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Case report

Nidotherapy: a new approach to the treatment of personality disorder

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Objective: To develop a treatment, nidotherapy, or nest therapy, so named because it aims to alter the sufferer's personal environment rather than symptoms or behaviour, in the management of personality disorders.
Method: Case studies, in which analysis of the environmental circumstances associated with the problems of personality disorder is followed by planned adjustment to that environment so that it makes a more appropriate fit for the personality.
Results: Sustained improvement was found in two individuals with personality disorder after nidotherapy. Those with persistent and predictable personality attributes are easier in principle to treat than those with episodic or variable problems.
Conclusion: Nidotherapy deserves further consideration in the management of personality disorders.

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Introduction

One of the most characteristic aspects of personality disorder is its persistence. This is one of the reasons why it was given a separate axis in the third revision of the Diagnostic and Statistical Manual of Mental Disorders (1). A condition that is pervasive and persistent implies that treatment is generally unhelpful and the condition will pursue its course irrespective of all interventions.

Although in recent years there have been several suggestions that patients with personality disorders can be helped by treatment, there is little evidence that underlying personality characteristics are altered although these may change spontaneously (2, 3). This suggests that any approach that reduces the impact of personality abnormality may be valuable while natural resolution is taking place. Treatments for personality disorder are focused on improving behaviours such as self-harm, and success is measured in reduction of such behaviour (4, 5); this tends to occur in the absence of personality change, although when there are 'dual diagnoses' of mental illness and personality disorder there are greater therapeutic challenges (6). An alternative approach to the treatment of personality disorder is to accept the personality as abnormal and almost impervious to intervention, but to try and minimize the problems it creates for the outside world as well as for the individual. This approach can be termed nidotherapy, after the Latin 'nidus', or nest, which is a natural example of an environment adjusting to the demands placed on it by an organism.

Material and methods

An attempt was made to develop a treatment that focused primarily on adjustment to the immediate environment. This led to the development of five core features of nidotherapy:

(i) the focus of treatment is on environmental change rather than intrapsychic change;
(ii) treatment is collaborative so the patient and therapist(s) together achieve consensus on what changes in personal environment are needed;
(iii) agreed environmental targets are set so that progress can be monitored and adjustments made in the light of this;

(iv) only aspects of the environment that are directly linked to the personality abnormality are relevant to nidotherapy;
(v) other strategies (e.g. cognitive and behavioural) may be involved as a consequence of nidotherapy but are independent from it.

Once these principles are adopted the pattern of therapy of personality disorder changes markedly (Table 1). The pressure commonly created by therapists to alter personality structure and thereby lead to more normal behaviour is removed and environmental-adjusting collaboration allows patient and therapist together to create a personal microcosm in which personality abnormalities are acknowledged fully and taken into account when planning physical and social changes. The following case histories describe how nidotherapy works in practice.

Case histories

1. A 33-year-old woman with three children became a cause of concern to social services because of her limited caring abilities. Investigations led to two of her children being taken into care and, after a further period of 2 years, her third child was also taken away. At this time she was referred to psychiatric services because she was felt to be isolated from society and had such poor social function. It proved very difficult to engage her as she would go to great length to avoid contact and it was uncertain to what extent she required compulsory treatment. Eventually, she was admitted under a compulsory order after threatening a community worker. A diagnosis of paranoid schizophrenia was made and she was admitted to an intensive care unit, where she was also noted to have auditory hallucinations as well as continuing hostility. After discharge from hospital she was transferred to supportive housing but resented the frequent monitoring of her progress, which she perceived as intrusion and tried to avoid contact. She also developed a marked tremor on antipsychotic drugs and these were steadily withdrawn and stopped altogether after 1 year and she remained completely free of psychotic symptoms. However, the improvement revealed marked schizoid personality features and she found it difficult to adjust to interacting with others in her hostel and tried wherever possible to avoid them. Enquiry and testing out her wish for isolation revealed that she functioned better with no contact and so a transfer was agreed to a supported flat where she would be left undisturbed apart from one visit each week from a support worker and a full review every 6 months. After 2 years she remains well on no treatment and is very happy with her life, which despite little interaction with other people now includes regular contact with her family.

2. A man aged 50 had repeated problems over hoarding at his flat for over 20 years. He would rarely discard anything and would keep food, particularly fruit, until it was rotting. He carried bottles of water and many plastic bags of belongings wherever he went, refusing to leave any of them behind as he insisted he might need each of them. Regular visits from the social services were necessary to stop the hoarding getting out of control, but eventually he was threatened with eviction because it was feared his flat had become a public health hazard. After admission to hospital as an informal patient, he was diagnosed as having had Asperger's syndrome in the past and concurrent severe anankastic personality disorder. He did not think that his life style was abnormal except that he was extremely lonely and his main objections were the removal of his belongings repeatedly, an intervention which he equated to rape. After full discussion over the implications of his disorder it was agreed that he would be allowed to return to his flat after it was redecorated according to his choice (the walls were all painted grey), and that weekly meetings would take place at his flat over the volume of goods coming in and going out. The patient agreed that this should ideally remain in balance and that, whilst his need for hoarding

Table 1. Essential differences between nidotherapy and other psychological approaches in personality disorder

Conventional approaches	Nidotherapeutic approach
Patient treated in the same way as others with psychiatric disorder with some acknowledgement made for diminished responsibility	Patient treated as maladaptive to the requirements of society and who therefore require special adaptations to be made to their physical and personal environment
Attempts made to alter behaviour to suit the requirements of 'normal' daily living	Attempts made to alter environment so it suits the requirements of the abnormal personality without compromising the function of society in general
Maladaptive relationships of patient need to be altered by personal change, with consequent reintegration into society	Maladaptive relationships of patient need to be accepted and fitted into a niche within society (i.e. society and environment changes, not the patient's fundamental personality)
Success of treatment measured primarily in 'objective measures' of behaviour and functioning	Success of treatment measured primarily in success of fit between personal microcosm and environment (probably best measured by quality of life)

was recognized and accepted, he should try and select those items that were least desired and allow them to be discarded. Although he did not think it was necessary for all of them to be thrown out he accepted that a cluttered environment led to a mismatch between him and others. He now spontaneously disposes of rubbish, but still hoards unless he can be reassured that a hoarded item can avoid destruction (e.g. by being recycled). One year later his flat remains in good order with no accumulation of rotting food and he is beginning to enjoy a better relationship with neighbours and all professionals concerned with his care.

Although this approach may be helpful in egosyntonic personality disorders (7), it is less so in egodystonic ones such as borderline personality disorder. When the personality is ingrained, well-established and accepted by the sufferer as a fact of life, the focus of nidotherapy is welcomed, as it is concerned with adapting the environment to the personality rather than changing the personality. Borderline and related emotionally unstable disorders differ from others in their wish to change (8) and the sufferer wants to have the central features of their personality removed, not accepted.

Discussion

The therapeutic outcome of the two patients, and in particular the acknowledgement of their need to have their environment selected personally rather than externally imposed, suggests that nidotherapy may be of value in the treatment of personality disorder and deserves further investigation and enquiry. In particular, the change of focus from patient to setting creates much less conflict than attempts to alter personality or behaviour and allows the environment to become a neutral interface between patient and therapist. In developing the concept further it is necessary to distinguish those elements which may overlap with other psychological approaches to the treatment of personality disorder, including cognitive therapy (9), cognitive analytic and dynamic psychotherapies (4, 10, 11). However, none of these has as their primary aim the modification and alteration of the patient's personal environment and in this respect nidotherapy appears to be specific.

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Invited comment

Severe disorders of personality (irrespective of the fact whether they are primary personality disorders or because of secondary changes of personality following mental disorders – probably the first case presented by the author) are indeed not always amenable to treatment and to change. There is a constant interchange between individual and environment and symptoms manifest in an interaction between patient and his or her social surroundings. Based on this proximity and mutual interdependence between individual and environment, Tyrer proposes a new approach of dealing with patients with severe personality disorders. The goal of the new therapy – so called 'nidotherapy' – does not consist in trying to change the patient. The therapy aims at influencing the patient's environment or at creating a niche where his or her abnormalities are no longer disturbing to others in a significant way. Thus, the environmental change rather than the change of the individual is stressed; personality abnormalities are acknowledged and, in fact, accepted. As the author himself admits, nidotherapy is more suitable for patients with egosyntonic disorders where the patient identifies himself with his symptoms not considering them as disturbing. Incidentally, just these patients are more difficult to treat