The Tidal Commitments: extending the value base of mental health recovery

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The emerging concept of recovery in mental health is often only loosely defined, but appears to be influenced more by specific human values and beliefs, than scientific research and ‘evidence’. As a contribution to the further development of the philosophical basis of the concept of recovery, this paper reviews the discrete assumptions of the Tidal Model, describes the development of the Model’s value base – the 10 Commitments – and illustrates the 20 Tidal Competencies, which aim to generate practice-based evidence for the process of recovery.

Key words: culture, mental health nursing, reclamation, recovery, Tidal Model, values

Accepted for publication: 25 September 2007

Problematising recovery

Twentieth-century psychiatry focused mainly, although not exclusively, on the containment of mental illness – doing things to patients, or for them, to reduce disturbance, rather than working with people, to develop more personally meaningful ways of living. By the end of the 20th century, the assumption that professionals could ‘fix’ mental illness was waning and increasingly was overtaken by the view that people should participate in, if not actually lead, their own ‘recovery’ (Davidson & Strauss 1992). The concept of ‘recovery’ has become a key aspect of mental health policy in many Western countries, especially where mental health legislation or policy is under review, e.g. New Zealand (Mental Health Commission New Zealand 2001), England (Repper 2000), Scotland (Scottish Executive 2006) and Ireland (Mental Health Commission 2006). Government-led reviews of mental health nursing in England (Department of Health 2006) and Scotland (Scottish Executive 2006) proposed that nurses should adopt a ‘recovery focus’, with its attendant ‘values’, as part of the modernization of the discipline. However, the exact nature of these ‘recovery values’ seems unclear. O’Hagan (2004), in New Zealand, acknowledged that, as another ‘import from America’, recovery tended to emphasize individual over social processes. Given that it had evolved from psychiatric rehabilitation (American recovery) was perhaps driven more by professionals than by service users’ (O’Hagan 2004, p. 1) and that ‘much of the American recovery literature accepted, at least implicitly, the biomedical model of “mental illness” (and) did not necessarily reflect all the values of the user/survivor movement’ (O’Hagan 2004, p. 2). O’Hagan’s reservations about pasting a recovery philosophy over traditional ‘mental illness’ values is well stated. People may well be ‘ill at ease’ with themselves or others, or ‘ill-fitted’ for the challenges that life presents. However, many might reject the idea that they are ‘mentally ill’, in any traditional medical sense (Buchanan-Barker & Barker 2002). This is neither a theoretical nor a semantic dispute. When people locate their problems within the world of their lived experience, the metaphorical nature of their ‘illness’ can become clear, with implications for any ‘recovery journey’.

The contemporary mental health recovery literature appears to differ little from the philosophical assumptions of Alcoholics Anonymous (AA) and Narcotics Anonymous.
derives from the philosophical tension between the inevitable (McLean 2003, Neuberger 2005). In part, this ‘compulsory treatment’, or ‘compliance’ conflicts are departments espouse recovery, while promoting ideas of (Barker & Buchanan-Barker 2003). Where government and professionals, is not at all clear (Goode 2000).

Many of the significant descriptions of recovery were developed by people who had been (or still were) psychiatric ‘patients’ and who professed a more optimistic, empowering approach to identifying the help people might need to deal with problems of human living.

While the literature does include a few studies of recovery, from a psychiatric-medical perspective (Harding et al. 1987, Harrison et al. 2001), recovery as a movement appears to be based more on philosophical conviction than scientific evidence. Recovery proponents argued that people with serious mental illness could recover and described some of the social and interpersonal processes, which appeared to aid or enable recovery (Fisher 1999). These accounts, which emphasize personal experience, echo Samuel Smiles’ ideas about ‘living by example’ when he first coined the term ‘self-help’ in the 19th century (Smiles 1996). How such accounts fit with the objective, unworldly ‘evidence’ beloved by researchers, politicians and professionals, is not at all clear (Goode 2000). However, mainstream services often assimilate alternative concepts, if only to become more ‘consumer-friendly’ (Barker & Buchanan-Barker 2003). Where government departments espouse recovery, while promoting ideas of ‘compulsory treatment’, or ‘compliance’, conflicts are inevitable (McLean 2003, Neuberger 2005). In part, this derives from the philosophical tension between the person-focus of recovery and the patient (or illness) focus of psychiatric medicine.

Sally Clay is a mental health advocate, and psychiatric survivor, with a 35-year-long experience of psychiatric ‘care and treatment’, with no illusions about the ephemeral nature of concepts like ‘recovery’ or how they might be used to meet political agendas. Almost a decade ago she wrote: Recovery is the latest buzz word in the mental health field. For the last year or so, I have been labelled ‘recovered’ from mental illness. (Clay 1999, p. 26)

When invited to discuss her ‘recovery’ with psychiatrists in New York State, she observed that the resulting discussions failed to address:

the nature of mental illness itself. . . . If we are recovered, what is it that we have recovered from? If we are well now and were sick before, what is it that we have recovered to? . . . The psychiatrists in our dialogue become visibly uneasy when the subject arises, and they divert the discussion to less threatening lines of thought. ‘Coping mechanisms’ are just such a diversion, an attempt to regard the depth of madness as something that can be simply ‘coped’ with. (Clay 1999, pp. 26–27)

The concept of recovery may well be so deeply personal that it defies definition. However, it has also become an important social construct, which potentially might mean different things to different people.

Clarifying the value base of recovery

Any aspect of health or social care practice has a long developmental history and an even longer timeline of theoretical and philosophical influence. Today’s popular ‘evidence-based talking cure’ – CBT – derives from the work of Beck (1952) and Ellis (1958), from 50 years ago, both of whom traced their philosophical influences centuries back. Notably, they devoted decades to describing and illustrating their discrete therapeutic processes, before beginning to study (research) their potential efficacy.

In this context the Tidal Model of Mental Health Recovery (Barker 1998, 2001, Barker & Buchanan-Barker 2005) is fairly young. Since its launch a decade ago, it has generated almost 100 projects in the UK, Ireland, Canada, Japan, Australia and New Zealand, from outpatient addictions, through acute and forensic units, to the care of older people with dementia (Buchanan-Barker 2004). Beyond the mental health field, practitioners in palliative care are exploring the Tidal Model as an alternative philosophy for death and dying. Here we aim to clarify the distinguishing philosophical assumptions of Tidal theory (Brookes 2006) by explicating the human values of the Tidal Model (the 10 Commitments) which provide a basis for auditing recovery-focused practice.

Although there are numerous models of ‘recovery’, Tidal was probably the first recovery model to be developed by nurses in practice (Brookes 2006) drawn mainly upon nursing research (Vaughn et al. 1995, Barker et al. 1999, Barker & Buchanan-Barker 2005). Tidal was originally described as a philosophical approach to the development of practice-based evidence in mental health care, inviting practitioners to ask: ‘how do we tailor care to fit
The 10 Tidal Commitments

The Tidal Model embraces specific assumptions about people, their experience of problems of human living and their capacity for change (Barker & Buchanan-Barker 2005). From these assumptions we have developed a set of related values, which provide practitioners with a philosophical focus for helping people make their own life changes, rather than trying to manage or control ‘patient symptoms’ (Barker & Buchanan-Barker 2005). The 10 Commitments remind us that although rules come from the head, reflecting our masculine selves (anima), commitment comes from the feminine heart (animus). To help judge the extent to which practitioners, in any setting, employ the 10 Commitments in 2002 we were invited to develop the 20 Tidal Competencies, which have since been used to audit recovery practice in several projects, notably in England (Gordon et al. 2005) and Scotland (Lafferty & Davidson 2006). Here, we present each Commitment accompanied by the respective Tidal Competencies.

Value the voice

The person’s story represents the beginning and endpoint of the helping encounter, embracing not only an account of the person’s distress, but also the hope for its resolution. The story is spoken by the voice of experience. We seek to encourage the true voice of the person – rather than enforce the voice of authority. Traditionally, the person’s story is ‘translated’ into a third person, professional account, by different health or social care practitioners. This becomes not so much the person’s story (my story) but the professional team’s view of that story (history). Tidal seeks to help people develop their unique narrative accounts into a formalized version of ‘my story’, through ensuring that, all assessments and records of care are written in the person’s own ‘voice’. If the person is unable, or unwilling, to write in their own hand, then the nurse acts as secretary, recording what has been agreed, conjointly, is important – writing this in the ‘voice’ of the person.

Competency 1: The practitioner demonstrates a capacity to listen actively to the person’s story.

Competency 2: The practitioner shows commitment to helping the person record her/his story in her/his own words as an ongoing part of the process of care.

Respect the language

People develop unique ways of expressing their life stories, representing to others that which only they can know. The language of the story – complete with its unusual grammar...
and personal metaphors – is the ideal medium for illuminating the way to recovery. We encourage people to speak their own words in their distinctive voice.

Stories written about patients by professionals are, traditionally, framed by the arcane, technical language of psychiatric medicine or psychology. Regrettably, many service users and consumers often come to describe themselves in the colonial language of the professionals who have diagnosed them (Buchanan-Barker & Barker 2002). By valuing – and using – the person’s natural language, the Tidal practitioner conveys the simplest, yet most powerful, respect for the person.

Competency 3: The practitioner helps the person express her/himself at all times in her/his own language.
Competency 4: The practitioner helps the person express her/his understanding of particular experiences through use of personal stories, anecdotes, similes or metaphors.

Develop genuine curiosity

The person is writing a life story but is in no sense an ‘open book’. No one can know another person’s experience. Consequently, professionals need to express genuine interest in the story so that they can better understand the storyteller and the story.

Often, professionals are only interested in ‘what is wrong’ with the person, or in pursuing particular lines of professional inquiry – for example, seeking ‘signs and symptoms’. Genuine curiosity reflects an interest in the person and the person’s unique experience, as opposed to merely classifying and categorizing features, which might be common to many other ‘patients’.

Competency 5: The practitioner shows interest in the person’s story by asking for clarification of particular points, and asking for further examples or details.
Competency 6: The practitioner shows a willingness to help the person in unfolding the story at the person’s own rate.

Become the apprentice

The person is the world expert on the life story. Professionals may learn something of the power of that story, but only if they apply themselves diligently and respectfully to the task by becoming apprentice-minded. We need to learn from the person, what needs to be done, rather than leading.

No one can ever know another person’s experience. Professionals often talk ‘as if’ they might even know the person better than they know themselves. As Szasz noted: ‘How can you know more about a person after seeing him for a few hours, a few days or even a few months, than he knows about himself? He has known himself a lot longer! . . . The idea that the person remains entirely in charge of himself is a fundamental premise’ (Szasz 2000).

Competency 7: The practitioner develops a care plan based, wherever possible, on the expressed needs, wants or wishes of the person.
Competency 8: The practitioner helps the person identify specific problems of living, and what might need to be done to address them.

Use the available toolkit

The story contains examples of ‘what has worked’ for the person in the past, or beliefs about ‘what might work’ for this person in the future. These represent the main tools that need to be used to unlock or build the story of recovery. The professional toolkit – commonly expressed through ideas such as ‘evidence-based practice’ – describes what has ‘worked’ for other people. Although potentially useful, this should only be used if the person’s available toolkit is found wanting.

Competency 9: The practitioner helps the person develop awareness of what works for or against them, in relation to specific problems of living.
Competency 10: The practitioner shows interest in identifying what the person thinks specific people can or might be able to do to help them further in dealing with specific problems of living.

Craft the step beyond

The professional helper and the person work together to construct an appreciation of what needs to be done ‘now’. Any ‘first step’ is a crucial step, revealing the power of change and potentially pointing towards the ultimate goal of recovery. Lao Tzu said that the journey of a thousand miles begins with a single step. We would go further: any journey begins in our imagination. It is important to imagine – or envision – moving forward. Crafting the step beyond reminds us of the importance of working with the person in the ‘me now’: addressing what needs to be done now, to help advance to the next step.

Competency 11: The practitioner helps the person identify what kind of change would represent a step in the direction of resolving or moving away from a specific problem of living.
Competency 12: The practitioner helps the person identify what needs to happen in the immediate future, to help the person to begin to experience this ‘positive step’ in the direction of their desired goal.

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Give the gift of time

Although time is largely illusory, nothing is more valuable. Time is the midwife of change. Often, professionals complain about not having enough time to work constructively with the person. Although they may not actually ‘make’ time, through creative attention to their work, professionals often find the time to do ‘what needs to be done’. Here, it is the professional’s relationship with the concept of time, which is at issue, rather than time itself (Jonsson 2005). Ultimately, any time spent in constructive interpersonal communion, is a gift – for both parties (Derrida 1992).

Competency 13: The practitioner helps the person develop their awareness that dedicated time is being given to addressing their specific needs.
Competency 14: The practitioner acknowledges the value of the time the person gives to the process of assessment and care delivery.

Reveal personal wisdom

Only the person can know him or herself. The person develops a powerful storehouse of wisdom through living the writing of the life story. Often, people cannot find the words to express fully the magnitude, complexity or ineffability of their experience, invoking powerful personal metaphors, to convey something of their experience (Barker 2002). A key task for the professional is to help the person reveal and come to value that wisdom, so that it might be used to sustain the person throughout the voyage of recovery.

Competency 15: The practitioner helps the person identify and develop awareness of personal strengths and weaknesses.
Competency 16: The practitioner helps the person develop self-belief, therefore promoting their ability to help themselves.

Know that change is constant

Change is inevitable for change is constant. This is the common story for all people. However, although change is inevitable, growth is optional. Decisions and choices have to be made if growth is to occur. The task of the professional helper is to develop awareness of how change is happening and to support the person in making decisions regarding the course of the recovery voyage. In particular, we help the person to steer out of danger and distress keeping on the course of reclamation and recovery.

Competency 17: The practitioner helps the person develop awareness of the subtlest of changes – in thoughts, feelings or action.

Competency 18: The practitioner helps the person develop awareness of how they, others or events have influenced these changes.

Be transparent

If the person and the professional helper are to become a team then each must put down their ‘weapons’. In the story-writing process the professional’s pen can all too often become a weapon: writing a story that risks inhibiting, restricting and delimiting the person’s life choices. Professionals are in a privileged position and should model confidence by being transparent at all times, helping the person understand exactly what is being done and why. By retaining the use of the person’s own language, and by completing all assessments and care plan records together (in vivo), the collaborative nature of the professional–person relationship becomes even more transparent.

Competency 19: The practitioner aims to ensure that the person is aware, at all times, of the purpose of all processes of care.
Competency 20: The practitioner ensures that the person is provided with copies of all assessment and care planning documents for their own reference.

Reclamation: in our own voice

Many psychotherapeutic models develop a special language that is awkward to use and patronizing to the uninitiated. In pursuit of the 10 Commitments, the Tidal Model eschews the use of jargon, valuing instead ordinary language, especially the everyday vernacular of the person, family or friends.

Traditionally, psychiatry has devalued the person’s voice, by promoting diagnostic jargon (Kirk & Kutchins 1997). Given the power imbalance between professionals and their ‘patients’, many people end up describing their own experience in the technical language of psychiatry and psychology, as if their own story was inadequate (Furedi 2003), suggesting that the psychiatric narrative has colonized all our lives (Barker 2003). The Tidal Model asserts that ‘lived experience’ is understood best through use of natural language – using the metaphors and grammar that fit most easily with the way people talk naturally about their experiences. Consequently, Tidal focuses on helping people reclaim the story of their distress and, ultimately, their whole lives.

In human affairs, reclamation means the efforts necessary to seek the return of one’s property. In the psychiatric context, reclamation means the return of one’s personhood and its accompanying story. The Latin root (reclamare) means ‘to cry out against’. Arguably, the emergence of the
‘user/consumer’ voice is one of the most powerful developments in mental health, worldwide, in the past 30 years. Such groups are reclaiming their story and personhood, through the act of ‘speaking up’ or ‘speaking out’, which is central to the act of reclamation within Tidal.

In Tidal terms, reclamation refers to the pursuit of a productive use of something that was lost or considered worthless. Typically, land submerged by the sea, is reclaimed for use as part of the mainland. In the same sense, that part of the person’s life, which was submerged – and invalidated – by the effects of mental distress, is reclaimed to become part of the whole person. Like land reclamation, the reclaimed experience of mental distress is beyond value. Once brought (metaphorically) to the surface, it becomes (again) part of the person’s whole lived experience.

The first Tidal step in facilitating reclamation, is to write all the main assessment ‘stories’ and subsequent descriptions of necessary care, in the person’s own voice, rather than translate these into professional note-taking. This focus on ‘my story’ appeals to users and consumers, illustrating the practitioner’s desire to work actively with the person, co-creating the story of the care. The psychiatric survivor and consumer advocate Sally Clay wrote:

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 venture, 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 2005)

Focusing on the person

The person’s story describes not only the circumstances that led to the person’s need for help, but holds the promise of what needs to be done to begin the process of recovery. Although influenced by different schools of psychotherapy, Tidal emphasizes ordinary conversation, which has a power that stands apart from that found in the therapeutic discourse (Zeldin 2000) and the ‘narrative’ of everyday ‘story-telling’ (Brunner 1990). As Fisher noted, human beings are homo narrans: natural story-tellers, constantly updated by the process of telling stories (Fisher 1987).

Commonly people with experience of Tidal say that ‘it doesn’t feel as if I am being treated; it just feels as if someone is listening to me’ and want to tell a story about what it was like. A woman with a long history of psychiatric hospitalization recognized how this ‘ordinary’ experience could become ‘extraordinary’:

Tidal has made room for my voice. I’m not just another patient who is mentally ill. I am a person with goals and dreams and a life worth living. I get to discover and learn and make changes. Now I can think, decide and act for myself. I don’t need someone else to save me anymore, because I have been given the opportunity to save myself.

To emphasize the centrality of practical action within Tidal, we borrowed the term – ‘doing what needs to be done’ – from the work of Shoma Morita, the Japanese psychiatrist who developed a form of ‘constructive living’ therapy, in the 1920s (Morita et al. 1998). Working within the ‘me-now’ of the story, the conjoint work of the professional and the person in care involves negotiating what needs to be done, which might begin to address or respond to a current problem of human living.

Problematizing Tidal

Within a decade the Tidal Model has progressed from a local solution for mental health nursing to an international model of mental health recovery, recognized and practised in several different countries. Those developing Tidal-focused services appear to derive something personally or professionally satisfying from the Tidal Model itself, many noting that its inherent values remind them why they ‘came into the field in the first place’. They often complain that they had no ambition to ‘carry out observation protocols’, ‘implement control and restraint procedures’, ‘attend endless meetings’ or ‘shuffle paper’. Instead, they took up caring to help people address, manage or otherwise ‘recover’ from whatever problems have overtaken them in their lives. By embracing Tidal, they appear to be reclaiming their original caring vocation.

As Tidal practice has evolved over the past decade, we felt an increasing obligation to clarify its philosophical – or value – base. We have reflected greatly on what we value – as persons and professionals – and also have learned much, over several decades, about what other people value. In helping others introduce Tidal into their practice we have tried to clarify what the Tidal Model ‘stands for’ and how it might be pursued. In so doing we have favoured the kind of everyday language that characterizes the model itself. No philosophical system will satisfy everyone, but the values embraced by the 10 Commitments appear to have a broad constituency, across nations, societies and cultures.

However, for some, ‘the only way to genuinely test . . . whether (the Tidal model) . . . makes a real difference’ would be through ‘a carefully planned and fairly large-scale clinical trial’ (Gamble & Wellman 2002, p. 743). We are not
averse to others undertaking such ‘scientific’ studies, but this is not one of our priorities. The major social movements, which have blossomed in our lifetime – feminism, black power and gay rights – did not reshape social attitudes and behaviour through the use of the randomized control trial, or any other ‘scientific’ method. Instead, they employed the ancient philosophical method of rhetoric. The ‘success’ of recovery movements, like AA, and the continued rise of the user/consumer ‘movement’ worldwide is also based on rhetoric and organized social action, seeking to communicate the beliefs and values of the group.

Gordon et al. (2005) argued that ample evidence existed for the impact of Tidal on practice. However, we would still urge caution. People often ask: ‘does the Tidal model work?’ We wonder what, exactly, they mean. All theories are merely ‘suppositions or systems of ideas, explaining something’ (Oxford English Dictionary). Models represent highly simplified descriptions of the ‘thing’ itself – in this case the process for enabling recovery. Therefore, we find it more appropriate to ask: ‘in what way, does the Tidal Model “work” for whom and to what particular purpose?’ At least in human affairs, ultimately, no ‘model’ and its supporting ‘theory’ can be shown to ‘work’. Only the individual practitioners and the organizational systems which support practice, might be viewed as ‘working’. However, we need also to ask: ‘working to what particular purpose?’

Here we have attempted to clarify the Tidal ‘purpose’, by re-framing its original philosophical assumptions and describing how, through ongoing collegiate dialogue we developed the 10 Commitments, which attempt to clarify the Tidal values and, the 20 Tidal Competencies, which might contribute to the study of recovery practice. We recognize that Tidal – as a developing theory of the recovery process and model for its practice – distills many thousands of voices of people who helped us to develop the model and who are the real ‘guardians’ of Tidal theory and practice. Many nurses take this guardianship role very seriously since it appears to extend their passion for psychiatry and the organizational systems which have blossomed in our lifetime – feminism, black power and gay rights – did not reshape social attitudes and behaviour through the use of the randomized control trial, or any other ‘scientific’ method. Instead, they employed the ancient philosophical method of rhetoric. The ‘success’ of recovery movements, like AA, and the continued rise of the user/consumer ‘movement’ worldwide is also based on rhetoric and organized social action, seeking to communicate the beliefs and values of the group.

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We valued the nurses’ stories. Now we collect stories that tell of their successes and their frustrations practising Tidal... We continue to strive to transform nursing practice and contribute to person’s journeys of recovery. There is ebb and flow in the process of implementing the model. Sometimes we faced setbacks, or at times we felt becalmed. There would also be times of success, great celebration and breakthroughs. We are sustained by our passion for excellence in psychiatric and mental health nursing and care – and by the stories. (pp. 462–463)

References


