The Tidal Model

Karin Tiemeyer

Chamberlain College of Nursing

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The middle range theory which will be examined in this paper is Phil Barker’s Tidal Model of Mental Health Recovery. Barker, a former painter, philosopher, and psychiatric nurse developed this model in conjunction with practicing psychiatric nurses and the patients. Much of Barker’s worldview he attributes to his art school experience. The tenants of Eastern religion ripple throughout the model which is also laden with the powerful and soothing imagery of water. Water and both its unpredictability and healing ability flow through the Tidal Model theory. According to Brookes, the Tidal Model was the first research-based model of mental health recovery and is now recognized as a key mid-range theory of nursing practice (Tomey & Alligood, 2006). The Tidal Model is strength-based, holistic and focused on the human response to living rather than the human response to disease.

The Tidal Model evolved as Barker applied cognitive behavioral theory, family and group work in his own nursing practice. As he observed people in chronic stress he observed their varying levels of personal resilience and integrity. Barker questioned the role of the nurse, the role of care, the need for compassion, understanding and human courage. He highly regarded the patient as a person who currently has a problem with living or is enduring a spiritual crisis rather than a mental illness. The Tidal Theory depicts the nurse as a helper or facilitator to this person in distress. This theory levels the playing field of mental illness and reconceptualizes mental health problems as unequivocally human rather than psychological, social, or physical (Tomey & Alligood, 2006). This paper will examine the mid-range theory of the Tidal Model and its ten commitments in direct relation to nursing practice. Specifically this paper will explore the application of the Tidal Model to the psychiatric inpatient setting as well as the leadership and management sector.

The Tidal Model is comprised of the following ten commitments with a brief description of each: 1) Value the voice. The person in the recovery process has a valuable story to tell. The story details the journey of the person’s distress and also the hope for resolution; 2) Respect the language. The person has their own unique language which does not need to be translated into psychiatric or clinical terms. Their language should be appreciated for what it is; 3) Develop genuine curiosity. The nurse, or helper, should express genuine interest in the person’s story and the human significance of the life story being told; 4) Become the apprentice. The person (or patient) is the expert and the nurse becomes the apprentice; 5) Reveal personal wisdom. The helper works diligently to assist the person in uncovering the wisdom beneath the story which will guide their journey of recovery; 6) Be transparent. The person and the helper become a team built on mutual trust and remain transparent at all times; 7) Use the available toolkit. The person’s story already contains tools that have worked in the past; 8) Craft the step beyond. The person and helper assess the present and formulate a plan for recovery; 9) Give the gift of time. Great value is placed on the time spent between the person and the helper; 10) Know that change is constant. The helper must cultivate awareness for the person that change is constant and inevitable (Tomey & Alligood, 2006).

This writer will examine in detail the specific commitments of the Tidal Model which can be applied to advanced nursing practice on the pediatric inpatient psychiatric unit. Valuing the voice of both the person and the person’s family is crucial to the delivery of individualized care. The power of the personal narrative is not to be taken lightly. This is done beginning with morning rounds which are attended by the treating physician, direct-care nurse, nurse practitioner, nurse care manager, social worker, occupational therapist, dietician, and pharmacist. The team comes together and the person’s intake story, their own personal story of distress, is reviewed. All disciplines weigh in on treatment recommendations and concerns. Day after day the story of that person is reviewed complete with updates on treatment modalities (for example cognitive behavioral therapy, medication, trauma therapy, role play) which have been successful or possibly ineffective. The voice is valued and the treatment reflects the story.

The nurse care manager respects the voice of the person and revises the plan of care as needed to reflect ongoing suicidal, homicidal or self harm ideation and the successful development of a safety plan. Care planning is a collaborative exercise with the emphasis on revealing solutions rather than solving problems (Tomey & Alligood, 2006). The nurse care manager also values the voice of both the physician and the family and acts as a liaison between the two parties. The nurse care manager hears the story from the family’s perspective as well as the person’s. At times there are cognitive distortions on either or both ends and the care manager must reconcile the two stories and present to the physician a critical and thoughtful analysis of the two stories. The nurse care manager must remember both voices have value and both voices may be equally distressed.

The nurse care manager must also recognize the importance of the personal narrative in the diverse cultures served as well. The nurse care manager has a responsibility to deliver holistic and culturally competent care. Many cultures respect the age old tradition of storytelling and find it has a therapeutic value. As stated in the website for the Tidal Model, “Ultimately, the model does not ‘work’, it is the people who are important. We need to remind ourselves constantly of this. As our Maori friends taught us: What is important in the world? It is the people, it is the people” (Barker, 2011). The nurse care manager must listen to the story and adjust the plan of care accordingly to assure the delivery of holistic care. Disciplines such as nutrition, pastoral care, holistic healing, or recreational therapy may be called upon to add their thoughtful input to a person’s distress.

The power of the story is also valued by the nurse practitioner who meets individually with each patient to ascertain their response to medications including benefits and side effects. Medication therapy is only a piece of the complex puzzle in caring for the psychiatric patient; however, at times the balance can shift between medications doing more harm than good. The nurse practitioner can value the voice and listen to the person’s response to medication as well as staff’s observation of the person’s behavior to medication therapy (for example are they anxious, overly sedated, displaying extrapyramidal symptoms?). The nurse practitioner can also function as a helper to the person as they work toward recovery by alerting the psychiatrist to an adverse response to medications or any other medical concerns which may arise. Acute observation and assessment skills of the APN can discern symptoms which appear alike such as depression and fatigue versus the effects of being overly sedated from medication.

Developing a genuine curiosity, the third commitment, for the person and their story allows the advanced practice nurse to hear the honest trauma and distress which has lead to the current crisis. This principle is directly linked to the role of the nurse as apprentice, commitment number four, in the person’s journey to recovery. These two commitments work synergistically. The clinical nurse specialist may engage in 1:1 therapy with the person to uncover the stressful events which have lead to hospitalization. The development of a therapeutic rapport is vital to the recovery process however the Tidal Model proposes this rapport take on a different tone than what psychiatric nurses may currently embrace.

Barker asks nurses to reframe their role as psychiatric nurses rather than assume the role put forth by Hildegard Peplau. Peplau believed both the nurse and patient participate equally in the therapeutic nurse-patient relationship. Barker puts forth the notion that the nurse must accept the role of the apprentice and the person assumes the role of expert in the healing process. There is still rapport and teaching however the roles are somewhat reversed. This may be challenging for advanced practice nurses such as care managers, nurse practitioners, and clinical nurse specialists who readily take charge and are accustomed to leadership roles in the inpatient setting. Nurses need to release their expectations and be present and available for the person to disclose their personal history.

Commitment number nine, giving the gift of time, is integral to a healing environment on the inpatient setting. Care managers can educate families regarding the juxtaposition between actual length of stay on the acute unit and the length of time required for true healing to take place. Families often may be under the impression their child will be “fixed” by discharge. The astute and compassionate care manager begins planning for discharge at admission. A crucial conversation with the family is necessary to dispel the myth that the treating physician will heal the child in five to ten days. The reiteration of the principle that the acute psychiatric unit is merely crisis stabilization can adjust the families’ expectations of a magical recovery. The nurse care manager can emphasize that recovery may be a lifelong process in many cases and offer hope that there is no expiration date on the recovery process. Hope can be distilled in the family that perhaps this moment in time is a bump in the road for the hospitalized person on the vast continuum of wellness.

The gift of time can also be shared with the person in crisis. The clinical nurse specialist conducting individual or group therapy can assure the person that the acute hospitalization is a launching pad for their ongoing personal discovery and recovery process. As stated in the Tidal Model, recovery begins at the lowest point for the person or at their lowest ebb (Barker, 2011). It is also the starting point for the person to unearth the gifts, skills, and strengths they already possess. These strengths will lead them on their own personal journey of reclamation.

The tenth commitment, knowing that change is constant, is widely applicable to the inpatient setting. On a superficial level there is the revolving door of mental health discharges and readmissions. The inpatient census fluctuates daily in terms of patient stability and nurse-patient ratio. The unit may be relatively calm on a Monday with five patients discharging in stable condition. The following day can be tremendously challenging for the inpatient team who may face five new admissions with varying degrees of psychosis and suicidal ideation. Nurse care managers may have the arduous task of creating comprehensive plans of care for new patients while also trying to offer additional support to unit nurses who may feel overwhelmed with multiple admissions and minimal staff. Nurses may be struggling to provide a safe and therapeutic milieu with many new people in various states of personal distress. Structure and limit setting are milieu management tools utilized by nurses. According to Oeye, Bjelland, Skorpen, and Anderssen, limit setting is a method of fostering patients and is comparable to the practice of raising children (2009). The Tidal Model proposes less limit setting by nursing staff which would empower the person in emotional or spiritual distress to set their own limits by realizing and utilizing their strengths.

On a deeper interpersonal level, the nurse can address the notion of change being a continuous motif throughout life. The nurse, assuming the role of professional helper, can cultivate an increased awareness of change as a constant in the person’s life. The nurse can help the person accept that change is inevitable and that nothing is permanent including the current crisis. The Tidal Model proposes that people must recognize how they experience change, that the experience of health and illness is fluid not static, and that there is no predetermined end goal.

Two real life examples of how the Tidal Model is currently applied to the latency psychiatric unit at Cincinnati Children’s Hospital Medical Center are spirituality group and the physician’s resistance to label young children with a diagnosis. This writer will begin by addressing the therapeutic aim of the biweekly spirituality group. This group operates on the notion that the participants may be in spiritual distress as put forth by the Tidal Model. According to Reverend Irv Moore, a pastor who conducts group therapy with kids on the inpatient psychiatric unit, his goal is to “have children connect their current pain with the strength they may get from having a higher power in their lives. I realize not everyone goes to church but I want to point out to kids that there is hope and unconditional love bestowed upon them by whatever god they look to in their lives” (Reverend Irv Moore, personal communication, November 22, 2011). Some tools used in spirituality group are drums (for a drumming circle), prayer circles, and singing and dancing. No specific denomination or religious affiliation is discussed but rather the group opens up people’s minds to the notion of help from a higher spiritual power.

The second example which demonstrates the Tidal Model’s principles currently being applied on the inpatient setting is the physician’s resistance to imposing a diagnostic label on a child. Dr. Cynthia Daugherty, adolescent psychiatrist, states “families often come in wanting a certain diagnosis which will get the family services and additional funding for state services. If a child truly has that diagnosis I will give the diagnosis but I won’t put a label on a child just for monetary purposes” (Cynthia Daugherty MD, personal communication, November 23, 2011). A clear diagnosis may not be bestowed upon a child during the first admission but rather after a pattern of behaviors and hospitalizations arise. It is not uncommon for a child to simply have the generic diagnosis of Mood Disorder Not Otherwise Specified for months or years until it is formally changed to Bipolar Disorder. Likewise the Tidal Model does not rely on labels and diagnosis but rather is a philosophy based on helping people who are currently in distress which is viewed as a temporary state. The label implies a long term state and confining condition. The Tidal Model supports a dynamic recovery process based on people reclaiming their lives through telling their stories.

The mid-range theory of the Tidal Model can also be applied to the leadership and management sector. The concept of transparency, commitment number 6, is rampant throughout hospital policy and management language. Many hospitals have adopted nonpunitive reporting methods for nurses to report medications errors and patient safety concerns to the hospital administrators. This transparency hopefully enhances the culture of safety. This transparency also minimizes the communication barriers between staff nurses and management by reducing nurse’s fear of punishment for medication errors.

Leadership can also redesign orientation models for new psychiatric nurses to learn the ten commitments which will enhance person-centered care. The solution-focus of the Tidal Model can be taught through workshops which utilize the Tidal theory curriculum. It provides specific directions for nurses and teaches the need for the holistic assessment of the person in distress. Leadership would need to allocate additional resources to teach this model as it requires courage and creativity to unlearn the deficit model and the notion of the nurse as expert (Tomey & Alligood, 2006). To fully embrace the Tidal Model leadership and management would need to also recognize that change is constant (commitment number ten). The philosophical shift would allow nursing to take the lead role in the healing process as opposed to physicians having the lead role as in most medical models. The first example of this occurred in Japan with the formal collaboration between Dr. Tsuyoshi Akayama and his staff. According to Tomey & Alligood, Dr. Akayama translated the Tidal Model into Japanese then taught his colleagues the material which set a trend for greater interdisciplinary collaboration with nursing taking the lead role (Tomey & Alligood, 2006).

Management also applies commitment number 4, becoming the apprentice, to the successful management of the psychiatric unit. The manager with the open-door policy will readily lend an ear to listen to feedback from unit staff, nurse care managers, nurse practitioners and clinical nurse specialists who have first hand experiences with the person in distress. The manager may not spend time directly on the unit with the patient population but can learn from nurses in advanced care roles what changes would benefit the unit. The nurse manager must also value the voice of the nurse care manager, nurse practitioner, and direct care nurses. The manager must be willing to assume the apprentice role in this case and learn from the direct care nurses.

One real life example of how a concept of the Tidal Model can be applied to leadership and management is the transparency exercised by leadership with the recent suicide of a psychiatric teen. Approximately 24 months ago a teenage girl was admitted to the adolescent inpatient unit for depression. It was omitted from her intake that she had previous suicide attempts by hanging at two other psychiatric facilities. Nonetheless she was still placed on precautionary fifteen minute checks which were reserved for the highest level of risky patients because she was refusing to contract for safety. On day three of her admission when the ancillary mental health staff went to check on her they had difficulty pushing her room door open. When the door was forced open they found the patient hanging by a sheet from the heavy wooden door. A downward spiral of events contributed to the eventual death of the patient. The mental health staff initially summoned staff for help however all other staff was in a group off the unit at the time and no one heard the call for help. After about three to five minutes the staff ran from the room and called security. Security reached the locked unit shortly thereafter but their badges could not be read by the badge reader. The hospital’s medical response team arrived as well and could not swipe their badges to enter either. It is suspected that a full ten minutes passed before any care other than basic CPR was started on the patient. She was transferred to the ICU and the next day was taken off life support and died.

The transparency exhibited at this awful time by the leadership in the department of psychiatry was authentic and admirable. The treating physician for this patient who died was actually the director of the entire psychiatric department. He was devastated and personally called the family to inform them of the incident. He never left the ICU for the 24 hours in which the patient remained on life support. The nurse care manager and social worker for the unit attended the funeral with the physician. The advanced practice nurse for the unit who was also the acting unit manager worked the unit so the charge nurse could also attend the funeral. Many staff from other psychiatric units covered staff so they could also attend the funeral.

Following additional grief support for the staff that was involved in the day’s event, hospital administration began the time consuming task of a root cause analysis. Hospital leadership, administrators, lawyers, nurses working in risk management, leaders within the psychiatric department, and all staff who provided care to the patient were on the root cause analysis panel. All barriers to timely care were examined as were the current safety procedures on the day of the event. Many policies were eventually rewritten due to the root cause analysis: all patients now remain on fifteen minute checks the entire length of their stay regardless of their level of risk, bathroom doors have been replaced with shower curtains (although bedroom doors are still in place at this point), doctors can now order bedroom doors to remain open at all times and no sheets in the room until bedtime, the number of cameras have doubled on the unit but due to state regulations cameras are still not allowed in patient rooms at this time, a suicide risk tool (SRT) has been implemented as well. This assessment is performed by the social worker in the emergency department, the charge nurse at admission, and the physician during the initial assessment. The higher the SRT number the higher degree of safety concern is the patient. The highest SRT scores indicate high level of safety precautions such as Imminent Danger (the person has 1:1 staffing), Arm’s Length (staff within arm’s length at all times) and Continuous Observation (staff must be able to see the patient at all times). Individual crisis management plans have been developed for aggressive and high risk patients. These plans and the specific interventions used in the last eight hours are reviewed and revised if needed on a shift by shift basis. These are just some of the changes implemented to ensure patient safety and hopefully prevent another completed suicide.

A second real life example of how the Tidal Model’s concept of change as something constant and expected can be applied to the continual turnover of nursing staff within the department of psychiatry. Management must contend with a high acuity work environment which often takes its toll on the nurse. Many experienced nurses comes to psychiatry expecting a slower pace with less turmoil and trauma associated with emergency rooms and intensive care units. The reality of inpatient psychiatry is a hot bed of acuity which can flip on a dime. Psychosis knows no boundaries and limits. Charge nurse Trudy Lopez, RN-BC, BSN recalled surviving a violent attack on her by a psychotic teen. “He just jumped over the nurses’ station and punched me repeatedly in the face until the doctor pulled him off me. My nose and jaw were broken and I was off work for two months. Not once did management call and check on me” (Trudy Lopez, personal communication, November 22, 2011). Trudy returned to the same unit to work but admitted to this writer she has symptoms of post-traumatic stress-disorder when a teen is admitted with a similar presentation as the teen who assaulted her. She also acknowledges she is not as quick to de-escalate a violent teen and will allow other staff to step in first. “I feel my sense of teamwork has suffered because I still have fear of being attacked again. I know I am not as strong of a nurse as I once was and in the end the patients may suffer” (Trudy Lopez, personal communication, November 22, 2011). Trudy’s experience reflects the toll violence takes on nurses as well as the need for compassionate leadership. Although Trudy remains a loyal employee, she also acknowledges she is less the nurse she once was. Management can learn from this and in future instances offer support to an injured employee so they realize they are valued and have a job waiting for them.

Management is challenged with high nurse turnover as this directly impacts skill mix on the unit. Nurses with clinical skills, wisdom, and experience balance out the novice nurse. The experienced nurse knows valuable milieu management techniques and can often think outside the box when a new situation arises. The novice nurse has not honed these skills yet and needs that skilled nurse as a mentor and teacher. Management can offer incentives such as self scheduling and flexible shifts to retain experienced nurses who are so vital to the delivery of quality care.

The Tidal Model’s purpose is to help people when they are at their most distressed. People need to be helped right away at this lowest point so they can learn what to do to manage the distress and what help they need from others as they journey through recovery. The actual Tidal Model encompasses three domains of world, self, and others. Each domain is viewed as a place in which the person in distress lives at different points in time. There are three components of group work for the person to engage in: discovery, information-sharing, and solution finding. The uniqueness of human experience and the lived experience is emphasized. The belief that one person can never fully know another person’s experience also applies to the state of mental distress for each individual. It must be experienced to be fully understood. Compassion is vital to this theory.

The Tidal Model is explanatory in nature primarily because it is based on ten commitments which explain how one phenomenon is related to another. Relationships between the nurse and person and the various dimensions of this relationship are explained through the ten commitments. The ten commitments detail the concepts in which the nurse (helper) and person (expert) should interact with one another in the recovery process. One example is commitment number 5 which states the helper is to assist the person with revealing personal wisdom. One way the nurse can do this is through appropriate use of self disclosure. This can be done professionally and successfully if the nurse exercises self awareness. According to Chitty and Black, “nurses should get their own emotional needs met outside of the nurse-patient relationship. Becoming aware of one’s needs and making conscious efforts to meet those needs in private life make professional, therapeutic relationships with patients possible” (2007). An example of a nurse using self disclosure with purpose would be the nurse revealing to a depressed teen a challenging time in his or her own life in which they struggled with depression and made it through. Stories of success offer inspiration and hope that recovery is possible.

A second example of how the Tidal Model is explanatory is that the model developed from a clinical research program. The research behind the model was based on actual nurse-patient relationships and interactions. Data was gathered by discussion, observation and the patient’s use of self report. Feedback was obtained from patients (the persons) and the ten commitments were developed in response as a framework for the nurse or helper. Commitment number two emphasizes the importance of respecting the language. Through hundreds of interviews persons revealed to nurses how valuable it was for them to feel understood at this moment in time-their time of personal crisis or distress. They wanted their simple, everyday language respected and maintained. They did not want their stories transformed into the arcane, awkward language of psychiatry (Tomey & Alligood, 2006). The preservation of the person’s own language infused their stories with the reality and the power the stories deserve. A real life example of this is a teen with Obsessive Compulsive Disorder who journals, in their own voice, the behaviors he or she cannot stop and the emotions related to these behaviors. The journal is then shared with staff and processed throughout the hospitalization as behavior modification strategies are utilized to support the person in distress.

One research study performed by Stevenson & Fletcher explored outcome measures after the Tidal Model was instituted in a hospital setting. Evaluating change can be a difficult task however this study sought to measure the impact of the Tidal Model on nursing practice. The study yielded the following results: an increase in the number of admissions and a decrease in the number of hospital days, a decrease in the need for the highest level of observation, decreased incidences of violence, self harm, and use of restraints (2002). Nurses also reported enhanced practice, greater patient involvement and experienced a greater presence with the patient. Care plans, created by nurse care managers, were thorough and clearly identified the person’s goals and targets. These plans were viewed as fluid works in progress and reflected the dynamic status of the patient. Ancillary mental health staff also reported greater patient involvement, increased focus on the patient, and overall improved sense of professional self esteem. These results support the success of this person-centered mid-range theory.

A second research study conducted by the Newcastle interdisciplinary team studies the nurses’ shift toward solution-focused interactions with their patients. The nurses participated in a solution-focused education series then both the nurse and patient outcomes were measured. The patient’s self report of empowerment, improved decision making capability, stronger sense of self direction and greater focus on the goal of lifelong recovery supported the theory that a solution-based focus could improve patient outcomes. Nurses also reported a greater sense of confidence, empowerment, increased knowledge, enhanced performance and increased competence in solution-based care (Stevenson & Fletcher 2002). Following this Newcastle study a similar study was replicated at The Royal Ottowa Hospital in Canada with the Tidal team. Similar successful results with improved patient and nurse patient outcomes resulted (Tomey & Alligood, 2006).

In conclusion, the Tidal Model and its ten commitments were successfully applied to advanced nursing practice on the pediatric inpatient psychiatric unit in this paper. Examples such as refraining from the use of labels, valuing the voice and the human experience, cultivating genuine curiosity and giving the gift of time supported the application of the Tidal Model on the inpatient unit. The theory was also successfully applied to the leadership and management sector by demonstrating the real life use of transparency during a hospital crisis. The knowledge that change is constant and inevitable was demonstrated through the realistic example of the high turnover rate of psychiatric nurses and the impact it has on the delivery of care. The use of the mid-range Tidal Model has evolved across the continuum of care and is no longer reserved for acute mental health inpatient. The theory is now known internationally as the Tidal Model of Mental Health Recovery and Reclamation. As persons in distress become empowered they are encouraged to reclaim their lives as they work toward recovery.

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