed environmental selection', 150 years after its publication in 1859.

Alpha children wear grey. They work much harder than we do, because they're so frightfully clever. I'm really awfully glad I'm a Beta, because I don't

work so hard. And then we are much better than the Gammas and Deltas. Gammas are stupid. They all wear green, and Delta children wear khaki. Oh no, I don't want to play with Delta children. And Epsilons are still worse. They're too stupid ... [Huxley, 1932, reprinted in 2004: p. 75]

This is another way, described above shudderingly in Aldous Huxley's *Brave New World* in which children are deliberately bred to be different in their talents (Alpha at the top of the intellectual tree and Epsilon at the bottom) and then taught in their sleep (hypnopaedia) to prefer their group above all others. But this extreme of artificial selection has always remained a totalitarian fantasy and quite intolerable to those who wish for autonomy almost above all else and for whom Thomas Jefferson's unalienable rights of 'life, liberty and the pursuit of happiness' mean so much more than promises of spuriously more enticing rewards. Nidotherapy offers the same opportunity as that of people working side by side in life in reasonable harmony without the need for direct competition, a phenomenon known well in all civilised societies as the division of labour. But by concentrating on extending it to the environment in all its forms the division of labour becomes the division of living and not just confined to the workplace.

The parallels with Darwinian evolutionary theory should not be taken too far, as he was writing about competition over hundreds of generations, whereas the aim of nidotherapy is to create an immediate environmental shift. But although Darwin was enticed (by the psychologist Herbert Spencer) into adopting the phrase 'survival of the fittest' to summarise the main principle of evolution, he began by using the 'survival of the adapted', thereby stressing the important fit between organism and environment. This is the key to nidotherapy – it not only recognises that paying attention to the environment in mental health is valuable but goes further by arguing that the systematic planning and management of the environment is the best way to create mental harmony as a long-term goal.

Attitudes to treatment in mental illness

People who are ill are handicapped and want treatment to reverse the handicap. Do they really? How often have you asked them? It is true of many, but not all, physical disorders, but certainly not the norm in many forms of mental illness. The uninformed visitor observing clinical practice in mental health services is often very surprised by the lack of interest in treatment. Those with the most severe mental illnesses, the psychoses, a spectrum that crosses from bipolar disorder to schizophrenia, are often remarkable in their antipathy to anything being delivered to them in the guise of therapy. I well remember a young man with schizophrenia who developed an inoperable tumour and slowly wasted away as the cancer took hold. But he almost ignored his bodily decay; everything seemed to be subsumed to his burning desire to be rid of antipsychotic drug treatment for his schizophrenia. His wish in his final days was to go home to his family and no longer be detained

under the Mental Health Act, and both were granted. Three weeks later he became very agitated by difficulty in breathing and I brought some diazepam to him at home to try and relieve these symptoms. As I gave the little box of tablets to him he sat up suddenly, gripped my arm and staring at me, said triumphantly, 'I don't have to take these, you know, because I'm not under a section now.' He died 2 days later having taken only one of these tablets; he remained consistent to the last.

This is not an isolated account of antipathy. Although they are clearly a selected group, most people who are in-patients in psychiatric wards are either ambivalent or hostile to treatment, no matter its nature. One of the standard explanations for this is that the most effective treatments for the manic phase of bipolar disorder and the positive symptoms of schizophrenia are the antipsychotic drugs, and these often attract the title 'dirty drugs' because of their wide range of adverse effects (it is no coincidence that the first of these, chlorpromazine, was called Largactil because of the large number of pharmacological actions it possessed). Unfortunately we remain with dirty drugs for psychoses as the newer versions just have a different range of adverse effects that give them no special advantages (Leucht *et al*, 2009).

It might be thought that antipathy to the adverse effect of these drugs was the reason for poor adherence to treatment, but other interventions for these conditions are equally unpopular. Cognitive-behavioural therapy was introduced for the treatment of schizophrenia 15 years ago and has been demonstrated to be of value, at least in the short term (Kingdon & Turkington, 1995; Tarrier *et al*, 1999), but its effects are not long-lasting and it has limited value in preventing relapse (Garety *et al*, 2008). What is more disturbing is that only a minority of people volunteer for the treatment and adhere to it. As Jan Scott (2008) has summarised the evidence with regard to schizophrenia, 'the world of routine psychiatric practice brings us into contact with some patients who do not want or do not respond optimally to antipsychotic medication, but who also do not always want or benefit from psychological therapies either.' When given the opportunity, is it not curious that only a minority of patients volunteer for a treatment that might lead to at least a reduction in the dosage of the antipsychotic drugs they are so keen to avoid?

This lack of enthusiasm for treatment is commonly put down to an absence of insight or sometimes an absence of capacity. If someone is not aware they are ill it is not surprising that they see no need for any remedy. But there are other reasons that cannot be put at the door of the illness and its direct effects. One of the reasons why patients are so dissatisfied with current therapeutic delivery systems is that they are perceived as making them into people they are not. Of course, if their symptoms improve with treatment and they recognise the advantages of these changes there is no problem with persisting with treatment as adherence is likely to be good. But many others do not improve quite in the same way; they want to be different in their general functioning but not in the way the services expect.

In addition, some people with long-standing disability such as personality disorder, intellectual disability and chronic psychosis, have accepted the way they are and feel that if they were more comfortable in their surroundings in all its physical and personal forms they would not need to have treatment for what other people, looking at the problem from a perspective quite different from that of the patient, regard as an intractable mental disorder.

The argument that various happenings and circumstances are the cause of problems with mental health is nothing new. A whole field of research has developed out of life events research and yet another into post-traumatic stress disorder that is now so well-developed some think of it as an industry. However, interventions for these disorders are focused on helping people to adjust to events and turbulency, not on changing the environment in a substantial and permanent way. Even those treatments that have been focused primarily on the environment – whether it be bed rest following myocardial infarction, sanatoria in the high Alps for those with tuberculosis, or light therapy for seasonal affective disorder – are making temporary and short-term changes to the environment only. Nidotherapy attempts to make a more permanent change. Sometimes this can overlap with direct treatment; one of our patients with seasonal affective disorder found out that he remained well if he visited members of his family in New Zealand in the UK winter, and decided eventually to go to New Zealand every year to keep his mood in good order (Tyrer *et al*, 2003a).

Although we live in an age that proclaims the advantages of diversity, we are in danger of becoming slaves to approved fashions and are increasingly intolerant of variety we do not share, which is especially true with much of the diversity demanded by the mentally ill. Nidotherapy acknowledges diversity in a more honest and open way than most other approaches. Dr Cawley persuaded Janet Frame to admit something she knew all along, ‘I was myself, I was an adult, I need not explain myself to others’, but over the years of conventional psychiatric treatment she had been told repeatedly that she was abnormal, even to the extent of having prefrontal leucotomy recommended, so it is not surprising she had begun to doubt her own beliefs. Many other patients, either suffering alone or in long-term psychiatric care, are in the same position as Janet. They feel they know themselves but are repeatedly told that this knowledge is defective, that they should be looking for a different person that ‘therapy’, whatever is nature, will enable them to discover.

Fundamental differences between nidotherapy and other psychotherapies

Although the differences between nidotherapy and other psychotherapies are addressed in more detail later in this book, it is also worth stressing them at this point. Nidotherapy is not just a form of environmental manipulation or social engineering, a social model of psychiatry (Tyrer & Steinberg,

2005) that regards most interventions in mental illness as examples of 'medicalising'. Such a model does indeed focus on the social environment but generally makes no attempt to change it specifically as a form of management. Nidotherapy is also none of the following: a rebadged housing advice service or accommodation bureau; a career development service that finds out your abilities and picks the right role; a lifestyle advisory service or an internet dating service that provides the perfect place to meet the person of your dreams (although it is prepared to use any of these agencies once a way forward (nidopathway) has been developed). Instead, it is essentially a complicated matching process whereby people's deep desires, vague wishes, fundamental opinions and lifestyle are understood sufficiently to ensure that environmental factors in all their forms are adjusted sensitively and specifically to make the best fit for the patient. There are many other treatments that take great account of the environment but they are all fundamentally concerned with making adjustments to the person, either exclusively or sometimes in connection with the environment, but in which all environmental changes are made to facilitate the person changes. Such treatments include person-centred planning, cognitive-behavioural therapy, modelling and shaping, schema-focused therapy, family therapy, systems theory, social case work and the care programme approach.

So in strict terms, nidotherapy is not a treatment because its prime purpose is to manipulate the environment or promote a better engagement with it, and any changes in the patient are secondary to this manipulation. When nidotherapy crosses the border into direct treatment of the patient it is no longer nidotherapy and can use any of the psychotherapeutic interventions described above. Quite often there is an element of nidotherapy in conventional mental health services, particularly when a clinical team gets to the point of saying 'Nothing has worked so far, what do we do now?' At this point of fitting a square peg into a round hole, therapists can sometimes take more interest in the hole than the peg. Even when it does get to this point there is a tendency to adopt a paternalistic approach in which the patient is a passive onlooker and the general attitude is 'You stay out of this for the time being. We'll sort out what you need and then let you know.' Often good environmental changes are being made at these times, but it is much better to have them recognised clearly instead of relying on 'sleep-walking nidotherapy' in which some aspects of the treatment are being used but neither patient nor therapist know what they are doing and why.

So the important questions to ask yourself if you are doing something that may or may not be nidotherapy are best expressed as:

- 1 Is the considered intervention designed to change the patient's environment in the long term?
- 2 Is the change designed specifically to promote the patient's environmental adjustment?

It is only when both are answered positively that we can conclude that nidotherapy is being practised. The other therapies described above are

all designed to change *people*, and although the environment may often be altered in these therapies, it is done as part of the treatment of the person.

The division between nidotherapy and other treatments is therefore straightforward. When nidotherapy crosses the border into direct treatment of the patient it is no longer nidotherapy, and when other forms of treatment cross from being patient-centred to entirely environment-centred they may become nidotherapy. It is useful to give an example from our practice to illustrate this. A patient whose main problem was obsessional hoarding used to carry a great many polythene bags with him when he went to the local supermarket. He was regarded as a hazard with all these bags and was banned from shopping there. When assessed by his nidotherapist he identified the difficulty of going to the supermarket as one of the environments he would like to visit. After negotiation he was persuaded to put his goods into only two bags and with these he was granted access to the supermarket again. Some would say this was an example of behaviour therapy with possible cognitive overtones but the behaviour had not changed in any fundamental way; it was just that many bags of apparent rubbish were converted into two bags and this was deemed acceptable. More importantly, the patient regarded it as a victory as all his hoarding principles had not been compromised in any way. The difference is subtle but relevant – if he had been persuaded that it was wise to take fewer possessions into the supermarket as he would have an obvious gain, this would have been behaviour therapy. The small difference is important; the environment had changed a little, the patient had not.

Ego-dystonicity and ego-synchronicity

Ego-dystonicity and ego-synchronicity were described by the psychoanalyst Franz Alexander more than three-quarters of a century ago (Alexander, 1930). Symptoms and behaviours that are ego-syntonic are consistent with the person's normal functioning and regarded as integral. Those that are ego-dystonic are viewed as alien and undesirable and so are desired to be removed as soon as possible. Sometimes the same symptom can be present in both groups. For most people the symptom of depression is ego-dystonic but when it becomes part of an integrated view of the world it may be ego-syntonic. Most nidotherapy is best suited to problems that are ego-syntonic – the ones that are problems to others but not to those who experience them, who tend to regard the difficulties created as caused by those who complain rather than by they themselves.

Of course there is bound to be overlap between nidotherapy and other forms of psychological treatment and it does no particular good to spend time quibbling over whether an intervention is really one therapy or another. The essential differences between nidotherapy and other forms of management are summarised in Table 1.1, but the underlying philosophy is at the core of all these differences. The nidotherapist takes people as they are and not as individuals who desire to be changed, and the challenge of 'treatment'

Table 1.1 Essential differences between nidotherapy and other psychological therapies

Essentials of nidotherapy	Essentials of other psychotherapies
Environment-centred	Person-centred
Makes no attempt to change the person	Directly or indirectly attempts to improve the person through change
Attempts to promote adaptation by selecting suitable environments	When attempting to promote adaptation does so in the context of helping the person to adjust better
Close relationship with person needed to understand environmental needs	Relationship with person developed to aid understanding and treatment of psychological problems
Aims to make the person feel more at home in every sense	Aims either to relieve the person of unpleasant symptoms or distress or to understand the person more
Collaboration at the environmental level allows the person to choose the most fitting of living settings	Collaboration, when promoted, is used as a means to effect personal change

is to reach the harmony of ‘perfect person–setting concordance’, or the ideal environment to match the needs of the person. This is the philosophy of adaptation, not of change, and it differs from all other psychological therapies in this regard. So when asking yourself whether something you do is nidotherapy or something else, just ask ‘Am I doing this because I want to change this attitude, symptom, behaviour or need, or am I accepting this as part of the person and want to accommodate it?’ It is clear which is the path to nidotherapy.