NIDOTHERAPY GUIDEBOOK

Peter and Helen Tyrer

Imperial College, London

This booklet is intended to help all who wish to practise nidotherapy. This includes the general public as well as health professionals of all kinds. As nidotherapy can be used in many different types of illness, the way it is given will vary greatly. But, nontheless, we are still trying to cater for everybody in this guide, even though it will be most helpful in rehabilitation and similar settings. For many other more difficult problems, this guide will not be enough and, because of this, references will be made at times to the companion book

on nidotherapy, *Nidotherapy: Harmonising the Environment with the Patient* (Tyrer & Tyrer, 2018). We have three sections on nidotherapy: what it is, how it should be introduced, and the four phases of management. The italicised points at the end refer to the different settings where nidotherapy can be practised, with bold italics for the case examples.

SECTION A. THE CORE OF NIDOTHERAPY

What does nidotherapy do and how can you make it happen?

Nidotherapy changes the world of the person who does not fit in. Most of us can adjust our own particular world to our own liking but many with mental

illness either cannot, or do not have the ability or opportunity, to alter their circumstances. So we need to help them. Here's how we do it.

1. We need to understand what is wrong with their present environment and circumstances. This is not easy. Understanding is not just listening to a set of complaints and noting them down. It involves getting to know what has happened to the patients in the past, what they want to see in the future, and what barriers are preventing their achievement. If you do this well, you can be their trusted environmental guide.
2. We need to sort out superficial wishes (e.g., 'I'll be alright if you just let me out of hospital') from real needs, and this requires you to know the person inside and out, so that you can pick up immediately which paths are right to follow and which will be dead ends.

3. Once we have got to know the person properly we can then carry out an environmental analysis. This is less complicated than the mental equivalent (psychoanalysis) but can still take some time. We need to know about every aspect of the environment, the physical surroundings, social contacts, especially those that are judged most important, and the personal environment, or the settings where the person feels most comfortable and safe. This assessment also includes examining past experiences as those times when the person has felt most comfortable and complete can often help to inform future environments.

4. Once we have the environmental needs identified, they need to be put into an appropriate order and a timetable needs to be set up for their implementation (assuming that is possible).

5. Finally, we need to monitor progress with the timetable and adjust if necessary, sometimes in major ways, before the goals are achieved.

As you might imagine, we often need extra help in this process, but the good nidotherapist will be involved from start to finish.

That is nidotherapy in a nutshell. But you will have further questions before you get started. What do all these terms mean and how are they connected?

We will anticipate these by answering five questions.

What exactly is nidotherapy?

Nidotherapy is the conscious manipulation of the environment to make a better fit for people who have problems, ones not being helped by other forms of treatment. It is named after the nest (*nidus* in Latin) as this represents a natural environment that is adapted to any shape. Because nidotherapy is not a treatment of the person, but of the environment, it does not clash with other

forms of treatment. The environment in nidotherapy includes the physical one (where you live and work), the social one (whom you meet and mix with), and the personal one (how you feel in relationship to the environment). These often overlap.

Who is nidotherapy for?

The person needing (not necessarily wanting) nidotherapy is like someone in distress who has arrived at a large house, perhaps many years ago. There are many rooms and a maze of long corridors, and after some time it is clear there is no easy way out. So, rather than trying to escape, the person asks for help or tries ways to feel more settled inside this prison. None of them seem

to work. Finally, nidotherapy offers a way out, literally. Without it, the house is like Hotel California in the well-known song, and you can never leave.

So nidotherapy should be considered when any mental disorder, mild or severe, has become fixed or long-standing, and all the recommended treatments have been used without success. It shifts the attention from getting improvement in the person to getting improvement in the environment. At first sight this appears contradictory. The person will still be the same even if we change the environment. But this is not exactly true, as when we fit in better we also feel better.

NB. Patients coming to rehabilitation units are all likely to have long-standing conditions and so most will be suitable for nidotherapy in principle. For those in

other settings nidotherapy may be needed when other environmental options have all been tried and failed, or there is genuine uncertainty about a way forward. In the UK social prescribing (Tyrer & Boardman, 2020) may be linked to nidotherapy; it is similar in principle.

Who should practise nidotherapy?

This is more difficult to answer. Some seem to have inborn skills; some can develop them, others do not quite get there. You will find out by the time you finish this guide. In our work we have often found that front-line workers who have the most contact with patients are the ones who make the best nidotherapists.

What conditions can be helped by nidotherapy?

Nidotherapy can be practised in any form of mental illness. But skill is needed in deciding when to introduce it in treatment. In general it is not usually wise to give nidotherapy during acute episodes of illness.
(There is no reason why it should not apply to all people, whether residents at rehabilitation units or elsewhere, but only when acute episodes of illness are over)

What are the goals of nidotherapy?

The goals of nidotherapy are set by the person being treated, not by the nidotherapist. It is a genuine person-centred form of management. This is a

natural consequence of nidotherapy being a true collaborative treatment in which the final decisions are made by the patient, not the therapist. So the goals can vary greatly but are all environmental ones – a new place to live, a new activity or job, a new relationship with others. Sometimes they are very complicated with many different facets, at others they are very simple. One of the most important rules in nidotherapy is to ‘let the patient decide’; do not force your own views, or the views of the system, and pretend they are ‘in the patient’s best interest’. If, through circumstances, you cannot achieve the patient’s goals, be frank about it and apologise. Of course, the main goal for a patient is to get better, and this often comes from a positive environmental change.

Is nidotherapy a treatment?

Although nidotherapy is often listed as a psychotherapy (eg. http://www.commonlanguagepsychotherapy.org/) it is not psychotherapy in the true sense of the word. Psychotherapy can be economically defined as 'the treatment of mental illness and associated disorders by psychological rather than medical means.' Giving advice and evaluating possible environmental changes is not then a psychological treatment, but some would argue that the exercise of nidotherapy involves psychological skills. It would be better to list nidotherapy as environmental management rather than as environmental treatment, since neither the environment nor the patient is receiving treatment directly. The patient receiving nidotherapy is like a piece in a large complicated jigsaw; the therapist is not altering its shape but finding the place in the jigsaw where it fits most comfortably.

SECTION B INTRODUCING NIDOTHERAPY

Although for complex problems many people need to be involved in nidotherapy this does not mean it cannot also be given very simply. Everyone can deliver nidotherapy to themselves and most of the time it is not difficult. If we do not like our environment, in whatever form, we change it for a better one. So we choose our occupations, the places we live, our partners, our friends and our life style. For most of us this is not difficult. We do not need advice. But for many with chronic illness, both mental and physical, the choices are not so simple. The right ones are either too difficult to achieve or the choices have never even been considered.

Who's who in nidotherapy

This guide has common principles but how they are used depends on (i) the quality of your relationship with the treated person, (ii) the amount of influence you have on the environmental factors involved, and (iii) your ingenuity (we will come back to that later). There are often many people involved in planning and giving nidotherapy; these are shown in Table 1.

Table 1

Title	**Role**	**Key functions**	**Links**
Nidotherapist	Guide patient through all stages	To develop a trusting relationship, complete environmental	With relatives, supervisor and co-therapists

		analysis	
Supervisor	Staff with approved training in nidotherapy	To select point at which nidotherapy is introduced, regular supervision	With nidotherapist and senior advisers
Senior adviser	Senior staff or colleagues with managerial skills	To ensure that nidotherapy is integrated with rest of patient care	With supervisor and decision makers
Co-therapist	To assist nidotherapist	To work closely with nidotherapist when more than one key person needed	With nidotherapist

Decision maker	Senior management and equivalents	To approve nidotherapy approved decisions (eg. specific discharge plan)	With senior advisers and sometimes with nidotherapist
Advocates	Nidotherapist and patient	To act on behalf of the patient when external review needed	With nidotherapist, decision makers and senior advisers

The remainder of this booklet outlines the skills needed, the training required, and the coordination of nidotherapy throughout the period of treatment.

In hospital structures these elements are usually always needed. In personal nidotherapy only the nidotherapist may be necessary

a*. *The role of the nidotherapist

The nidotherapist is the central person in the treatment programme. Their task is to create a relationship of trust and acceptance with the patient so that the environmental analysis that follows will lead to a pathway chosen and endorsed by both patient and therapist.

b. The role of supervisor

The supervisor needs to be approved for this role. There are annual nidotherapy training workshops held every year and other training sessions

can be arranged when necessary. The accreditation system for supervisors is still in development but we emphasise that good background understanding of mental illness is an important aspect, so that treatment programmes are not set up prematurely.

(In intensive nidotherapy a well trained supervisor is needed to select the time nidotherapy should start and help with its implementation and monitoring. In general practice and other similar settings, some knowledge of nidotherapy is required but to a much lesser degree. A social prescribing link worker could in principle take on this role.)

c. The role of senior advisers

Senior advisers will often be the line managers of other staff in hospital structures. In others they may be key people in a household or care home, senior management in charitable institutions, and administrative staff in correctional and other institutions. They need to be appraised in advance of major plans being made in nidotherapy.

d. The role of co-therapists

It is often an advantage for a nidotherapist to have assistants in their work. Such co-therapists may be outside the formal care system (eg, relatives, close friends, work colleagues) and need not have full training in nidotherapy. But if they understand the planned environmental changes (nidopathways) they can often help to implement them, particulary outside hospital. These are discussed further in the book (Tyrer & Tyrer, 2018, Chapter 6).

(When nidotherapy leads to a major change of environment (it often does) it is appropriate to co-opt, and if necessary train, co-therapists in order to maintain the programme).

e. The role of decision makers

Decision makers are needed to approve transfer to other hospitals, release from prison, placement in care homes, other supervised accommodation and independent living. They do not need to have specific knowledge of nidotherapy but do require understanding of the logic involved in the nidotherapy process.

f. The role of the advocate

Advocacy in nidotherapy is an important aspect of management that is often needed at critical stages. The nidotherapist can pass on to the advocate the beliefs, wishes and concerns of patients and the environmental options that have been chosen and why. This adds reinforcement to nidotherapy plans. Frequently arguments for a specific course of action may be misunderstood, especially if imperfectly put by patients who cannot always express their views well. If these are put in much better focus by an advocate they are more liable to be accepted. Examples of successful advocacy are given in the book (Tyrer & Tyrer, 2018). Often, when the nidotherapy solutioin is a complex and intricate one, the nidotherapist may choose (or be chosen) as the best advocate for the patient.

Who should be the nidotherapist in a clinical team?

The list of responsibiities above does not preclude any of the staff in a clinical team taking on the role of nidotherapist. The following example illustrates this.

Derek was a young man with borderline intellectual difficulty and unmanageable behaviour who had been in hospital for over a year without any progress being made. He was mainly incoherent, would not engage with nursing or medical staff and when attempts were made to persuade him to do anything perceived as therapeutic he became aggressive. It was very difficult to reach any form of diagnosis. Eventually he was seen by the music therapist in the team. Derek, surprisingly, agreed to accompany her to the music room and she

offered him some percussion instruments for him to try, which he laid about with gusto while she accompanied on the piano. They improvised together. However, just as they were beginning to come together, Derek suddenly stood up and walked out. The music therapist understood this as Derek regulating his distance from her, and continued to offer the same time each week. Gradually, after a few more fractured attempts at connection, Derek began to settle into the co-improvisation in a more organised way. He began making whole melodies and even chord progressions on the piano, accompanied by the therapist on the violin.

Over the course of this treatment he became more manageable in the ward. He cooperated with nurses, his antipsychotic medication was

reduced and he was able to meet his relatives and converse with them. Within three months he had progressed in music therapy to such an extent that in recordings of the sessions it was difficult to tell who was the professional and who the patient.

After four months of starting treatment he was able to be discharged to a supportive home where he settled in well. He did not require readmission.

This example is unusual in that it was impossible at first to know what the patient really wanted, so decisions had to be made blind. This was proxy nidotherapy, and it sometimes becomes necessary. But, once started, it was

clear who was the nidotherapist. Nobody else came close. So although the course of this problem was an unusual one it shows that the person who is best able to make a good collaborative relationship with the patient is likely to be the best nidotherapist.

Introducing nidotherapy on arrival

It is not easy to introduce nidotherapy. The name sounds like mumbo-jumbo even though the ideas behind it are quite straightforward. Here are some suggestions:

1. To be said after the initial assessment of a patient on admission to hospital - 'there must've been times when you have been in hospital that

the environment, that is to say the people in the ward and the attitude of the staff, has made you feel either better or worse. What we would like to do in this hospital is to give special attention to all aspects of the environment, not only now, but looking ahead to the future. As you are the best person to know how you feel in any situation you are going to be the key to any changes that are made. So the plan is to get to know you well and work out ways of making the environment work for you, not only in hospital but when you leave.'

2. To be said in an outpatient consultation - 'we seem to have got a bit stuck about your treatment and progress. Sometimes, as it often said, we need a change in scene. But there are many changes that one can consider. These are all linked to the environment- everything that is round about us- and I wonder if we could look at that as a way forward.'

3. To be said in a non-clinical situation - 'we need to look at every aspect of the problem here, not just your symptoms and feelings. What can we do to change your life in all its respects to help.'

It is not always necessary to bring up nidotherapy directly. You can introduce it by stealth in various ways:

(a) to be said shortly after admission:
'How do you feel about coming here? Do you feel comfortable (with the ward, with the other patients, with the staff)?
We are asking these questions as we want to pay attention to all the things going on around you, not just how you are feeling. While you are here we

want to make sure we take notice of your views about the surroundings as this is going to be important in planning your time here and when you leave.'

(b) at any time in the early stages in discussing progress:
‘We are not just interested in how you are now, but how you are in your surroundings. The idea behind this is that if you are comfortable in where you are and with the people around you, that this should be taken on board in planning your future. We want to create the circumstances where you feel right’.

(c) when talking about responsibility:
‘We want you to help us in making the right decisions for your future. Rather than decide things for you, we want to have your views on where you want to

go in life. This will help us to make the right choices, and, in the end, these are your choices and you need to make them work’.

SECTION C. THE PHASES OF NIDOTHERAPY

We need to go back to the ‘large house’ analogy earlier to sort out the four phases of nidotherapy. When stuck in a building from which there is no obvious escape you first try and find a route out. When this fails you may wish to call on others to help. But you have to trust them and not believe they are part of a system to keep you in the house. So the first part of nidotherapy is to get the confidence and trust of the patient – breaking the personal barriers. This can take some time. The second is to look at all the parts of the house

where there might be a way out and deciding which are the most promising ones to follow up - examining the obstructions. The third is the exciting component; planning how and when to get out - the escape strategy. Finally, guidance is often needed in getting to the right destination after you have escaped.

Phase 1. Breaking the personal barriers

Many of the people who could be helped by nidotherapy have become disillusioned with mental health services and do not trust others who purport to help them. This is a particular problem when patients are passed from service to service and seldom have the chance to make meaningful relationships. So when faced with suggestions about a new type of therapy, patients tend to be

non-committal or even cynical. When discussing changes in their circumstances, they often claim the changes they want are regarded as unattainable or being prevented by others. In this context 'others' include many health professionals and their colleagues, who all too often are put into a collective box and labelled 'the system'. Those in ‘the system’ are seen as working to preserve the system, and wrongly perceived as not on the patient's side. This concern may appear exaggerated but even in the best of services failure to improve is associated with feelings of resentment, not always expressed, and an air of suspicion when something new is suggested. Generally there is greater mistrust whenever a new therapist appears on the scene, or when a patient has just been admitted. In breaking down the barriers that can prevent the collaborative relationship necessary for successful treatment from developing, it is necessary to follow some essential

principles and avoid traps.

The essential elements include:

(1) acceptance of patients as they are with an understanding of how they feel without ascribing pathology to any behaviour,

(2) attempting to put yourself in the patient's shoes to such an extent that you can sympathise with their frustrations and irritation in a genuine way (eg, 'I can quite understand why you felt like that. I think I would be equally upset in your position.....').

(3) divest yourself of status so you can deal with the patient at their level. This can be very difficult, not least as complete equivalence is impossible; the therapist always has extra assets.

(4) let the person speak; even if he or she is loquacious, do not interrupt them in mid-flow as this will give the impression you have already come to a conclusion about the problem.

The traps to avoid are:

(1) getting involved in discussion over the meaning of symptoms or other forms of possible pathology. You are here as a nidotherapist, not as a psychotherapist or expert in mental health expertise.

(2) jumping to any decisions about environmental options prematurely. What appears on the surface initially may be a long way from the necessary environmental change. This is especially concerning when the patient insists that only one environmental change is needed (eg, discharge from hospital).

(3) any suspicion of paternalism (ie, we know what is best as we have a broader perspective and can decide what is good for you), condescension or expertise. Nidotherapy is truly collaborative; you cannot make decisions alone and hope to drag the patient along behind. Even when the therapist has identified what appears to be the right way forward it is important to help the patient accept and, eventually, own this decision so it is truly a personal one when it is carried forward.

Phase 2. Examining the obstructions: Environmental analysis

There may be several ways of getting out of the prison house and each obstruction to escape has to be examined carefully. Sometimes there is an

obvious exit that is blocked, at others there may be many more and it is difficult to pick on the best one or look at several simultaneously. Environmental analysis can be regarded as the mental equivalent of psychoanalysis, but it is all in the open, nothing can be attributed to the unconscious, and it can be exposed for all to see. One of the positive aspects of environmental analysis is that it does not directly challenge the person's mental integrity. Psychoanalysis can be very challenging, as everyone who has encountered it will understand. But there is no need for transference or counter-transference, projection or defence mechanisms in nidotherapy. The discussion of environmental problems should be neutral and quite devoid of anger, irritation, attribution of motives (hidden or overt), blame, or transference or counter-transference. Put more simply, if you follow the instruction 'stick to the environment, don't get diverted', you will be

on safe ground. But also note that environment in this context is a blanket term that covers a great deal more than the physical environment - nidotherapy is not a form of Feng shui. The physical, social and personal environments of the patient all have to be embraced in nidotherapy. So the wish to be in better accommodation, the desire to be in the company of some people but not others, and the need to be in an environment where the person feels safe, are all appropriate to be examined in the environmental analysis, and the features that prevent them as possible obstructions to progress.

There are several ways of carrying out this analysis - making lists of all the wishes of the patient and attempting to put them in priority order, exploring in depth the one or two prominent needs that most concern the patient, or approaching the subject indirectly by asking what is wrong with the present

situation and then adding a possible suggestion or two for change. There are nidotherapy scales, including fidelity ones, in both our books on nidotherapy but these are not mandatory.

Because the patient's preferences are important to begin with the assessment can be made on their terms, not on yours. It may well change later, and here the therapist may be the one who guides, but not at the start. Here is another example:

Fred is a young man who is chronically depressed. He lives with his family, is unemployed, but has little need for extra income but resents having to live there with them. In the environmental analysis his

annoyance at being at home was identified as the most prominent one to change. He wanted to move out. But in further discussions, also involving his family, other factors, including the need for further training, his lack of social contacts and isolation, became more prominent. In the end it was agreed that he might stay at home but enrol on a further education course to obtain suitable qualifications. He embraced this with enthusiasm eventually and nidotherapy ceased when he had started on a course and was doing well. Sometimes the analysis yields so many options it is difficult to know how to start. It is all very well to have a shopping list of wants, but many of them will not have been thought through and be originally viewed as unimportant. But they may not be on reflection. The task of the nidotherapist is to evaluate which of these are feasible, and which fit in best with the patient's background and beliefs. The good nidotherapist should be a

catalyst for change; able to pick up on the small and make it large. The alternative problem is one where no options are offered at all by the patient. They cannot be constructed out of nothing, so here there have to be discussions to identify possibilities. They will be there; they just need a bit of searching.

The essential principles in environmental analysis are:

(1) remember to include all aspects of the environment, and in doing this it is often wise to avoid using the word 'environment' as it is too linked to the physical environment in common usage, so ‘circumstances’, ‘situations’, ‘ surroundings’ can be used instead.

(2) separate all aspects of caring for or treating the patient from this analysis. This does not mean that when the type of treatment or its effects are ignored when they are brought up, but only their environmental attributes discussed. Thus it is perfectly proper to discuss the apparent hostility of the environment with someone who is paranoid, and even the change in this apparent hostility with treatment is relevant to this, but you must not enter into discussions about psychopathology or clinical management. The only exception is when at the end of environmental analysis it is felt that a sought after change seems to be at variance with current clinical management or policy. This tosses the subject into the clinical arena and at some point it will need to be discussed with others. Keeping the discipline of sticking to the environment is not always easy, especially for those who are trained to care as part of professional development. If you find yourself wanting to treat symptoms and care for

distress please stop and think again. These feelings are understandable but they interfere with nidotherapy.

(3) challenge the patient gently if the changes requested do not seem practical or feasible, but do not dismiss them lightly or scoff; there may something valuable that can be rescued from apparent futility,

(4) do not be afraid to bring your own experiences into the discussion as this can be part of good collaboration (eg, 'I used to feel the same way when I was interviewed by people in authority but then I realised it was very different when I saw them socially - they were just like you and me underneath'),

(5) test out ideas before considering them in practice, such as asking the patient either to envisage what they feel like if the environmental change occurred, or asking them to try something similar to the suggested change (eg, if the patient wanted to live alone he or she could try this in some form for a few days and feed back their experiences).

The traps to avoid are:

(1) arguing over what is or is not an environmental change - these will be naturally sorted out in further discussion,
(2) getting hooked on to a possible change too early and then seemingly letting the patient down when it is abandoned. It is better to be circumspect and cautious at first until all possibilities have been considered,

(3) taking control of the interviews to try and force the pace. Remember that the changes that are recommended are ones that have to be endorsed fully by the patient and accepted as their own. Cajoling people into changes that seem reasonable to the therapist but not fully accepted by the patient are very likely to fail,

(4) getting into highly confidential or secretive discussions, as there is bound to come a point at which at least partial disclosure of some sort to others is going to be necessary. There is a danger too that this can lead to an impression in the patient's mind that 'it is just you and me against the world'.

Phase 3. Planning the escape: the nidopathway

After the hard work has been completed the way out of the prison house has been identified. The time and date of the escape are now known and the different stages that follow are also detailed. The timetable and review points are also known. This phase can be very straightforward, but only if all the elements have been checked and the personnel involved at all levels have approved the arrangements. Good examples are given in the second edition book.

The essential principles of this phase are:

(1) ensure that the patient is 100% behind the change. If not, there is a danger if things go wrong that you, the nidotherapist, could be blamed for things going wrong.

(2) Get the timetable right. This usually means that every timing has to be provisional and, if there are delays, disappointment will be less.

(3) Do not set the targets to be attained too far ahead. Three months is good enough.

(4) Make it clear which are the responsibilities of the patient and the nidotherapist during this phase. There is always the possibility that the patient may sabotage the plan at the last moment, either unwittingly or as a consequence of the ‘Prufrock syndrome’ (pp. 28-29 in second edition), the sometimes more comfortable position of making sure nothing changes so criticism of ‘the system’ can be maintained.

(5) Do not abandon the patient in midstream. Once a patient goes to a different facility the nidotherapist may feel the necessary work has been

done, especially if the therapist has no jurisdiction over the new environment. If this is the case the therapist must make links with the new equivalents in the other structure, keep them abreast of the plans before the change takes place and keeps a liaison channel open afterwards.

(6) Give abundant praise once achievements start to be made. This is the time to emphasise the patient's role in the process of change.

The traps to avoid are:

(1) Do not raise hopes too much in advance. An excellent way forward can be agreed but then cancelled at the last moment as a senior colleague

either cannot approve it or some other person up the line has not allowed it to go ahead. So always be cautious and point out the snags.

(2) Maintain a professional relationship. There is sometimes a tendency to idolise a therapist who seems to offer a special way forward. The opposite of the advice in (5) above is the need for the patient only to relate to the original nidotherapist even when there are good reasons to move on and trust others equally. As mentioned in the 2018 book we have not come across this in our own practice but it is certainly a possible risk.

(3) Even though you as the nidotherapist may be the main person who has planned the ‘escape route’ do your utmost not to promote it. The patient is now in the driving seat and you must not change places.

Phase 4. Reaching the goal

If you are lucky the last phase of nidotherapy will look after itself as all the parts planned in Phase 3 will have completed according to the original timetable. But it is more likely that further obstacles will appear on the route. Here the nidotherapist will continue to act as a guide and help in negotiating a way round them. Many of these hurdles are easy ones to deal with, but if the patient is in unfamiliar territory and had little practice in dealing with everyday matters that others would find easy, it becomes necessary to add a helping hand. In our books this is called ‘monitoring of the nidopathway’; this is a little over the top for what may be only minor interventions but they are nonetheless important. In this area some colleagues attending our workshops have commented that the tasks here are, in the jargon of today, deskilling, but

they are not. The relationship between the nidotherapist and the patient should now be a strong one and the value of independent advice, even on matters that could be considered trivial, is positive and sustaining.

The essential principles of this phase are:

(1) Keep contact as long as it is desired after the ‘escape’ is made, but with a longer and longer leash, so that after some time only the occasional phone call is needed. Some people are nervous about giving their contact details, including phone numbers, but some means of contact is necessary if nidotherapy is to be concluded successfully.

(2) Maintain liaison with relevant services and individuals (eg relatives) so that if there are problems not admitted to or addressed there is still a channel open for further intervention.

(3) When dealing with obstacles always keep the main aim in view, so that if changes are needed they do not compromise the main goal.

(4) If, by some mischance, it becomes impossible to achieve the central goal then the next best one needs to be identified and followed through. This, ideally, will have been discussed in phase 3 of nidotherapy but if it is totally unexpected a full review may be needed.

The traps to avoid are:

(1) Do not be persuaded that you are the only person who can deliver nidotherapy. If the plans are clear the responsibility can be passed on to others.

(2) Do not present yourself as the universal problem solver for the patient. Remember, the responsibility for the nidotherapy programme is a shared one and ultimately owned by the patient.

(3) When problems do arise in monitoring progress try as much as possible to share decision making with other personnel. Although you may be perfectly capable of doing this on your own as the therapy is now tailing off it is better to have controlled detachment.

When should nidotherapy end?

One of the major problems of what are now called ‘health technologies’ is that they set limits on treatment, usually giving a standard number for a normal course and extra for an intensive one. Whilst this is understandable at a managerial level it is utterly stupid at a clinical one. So a nidotherapy course must be open ended. It may sometimes have to be circumscribed by illness, situation (eg, moving abroad), or by refusal by the patient or others to allow engagement. If the nidotherapist is part of a system that does not allow follow up this may also prevent the open-ended approach. But the principle to be made clear at the beginning of treatment is that the therapist intends to stay with the patient until the environental aims have been achieved. Some form of contact is usually possible and we have found that even an occasional telephone conversation once every two years can still be highly reinforcing.

So do not make nidotherapy time-limited. End it my mutual arrangement, not by external diktat.

We finish this guide by listing the ten principles of nidotherapy and describing the case of Heather. Her experience is described in more detail in a notable case example published in 2017 (Spears et al, 2017). Heather was a severely ill patient who had been under the care of Dr Ben Spears, a psychiatrist from Prince Edward Island in Canada, for over 20 years. She had been diagnosed with severe depression together with borderline and other personality disorders and had attempted suicide over 25 times, including proxy attempts such as swimming out to sea on a rip tide expecting to be swept away. She was certainly eligible for nidotherapy as no treatments had been effective and

she remained very unwell. Then Dr Spears attended a nidotherapy workshop in 2012 and her life changed greatly shortly afterwards.

Her experience is worth recapitulating as it illustrates the ten principles and the four phases of nidotherapy very well.

The ten principles (explained in greater length in the second edition of the nidotherapy book) are:

1. All people have the capacity to improve their lives when placed in the right environment
2. Everyone should have the chance to test themselves in environments of their own choosing

3. When people become distressed without apparent reason the cause can often be found in the immediate environment
4. A person's environment includes not only place but also other people and self
5. Seeing the world through another's eyes gives a better perspective than your eyes alone
6. What someone else thinks is the best environment for a person isn't necessarily so
7. All people no matter how handicapped have strength that can be fostered
8. A person's environment should never be regarded as impossible to change
9. Every environmental change involves some risk but this is not a reason to avoid it
10. Mutual collaboration is required to change environments for the better

Heather's case example

Heather had always wanted to leave the family home as she felt her life there was too constricted but she did not know how (Principle 1). She had an idea, but it was nothing more than that, of living independently in the company of her dog (Principle 2). When her psychiatrist, Dr Ben Spears, attended a nidotherapy workshop in February, 2012, he had already been seeing Heather for 22 years. He had tried very hard to improve her mood and prevent her suicidal behaviour but despite many external referrals to psychologists and counsellors, prescriptions of psychotropic drugs, and psychoanalytical therapy she was making absolutely no progress. On one cold December day, Dr Spears had seen Heather in his office, felt she was severely unwell, and took her to the psychiatric ward at the local hospital. After admission, as Heather had brought her dog with her to the appointment, Dr Spears took the dog

back to the family home in his car. This was the first time he had been to Heather's home in 22 years and he was shocked to find a cheery, noisy gathering of family members oblivious to the dangerous suicidal state of their daughter. This upset him greatly and so he felt impelled to practise his first formal nidotherapy intervention.

He asked himself, '"was this the right environment for Heather to be in and was this the reason why all her previous drug and psychological treatments, together with psychodynamic treatments, had been unsuccessful" (Principle 3). When he saw Heather after her recovery he commented on the family's apparent lack of interest in her welfare. 'They've always been like that', she replied, 'never make a fuss and everything will sort itself out. Anyway, I'm always the last one to be

considered' (Principle 4). For the first time in their acquaintance, Dr Spears saw how low Heather's position was in the household and how undermined she must feel with very little support from any member of the family (Principle 5).

With his experience from attending the nidotherapy workshop he was sure there was a way forward for Heather. When he discussed her feelings about her past life and the merits and disadvantages of staying at home she was despondent (Phase 1 in nidotherapy). "I'd like to leave and be on my own but my dad and mum think I should be looking after them now they are getting older' (Principle 6). But this did not seem a good argument to Dr Spears. Despite Heather's frequent suicide

attempts she was not incompetent at looking after herself and her needs, so he felt she was able to live on her own (Principle 7).

After looking at a range of options together (Phase 2 in nidotherapy), Heather and Dr Spears decided that the best way to improve Heather's mental health was for her to leave home and live elsewhere. This was a clearly not the family's wish but it was necessary (Principle 8). This option was discussed with Heather's parents as a form of treatment for Heather, and did not imply any criticism of the family; it was just that leaving home was the right way forward. The risk that she might continue to attempt suicide and be under greater chance of succeeding if she was alone was one that was worth taking (Principle 9).

The family were surprisingly in agreement with this 'nidotherapy policy' and just wanted reassurance that Heather would not disappear from their lives. She was very happy to agree with this as, despite all the problems she still loved her family and wanted to support them when they were in need (Phase 3 of nidotherapy). Following this decision, Heather felt better immediately. (That was a good sign – she had made the right decision. But there were several problems remaining. What accommodation was available? Would she be able to take her dog with her? Could she earn enough money to support herself? Heather had left the parental home after living there all her life. She felt immediately relieved that the nidotherapy recommendation made by her therapist had been accepted by the family, but she needed to get new accommodation and needed to find somewhere that would allow her to keep her dog.

With the help of her therapist she was able eventually to find suitable accommodation within her means, move all her belongings, move the dog and later get another, and obtain a part-time job that allowed her to be self-sufficient. None of these were beyond her ability but it was very helpful to her to still have the nidotherapist on hand, both to confirm her plans were feasible and support the decisions she had made. It was with the help of Dr Spears that suitable accommodation was obtained through the Fitzroy Centre Club House, one of the many organisations linked to the International Center for Clubhouse Development, a major contributor to psychiatric rehabilitation. Within a few months she had moved out to be independent for the first time in her life (Phase 4 of nidotherapy). In making these decisions Heather was always the prime mover; Dr Spears was a facilitator but not a driver (Principle 10).

Eight years later Heather is remarkably well and both to herself and in the opinion of all she knows, she is cured. She works part-time as a home-help (she is very experienced and sympathetic in this role). Her father has now died but she sees her mother regularly and is able to assert herself and not be bullied into activities she feels are unnecessary. She also has important roles in her local church and has many friends.

Finally, here are some nidotherapy exercises to help in finding out if you have picked up the essential principles from this guide. There are more in the first edition of the nidotherapy book (Tyrer, 2009).

Nidotherapy exercises

A. Margery is a woman of 25 with a mixed eating disorder of bulimia and anorexia has apparently responded to a treatment regime mainly involving cognitive behaviour therapy. Unfortunately, whenever she leaves the intensive contact she has at the hospital (she attends a day service four times a week) her problems return to some degree and are only reversed by increasing the frequency of day attendance again. It becomes clear on assessment that the problems lying behind her eating disorder are closely related to the family environment, where her parents are excessively concerned over her eating and monitor her all the time, increasing both her

anxiety and her eating disorder. She has never lived away from home before.

Questions: (1) Is Margery suitable for nidotherapy?

(2) Which of the following changes is most likely to help Margery's eating problems (assuming Margery has equal interest in all)?

(a) increasing attendance at the day hospital

(b) family therapy with Margery and her parents to reduce controlling behaviour

(c) moving away to a different setting where there is less preoccupation about food

B. Malcolm is normally a somewhat isolated but self-sufficient farmer who has become chronically depressed. He has not responded to antidepressants and is scornful of psychological therapies. He is demoralised by the same system of dairy and arable farming that he has been involved with ever since leaving school, and which is yielding fewer and fewer returns.

Question: How is nidotherapy most likely to help him?

(a) by introducing him to other farmers who are, or have been, in the same position but have changed their practices

(b) by exploring with him what thoughts he has about the future of farming

(c) by finding different ways of using his land to make money (eg, selling for housing, creating a solar farm)

C. David is an in-patient with chronic schizophrenia with mainly negative symptoms. He has to be encouraged greatly to take part in any activities in the hospital and whenever he is discharged to supported accommodation he refuses all responsibilities, sabotages efforts at collaboration and requires readmission. When asked about this, he says that he likes none of the places which have been offered to him. He accepts that he has to take responsibility in any nidotherapy programme.

Question: How would you proceed?

(a) as he prefers being in hospital accept that this is probably the best environment for him

(b) determine which is the best type of placement for him and ensure that once he is transferred all the necessary resources he had in hospital are maintained for at least several months

(c) find out what he likes and does not like in the previous placements, and consider what he would really like in an ideal one

ANSWERS

A. Margery. 1. Yes

2. (c) Assuming Margery is willing to move away from her parents and to try a less food-dominated environment an appropriate one can be chosen (eg, hostel, independent living, living with friends or relatives) but with constant awareness of her capabilities and wishes.

B. Malcolm. (b) By studying his past experiences the reasons for his current depression can become clearer. These could include, amongst others, financial stresses, isolation, fatigue, and physical disability. By analysing past positive experiences a way forward is likely to be found.

C. David. (c) A collaborative process needs to be established. Once done, it is highly unlikely that there he has no preferences for living outside hospital that are less attractive than staying inside the hospital setting. The ones he likes must be fostered and he can then be praised for finding the right placement, rather than yet another failed one that has been foisted on him by others.

You will note in all these examples the options that are not consonant with nidotherapy are ones where others are making decisions on behalf of the patient without proper consultation. The answers should come readily if you have understood the principles of nidotherapy well. If you failed to get all of them right please read the guide again, and remember the definition of nidotherapy – '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, 2003). Do not go back to the old ways of thinking.

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