

Uncommon Sense: The value base of the Tidal Model

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It is just over five years since the publication of the first report on the Tidal Model (Barker 1998). Since then nurses from all four corners of the globe have begun to express interest in this alternative model for mental health recovery. What began as a local attempt in Tyneside to re-focus acute mental health nursing care, has developed into recovery paradigm for the whole mental health continuum, proving attractive to staff in both hospital and community settings, working with older and younger people alike (Barker, 2002). By far the commonest comment received through the Tidal Model website is – “this reminds me why I came into nursing in the first place”.

The Tidal Model develops Peplau’s original emphasis on the nurse-patient relationship (Peplau, 1952) to include an appreciation of the chaotic nature of change, which is the only true constant (Barker, 1996). The Model emphasises ways that nurses might help people in their care become aware of the small changes which are occurring *to* them, and *through* them, as part of their everyday reality. Most importantly, the Model emphasises pragmatic ways that people might learn ‘what works’ for them and *why*. Such ‘personal wisdom’ represents the basis of the person’s recovery – the knowledge they will use to navigate the metaphorical storms of the recovery voyage.

International Developments

By the beginning of 2004 almost 100 formal Tidal Model projects had been established worldwide. Most of these projects are in England, Wales and Scotland, but exciting developments are also happening abroad.

Nurses in the Irish Republic were the first to introduce the Model into community care – first within a day hospital project and then in a Primary Care setting at *Tosnu* – Gaelic for ‘a fresh start’ -, attached to a health centre in Cork city. In New Zealand, nurses at the *Rangipapa* forensic service in Porirua have been developing their care around the Tidal Model for almost three years and were the first forensic service in the world to adopt the model. The Tidal Model’s emphasis on narrative has proven particularly attractive to the indigenous Maori and Pacific Islands people, who greatly value the power of story telling. In Canada, nurses at the Royal Ottawa Hospital have implemented the model across most of their services, including their substance abuse programme – both residential and

community. This represents the first use of the model with people with drug and alcohol related problems. The Royal Ottawa Hospital has developed a specific curriculum for teaching the model and one of the graduate students has developed the model for use in family work. Finally, in Australia there is considerable interest in using the model within palliative care. The model's focus on the 'here and now' of everyday experience aims to identify the conditions necessary for promoting what the person would call a 'good life'. Naturally, the same process is possible for promoting the idea of a 'good death', which is the culmination of the 'good life'.

A Philosophy of Constructive Living

Although the Tidal Model has led to the development and adaptation of specific 'tools' of assessment and care delivery, it is essentially a philosophical approach to mental health care. The Model emphasises the fact that the individual nurse is the key 'tool' that might begin to unlock the person's potential for recovery. The principles upon which the Model is based, and the various principles for its practice are, like all theories, merely 'ideas on paper'. The Model assumes that knowing 'how' to aid recovery is more important than simply knowing 'that' recovery is possible. Consequently, the focus is always on the recovery attitude and the infinite range of possible practices that might flow from such an attitude.

Regrettably, in much contemporary nursing practice the emphasis is on 'documentation' and other forms of paperwork, which can dominate the nurse's field of vision. Most of these paper templates derive from legislation or come via some other 'top down' route. Not surprisingly, the *point* of these paper exercises is often either lost or unclear to the practitioner, far less the person in care. In the Tidal Model the paperwork is seen as similar to the ship's log: merely a record of the journey that has been taken and the various events that have occurred en route. The record is merely an attempt to capture some of the attempts that have been made, to help the person begin or undertake the voyage of recovery.

The Tidal Model developed from practice research into what people *needed* nurses for: what do people and their families *value* in nurses? –what do nurses *do* that appears to make a difference? (Barker et al 1999). Related research on the dynamics of empowerment (Barker, Leamy and Stevenson, 2000) helped develop further our understanding of how the nurse and the person (and/or family) could become a team – working together to identify and enact the necessary steps on the road to recovery.

At its heart, the Tidal Model is an attitude to caring for people in mental distress and their families. Without the mind set the technology is worthless. This is clearly one of the most challenging features of the Model, especially for the 'novice'

practitioner.

In the current 'evidence-based' culture of health care, there is an assumption that certain processes or procedures either *work* or don't work. This may be partly true of some medical interventions – such as the effects of drugs or ECT, which act in a physical manner. However, even here the 'placebo' can account for at least some of the change effected (Evans, 2003). It is important to emphasise that the Tidal Model *per se* does not work. The practitioner is the instrument or medium of change. If the practitioner does not have the capacity to use the Model appropriately *and* creatively, then the practitioner will likely generate disappointing results. . However, this is true of all 'therapies' and approaches involving interpersonal interaction (Hubble et al, 1999). For many nurses, the opportunity to exercise their creativity whilst honing their existing interpersonal skills is one of the attractions of the Model.

The Model embraces very specific assumptions about people, their experience of problems of living and their capacity for change. These values – which I called the *Ten Commitments* – probably represent the key attraction for nurses who are more interested in helping people make their own changes, rather than trying to manage or control patient symptoms (Barker and Buchanan-Barker, 2004).

1. **Value the voice:** the person's story is the beginning and endpoint of the whole helping encounter. The person's story embraces not only the account of the person's distress, but also the hope for its resolution. This is the *voice of experience*.
2. **Respect the language:** the person has developed a unique way of expressing the life story, of representing to others that which the person alone can know. The language of the story – complete with its unusual grammar and personal metaphors – is the ideal medium for lighting the way.
3. **Develop genuine curiosity:** the person is writing a life story but is not an 'open book'. We need to develop ways of expressing genuine interest in the story so that we can better understand the storyteller.
4. **Become the apprentice:** the person is the world expert on the life story. We can begin to learn something of the power of that story, but only if we apply ourselves diligently and respectfully to the task by becoming the apprentice.
5. **Reveal personal wisdom:** the person has developed a powerful storehouse of wisdom in the writing of the life story. One of the key tasks for the helper is to assist in revealing that wisdom, which will be used to sustain the person and to guide the journey of reclamation.
6. **Be transparent:** the person and the professional helper become a team. If this relationship is to prosper both must be willing to let the other into their confidence. The professional helper is in a privileged position and should model this confidence building by being transparent at all times, helping the person understand exactly what is being done and why.
7. **Use the available toolkit:** the person's story contains numerous examples

of 'what has worked' or 'what might work' for this person. These represent the main tools that need to be used to unlock or build the story of recovery.

8. **Craft the step beyond:** the helper and the person work together to construct an appreciation of what needs to be done 'now'. The first step is the crucial step, revealing the power of change and pointing towards the ultimate goal of recovery.
9. **Give the gift of time:** there is nothing more valuable than the time the helper and the person spend together. Time is the midwife of change.
10. **Know that change is constant:** the Tidal Model assumes that change is inevitable for change is constant. This is the common story for all people. The task of the professional helper is to develop awareness of how that change is happening and how that knowledge might be used to steer the person out of danger and distress back on to the course of reclamation and recovery.

In keeping with these values, the Tidal Model avoids cumbersome jargon, cherishing ordinary language, especially the person's natural voice. The Model is focused on what needs to happen for people to feel that they are moving forward in their lives. This emphasis on 'constructive living' embraces the belief that we all are in a constant process of change, albeit one involving often highly subtle changes. What we need to do is to navigate the process of change – steering ourselves, and the ship of our lives, through our 'sea of troubles' in a constructive direction.

Reclamation: In Our Own Voice

Traditional psychiatric care often diminishes the person's voice, especially by over reliance on diagnostic jargon (Kirk and Kutchins, 1997). Regrettably, many people have come to talk about themselves using the technical terminology of psychiatry and psychology, as if their own story – spoken in the vernacular – was not good enough (Buchanan-Barker and Barker, 2002; Furedi, 2003). This suggests how the narrative of all our lives has been colonised by psychobabble (Barker, 2003). The Tidal Model recognises that people's 'lived experience' is understood best in their natural language – using the metaphors and grammar that fits most easily with the way they naturally talk about such experiences. Consequently, the Tidal Model focuses on helping people *reclaim* the story of their distress and, ultimately, that of their whole lives.

Increasingly, we have called this approach recovery *and reclamation*. In much the same way that land that was once submerged by the sea, is reclaimed for use as part of the mainland, so that part of the person's life, which was submerged – and invalidated – by the effects of mental distress, may be reclaimed to become part of the whole person.

The first practical step in aiding this process of reclamation, is to write all the main

assessment 'stories' and care plan action, in the person's own voice; instead of translating the story into the third person of professional note-taking. This emphasis on 'my story' – as opposed to a professional interpretation – is probably the aspect of the Model that most appeals to service users and may well be the most unique feature of the Model. Certainly it is the most dramatic illustration of the nurse's desire to work actively *with* the person, in co-creating the story of the need for care. As the American mental health advocate, and psychiatric survivor, Sally Clay has said:

“The Tidal Model makes authentic communication and the telling of our stories the whole focus of therapy. Thus the treatment of mental illness becomes a personal and human endeavour, in contrast to the impersonality and objectivity of treatment within the conventional mental health system. One feels that one is working with friends and colleagues rather than some kind of “higher-up” providers. One becomes connected with oneself and others rather than isolated in a dysfunctional world of one’s own” (Clay, 2004).

The Evidence of Human Caring

The person's story contains not only the details of circumstances, which led to the need for help in the first place, but also holds the promise of what needs to be done, to address the 'need for nursing'. By beginning to talk about what is 'wrong' and what might be done to 'right' it, the person begins to give birth to what needs to happen next. If this is not an actual solution, it will at least represent a constructive step in the direction of finding a solution, or beginning to live with these problems of living. For this reason, talking, conversation and discussion are the key 'tools' of the Tidal Model.

Although influenced by different schools of psychotherapy the Tidal Model is not a form of psychotherapy or counselling. As a therapist and counsellor myself, I believe that it is more important than that! It involves live *conversation* – the natural process through which, as Sally noted, people discover more of themselves through discourse with others.

A common story told by people on the receiving end of the Model is that “it doesn't feel as if I am being treated; it just feels as if someone is listening to me”.

Perhaps because nurses are often viewed as very different from therapists, they have an opportunity to establish different working relationships with the people in their care. The Model emphasises 'ordinary' conversation as the medium for identifying where the person is 'at' and what needs to be done to move forward. Most nurses – and the various 'assistants', 'aides' and others who support them – do not have formal psychotherapeutic training. However, my experience is that this does not prevent nurses from being able to transform the 'ordinary' into an

‘extraordinary’ and powerful form of helping.

In their role as ‘patients’ people possess the deepest and most extensive knowledge of what it is like to be in need of nursing care. The primary task facing nurses – and other members of the helping team – is to learn from the person *what needs to be done*, to address or meet their need. The Model has borrowed the use of this term – ‘doing what needs to be done’ – from the work of the Japanese psychiatrist, Shoma Morita, who over 80 years ago began to develop a form of ‘constructive living’ therapy, influenced by Zen Buddhism and the principle of acceptance of change (Morita et al, 1998). The conjoint work of the nurse and the person in care is to negotiate what really needs to be done now, to address or respond to the person’s current problems of human living. Within such collaboration nurses may set the stage for the drama of care, and act as sophisticated ‘stage hands’. However, ultimately the person is the key actor and scriptwriter – the star of the whole show.

Believing in Nursing

Research over the past decade provides evidence that service users and their families’ value nursing and nurses (Barker et al, 1999; Rogers, Pilgrim and Lacey, 1993). However, as a discipline nursing still appears to struggle to assert its professional identity. Psychiatrists, psychologists and other therapists often only have fleeting or highly selective contact with service users – engaging in a form of psychiatric ‘hit and run’. Yet these are the disciplines, which dominate the public story of mental health care. Maybe the public have come to believe in the importance of these disciplines, because they believe so strongly in themselves. Despite their strength in numbers – accounting for at least 60 per cent of the mental health workforce, and often more than 90 per cent of professional contact time – especially in residential care – nurses remain marginal figures in the politics of mental health. However, within the Tidal Model nurses are the ‘ordinary seamen’ on the good ship Recovery – the key crewmembers who will help the person in care navigate towards the possibility-land of recovery. On such a metaphorical ship the Captain is *not* the psychiatrist, or psychologist, locality manager or social worker, but is the person in care.

In this highly scientific and technological age it is almost taboo to talk of belief far less *faith*. Faith *can* move mountains, and represents a critical factor in recovery. People need to believe that recovery is possible. Similarly, professionals need to believe in the person’s capacity for recovery if this is to happen. However, nurses need to believe in themselves as vital crewmembers on the person’s voyage of recovery, if their value is to be fully realised. Sadly, many nurses appear dispirited and struggle to express their belief in their therapeutic potential. However, people like Sally Clay who have made the recovery journey, are in no doubt as to the

value of the 'extraordinary ordinariness' of genuine nursing. If a revolution in mental health care is taking place within the Tidal Model, this involves nurses re-discovering the value of nursing as a therapeutic practice in its own right. Interdisciplinary teamwork is important, but ultimately will prove ineffective if nurses – the core members of any team – do not believe in themselves, and their capacity to enable the process of recovery.

This talk of *faith* clashes somewhat with the rhetoric of evidence-based practice, with its assumption that there might be one method, which might be the 'best' way to work with all, or at least most people. The wisdom of common sense tells us that people vary greatly. What 'works' for one person will not work for another. Often what 'works' for one person, at one moment, will not 'work' for them even a short time later. Effective caring is about being sensitive to such subtle changes; building these tidal rhythms into the flexible care the person needs. Good nursing draws from a well of common sense that taps into the evidence of what takes place between the nurse and the person in care. Often, this is so rare, that it really should be called 'uncommon sense'. This uncommon sense is, at least, as powerful as the evidence of what 'works' for people in general.

The Virtues of Nursing

The Tidal Model is probably the first recovery approach, which grew directly out of nursing research and was developed in practice by practising nurses. We live in an era when nurses are being repeatedly asked to convert to 'multidisciplinary models', to become this or that kind of 'therapist', and even to consider the possibility that mental health nursing might not survive, at least not as a discrete professional discipline. These various threats to the nursing identity are clearly part of the attraction of the Tidal Model, which reminds nurses of their core value and offers a medium for developing and extending the practice of a 'genuine nursing of the mind' (Podvoll, 1991). Most nurses' experience of theoretical frameworks involve models of nursing that were developed in university departments, far from the 'care face' of actual practice. That the Tidal Model was developed from practice-based research into psychiatric nursing, and is being developed *in practice* by *practising* nurses, seems to validate the discipline. As noted earlier, for many nurses nursing is *not* about curing people or even fixing them. Politicians and tabloid editors may want nurses to become gaolers, turn keys or community police. However, many nurses want to return to the essence of nursing as a caring discipline. Nursing involves – as Nightingale said - putting the person in the right conditions to be healed by Nature or by God. The Tidal Model accepts this as the essential heart of human caring: what do we need to do to help put the person in the right conditions so that (s)he might begin and continue the voyage of recovery? , It is heartening that so many nurses are attracted to returning to the roots of their vocation, re-engaging with the whole story of human

distress and recovery.

The metaphor of the voyage of discovery of mental health, reminds us of the need to be pragmatic in planning care. It also reminds us of the healing potential of metaphor itself. When we talk of 'mental' distress, words often fail us and so we resort to metaphor. It is 'as if' we are drowning; it is 'as if' we have been boarded by pirates. The voyage of care is also very much a metaphor.

When people are shipwrecked by the experience of mental breakdown, they need a safe haven where they can rest before beginning the necessary repair work, which will make them sea-worthy again. We all may have a general understanding of what a 'safe haven' would be like, but genuine person-centred care requires us to explore the specifics of what this might be, for *this* person, at this point in her or his life.

Once people begin to find their 'sea legs' again, they will be ready to set sail again on their 'ocean of experience'. However, only the person can tell us when they are ready'. Only the person knows where they were headed when the disaster of the shipwreck struck. The experience of psychic shipwreck often leads to a review of the person's life, and a serious change of plans for the next stage in the life voyage. Only the person can approve these plans. The person was, is and will always remain the Captain of the ship. This metaphor teaches us the most important skill of all - professional humility.

Pro-person not Anti-Psychiatry

The Tidal Model makes a special point of avoiding the use of jargon and especially endorsing the use of psychiatric and psychological constructs of 'mental illness', preferring instead to talk of mental distress or 'problems of living'. This has led many people to ask if the Model is 'anti-psychiatry'. The philosophy underpinning the Model finds little value in being 'anti' anything, except perhaps obviously objectionable things like abuse, indignity, the infringement of human rights and other, more subtle forms of disempowerment. Instead, it is 'pro-person'.

It is interesting that many psychiatrists and psychotherapists find an echo of their own caring disposition in the Tidal Model, and recognise that the tide is turning in favour of the 'pro-person' approach. Dr Tsuyoshi Akiyama came to the UK to study nurses practising the Model in England and, on his return to Japan, translated all the available training materials into Japanese, so that he could teach both his psychiatrist and nursing colleagues in Tokyo. Dr Akiyama noted that:

The Tidal Model helps the patients to be aware of and accept themselves as they are and it helps them to aim at changing at the same time. This is an interesting therapeutic contradiction. This therapeutic contradiction

coincides with much Chinese and Japanese philosophy. The patriarchal model is fading away in Japanese mental health care. Now it is legally required to respect the patient's right and to provide appropriate explanation to obtain consent. Many Japanese psychiatrists are still not fully aware of this change. They do not understand the necessity and the value of healthy assertion, and do not appreciate what the nurses can contribute in this task (Barker and Buchanan-Barker, 2004).

Rather than seeing this as a challenge, psychiatrists like Dr Akiyama view this as complementary to their own work. Dr Jean-Claude Bisslerbe is Professor of Psychiatry at the University of Ottawa. Commenting on his nursing colleagues' adoption of the Tidal Model he said recently:

"The Tidal Model is an excellent approach. It parallels and enriches physicians' clinical approaches with its assessment of the patient's personal clinical picture. In our setting, it supports the move to a research-based program. Nurses have a closeness in their relationships with patients, and their involvement needs a framework with goals and boundaries as offered by the Model. The Tidal Model promotes nurses' self-confidence, fosters interaction, and increases inter-disciplinary teamwork. The Personal Security Assessment and Plan, especially for suicide is excellent, tactful, and thorough. Nurses who practice within the Tidal Model don't need anything more, it is enough". (Barker and Buchanan-Barker, 2004).

The move towards the development of genuinely empowering and person-centred forms of mental health care has begun, but there remains much to be done to make this a reality for everyone in mental health care. As part of its own contribution to the recovery paradigm, the Tidal Model has covered a considerable amount of water in a very short space of time. In the process, has seen the need to make several adaptations to its working practices and to clarify further its philosophical focus. This reminds us that the voyage of recovery is something that both professionals and the people in care need to undertake. It reminds us too that the voyage – not the destination – should be our primary focus, if we are to stay on course.

For some professionals, the pragmatic humanism of the Tidal Model may prove to be challenging. However, just as a lifesaver cannot execute a rescue without getting wet, so the mental health professional must, metaphorically, 'get into the water' with the person in distress, to be of genuine assistance. For some professionals, the task of negotiating the 'psychiatric rescue' and supporting the 'necessary emotional repairs' needed before recommencing the voyage may prove too difficult. *Genuine* psychiatric rescue and *genuine* mental health discovery are not for the foolhardy, and certainly not for the faint hearted. We all need to ask ourselves, what kind of a person, showing what kind of commitment, would we want to be 'there' for us, were the ship of our lives to founder on the

rocks? The answer might tell us much about the kind of mental health professional we need to become ourselves, and need to facilitate in our students and colleagues.

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