The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing

P. BARKER PhD RN FRCN

Professor of Psychiatric Nursing Practice, University of Newcastle, Department of Psychiatry, Royal Victoria Infirmary, Newcastle Upon Tyne NE1 4LP, UK

Correspondence:
P. Barker
University of Newcastle
Department of Psychiatry
Royal Victoria Infirmary
Newcastle Upon Tyne NE1 4LP
UK

BARKER P. (2001) *Journal of Psychiatric and Mental Health Nursing* **8**, 233–240

The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing

Nursing theories and nursing models have a low profile within psychiatric and mental health nursing in the United Kingdom. This paper describes the philosophical and theoretical background of the Tidal Model, which emerged from a 5-year study of the 'need for psychiatric nursing'. The Tidal Model extends and develops some of the traditional assumptions concerning the centrality of interpersonal relations within nursing practice. The model also integrates discrete processes for re-empowering the person who is disempowered by mental distress or psychiatric services or both. The paper reports briefly on the ongoing evaluation of the model in practice.

Keywords: empowerment, holistic, interpersonal relations, narrative, nursing theories and models, psychiatric nursing

Accepted for publication: 27 November 2000

Introduction

The emphasis of mental health care has shifted dramatically in recent years to a concern for people with 'serious and/or enduring mental illness', especially 'schizophrenia' (DoH 1994). At the same time, biological, neuroscientific and genetic theories have become increasingly accepted as complete 'explanations' for serious and enduring forms of mental distress (Keen 1999, Newnes *et al*. 2000). Despite such popular acceptance, a considerable body of research exists which challenges these assumptions (Dawson 1994, 1997, Lehtonen 1994, Tienari *et al*. 1994, Keen 1999). More importantly, there is evidence that viable alternatives to such biological constructions of mental distress exist, suggesting the possibilities for more holistic forms of psychosocial intervention (Alanen *et al*. 1991, Pylkkanen 1997). As Keen (1999) has noted, the public and political anxiety expressed over the 'uncertainty' of ever identifying any single causative factor for serious forms of mental ill-health (such as schizophrenia) has generated a form of pragmatism that risks stifling the continued search for true understanding of such problems of human living. In nursing, such pragmatism – predicated on acceptance of biological explanations and behavioural control – risks 'damaging nursing relationships by stigmatizing or alienating sufferers, and creating a workforce of distanced, potentially oppressive nurses (Keen 1999, p. 422).

The Tidal Model springs from a similar set of assumptions to those expressed in the work of Alanen *et al*. (1991) when they suggested that people, their families and those close to them need to be helped to:

> conceive of the situation (e.g. admission) as a consequence of the difficulties the patients (sic) and those close to them have encountered in their lives, rather than as a mysterious illness the patient has developed as an individual.

Such a respectful approach to addressing the lived experience of the person and her/his significant others is diametrically opposed to the so-called 'psychoeducational approach', which assumes an organic basis for schizophrenia (Falloon *et al*. 1984, Tarrier 1991, Kavanagh 1992) and which consolidates the public conception of mental illness as a function of a (largely irrecoverable) damaged or disordered brain.

The Tidal Model assumes that the kind of help needed by people in great mental distress is akin to developing a form of increased awareness or higher education. The model assumes that, apropos Rowan (1993), no-one can bring someone to a level of personal understanding or knowledge who has not already reached it themselves.

The status of nursing models and theories

Despite more than 40 years of controversy (Szasz 1961, 2000, Newnes *et al*. 1999, 2000), the medical model continues to dominate mental health services (Engel 1977, Barker *et al*. 1989, Gordon 1990, Thomas 1997). More recently the 'biopsychosocial' model stimulated by Engel (1977) and other 'psychosocial' models (e.g. Foa 2000) have emerged and are now deployed by various disciplines, in their efforts to develop more broad-based forms of treatment. It is perhaps unsurprising, however, that a specific model of nursing for psychiatric and mental health care has failed to emerge, at least within the United Kingdom, or that nursing theories have been so badly received by nurses themselves (McKenna 1993, Gournay 1995). Unlike medicine – with its relationship to the physical sciences – and disciplines drawn from the social sciences – like clinical psychology and social work – nursing has long been viewed as an intellectual lightweight, with a limited research background and no real home in either the health or social sciences (Barker 1990, 1997). Traditionally, nurses have been cast as a supporting act in the therapeutic drama. As Nightingale first observed, nurses are like foot soldiers – carrying the generals' plans into the battle against illness (Nightingale 1969). Two hundred years after Nightingale, nursing still appears to be haunted by the ghosts of the Crimea (Group & Roberts 1974) as many nurses themselves reject the potential for an independent nursing voice (Gournay 1995).

The marginalized status of nursing might also explain why so many mental health nurses have tried to validate their therapeutic standing as nurses by moulding themselves in the shape of some more established, therapeutic agent (Barker 1982, Barker & Fraser 1985, Kinsella 1993, Michael 1994). The ubiquitous concept of the nurse therapist implies, perhaps, that nursing *per se* is not, or could never be, therapeutic (Williams 1996). Some nurses have explored the possibilities of established general nursing theories or models for mental health nursing practice (Thompson 1990, Miller 1991, Reynolds & Cormack 1991, DeHowitt 1992, Lacey 1993, Doncliff 1994, Jones 1996, Flaskerud 2000, Murphy *et al*. 2000). However, despite a consistent critique of the myriad assumptions of medical and biopsychosocial models of 'mental illness' (Dawson 1994, 1997, Barker 1996, Barker & Reynolds 1996, Hopton 1996, Clarke 1997, 1999, Keen 1999, Barker & Stevenson 2000), many nurses appear satisfied to settle, pragmatically, for a subordinate role within a medically dominated mental health (sic) service (Hamera *et al*. 1992, Gamble 1993, Warner 1993, Abbondanza *et al*. 1994) that Nolan (1993) saw as their traditional 'supportive' function.

Although reservations have been expressed about the appropriateness of some models of nursing for mental health nursing (Barker & Reynolds 1994, King 1994), there can be no serious objection, in principle, to establishing the discipline of psychiatric nursing on nursing theory, or to the construction of nursing models to support the enactment of nursing practice. Indeed, the development of such a theory-based model of nursing practice could be described as a professional obligation (Hopton 1996).

Emphasis continues to be placed on multidisciplinary teamwork and models, such as the biopsychosocial model (Chafetz & Ricard 1999) that arguably might facilitate such teamwork. However, nursing practitioners are aware that the medical model is stronger than ever in clinical psychiatry (Dawson 1994, 1997, McMinn 1995, Antai-Otong 2000). Similarly, theorists in the social sciences show no sign of abandoning their development of various psychological and social models that might further illuminate alternatives to traditional psychiatric medical treatment (Callahan & Bauer 1999, Markowitz 1999). These developments suggest that any model of psychiatric and mental health nursing practice must emphasize not only the 'need for nursing', but must be congruent with the responses of other disciplines to the person's need for medical and other therapeutic interventions.

A radical, catholic model of mental health nursing

The Tidal Model (Barker 1998, 2000) was developed from the Newcastle University 5-year study of the 'need for nursing' (Barker 1996, Jackson & Stevenson 1998), which generated a substantive theory of nursing practice in mental health care (Barker *et al*. 1999a, 1999b). The Need for Nursing study sought to clarify the discrete roles and functions of nursing within a multidisciplinary care and treatment process. By translating the theory of the need for

nursing into practice, the Tidal Model developed many of Peplau's assertions about the importance of interpersonal relationships for nursing practice, and also incorporated a model of the process of empowerment (Musker & Byrne 1997) developed within a parallel study (Barker *et al.* 1999b). These theory-generating studies continued the tradition of inquiry involving the interpersonal processes of nursing practice (Peplau 1952, Altschul 1972) which sought to clarify further what nurses should do as a caring response. Arguably, this interest in the 'proper focus of nursing' (Barker & Reynolds 1996) has become unfashionable, as emphasis has switched to the work of multidisciplinary teamwork. However, given the key position of nursing as an agent of therapeutic intervention, there is at least some value in clarifying the basis from which nurses might work into multidisciplinary teamwork.

The Tidal Model was originally introduced into acute psychiatric care settings in 1997 (Barker 1998a), but since the concept of a 'care continuum' has been developed which emphasizes the person's need for three discrete forms of care: 'critical', 'transitional' and 'developmental'. The care continuum spans the hospital–community divide emphasizing that need should be the primary focus for care, rather than the setting within which it is delivered (Barker 2000).

The Tidal Model is a radical, catholic model of psychiatric nursing practice, focused on the care processes that are fundamental (radical) to nursing practice in mental health and appropriate for any care setting and any mental health population (catholic). Although focused on identifying the necessary processes of nursing care, the discrete practices involved are intended to be complementary to the care and treatment offered by other disciplines.

Water – the core metaphor

Borrowing from chaos theory, Barker (1996) acknowledged the fluid nature of human experience, characterized by incessant change and unpredictability. This fluidity provides the basis of the core metaphor of the Tidal Model:

> Life is a journey undertaken on an ocean of experience. All human development, including the experience of illness and health, involves discoveries made on the journey across that ocean of experience.
>
> At critical points in the life journey the person experiences storms or even piracy (crisis). At other times the ship may begin to take in water and the person may face the prospect of drowning or shipwreck (breakdown).The person may need to be guided to a safe haven to undertake repairs, or to recover from the trauma (rehabilitation). Once the ship is made intact or the person has regained the necessary sea-legs, the ship may set sail again, aiming to put the person back on the life course (recovery).

Unlike normative psychiatric models, the Tidal Model holds few assumptions about the proper course of a person's life. Instead, the focus is on the kind of support that people might need to rescue them from crisis, or to help put them back on the life course (development). The Tidal Model recognizes that the life experiences associated with mental ill-health are invariably described in metaphorical terms.

People who experience life crises are (metaphorically) in deep water and risk drowning, or feel as if they have been thrown on to the rocks. Those who have experienced trauma (such as injury or abuse), or more enduring life problems, often report loss of 'sense of self', akin to the trauma associated with piracy. Such people need a sophisticated form of life saving (psychiatric rescue) followed, at an appropriate interval, by the kind of development work necessary to engender true recovery. This may take the form of crisis intervention in the community or the 'safe haven' of a crisis stabilization unit, or inpatient setting. Once the rescue is complete (psychiatric nursing) the emphasis switches to the kind of help needed to get the person 'back on course', returning to a meaningful life in the community (mental health nursing).

The Tidal Model assumes that people's 'need for nursing' cannot lie in some 'either/or' world of community or hospital, general or specialist service, acute or continuing care, but rather flows across these artificial boundaries, as the nature of the person's needs shift – often imperceptibly. This focus on the care continuum aims to promote the kind of 'seamless' care that risks becoming mere rhetoric. The caring response, expressed by nursing, needs to flow with the person, adapting itself to the person's changing needs. Regrettably, the worlds of community and residential care have suffered from artificial distinctions. If we maintain a focus on the needs of the person – for critical, transitional or developmental care – the interdependence of different services, to meet different needs, becomes apparent.

A range of discrete holistic (exploratory) and focused (risk) assessments have been developed within the Tidal Model. These facilitate a person-centred approach and generate interventions that emphasize the person's extant resources and capacity for solution finding. These various assessment and intervention processes are intended to support rather than restrict practice. The various methods that have been defined in the training programme for the model (Barker 2000) allow the nurse a better view of the person and the territory of care, and provide the creative space necessary to respond to someone in crisis. By acknowledging the need for a continuously flexible response to the person, the Tidal Model also recognizes the

chaotic nature of human behaviour, and especially of human experience (Barker 1996).

Re-conceptualizing the person as patient

The Tidal Model employs a caring construct which rapidly appears to be obscured by myriad therapeutic concepts borrowed from other disciplines or fields of human inquiry (Reynolds & Scott 1999). Whereas most, if not all, therapeutic constructs aim to effect some change, in the presentation of the person who is the patient, the Tidal Model has more modest ambitions, which may – ultimately – be more ambitious. Rather than engaging with the disorder or illness, the Tidal Model focuses on contacting the person (Barker 1997). The aim of this engagement is to understand the present situation of the person, which includes the relationship with illness and health. Although the nurse expresses a curiosity about the person, this is in pursuit of knowledge of what is happening within the person's experience of world, self and colleagues; and what this might mean in terms of essential care of the person.

The model employs three dimensions as a means of representing personhood: world, self and others. In the world dimension, the focus is on the person's need to be understood. This includes a need to have the personal experience of distress, illness or trauma validated by others. A specific assessment format (the Holistic Nursing Assessment) has been developed to document, in the person's own voice, the significant and meaningful events occurring at that particular time, and what the person perceives as needing to be done to respond to these events.

In the self dimension, emphasis is given to the person's need for emotional and physical security. A specific assessment format – the Security Plan – has been developed to identify the kind of support necessary to ensure personal security, and to offset the risk of harm to self or others through direct action or neglect.

In the others dimension, emphasis is given to the kind of support and services which the person might need to live an ordinary life. This dimension emphasizes the need for specific medical, psychological or social interventions, including other vital areas of everyday living, such as housing, finances, occupation and leisure.

Within each of these dimensions the nurse aims to explore the person's construction of experience through narrative (Holdsworth 1995, Tilley 1995, Saunders 1997) employing the concept of the therapeutic alliance (Hummelvoll 1996). In each dimension of assessment and intervention, emphasis is given to engaging the person fully in the process of determining and, where possible, contributing to the interventions that might meet the person's needs. The narrative structure of the model is developed expressly in the care plans, where the assessment record documents the person's needs and problems verbatim, rather than translating the person's account into the professional language of psychiatry.

The necessary care required by the person will, invariably involve a balance or fusion between the differing constructions of the person and her/his 'significant others'. The empowerment, narrative basis of the model acknowledges that what 'needs to be done' will be determined, largely, by the person's 'personal science' (Mahoney 1974), and the model draws heavily on systemic and solution-oriented approaches (Bulmer 1994, Webster *et al*. 1994, 1995), which emphasize personal problem solving and revealing and employing personal resources.

In acknowledging the centrality of the narrative as the medium of the self (McIntyre 1981) emphasis is given to maintaining the integrity of the narrative through carefully constructed collaborative inquiry. The person's sense of self, and world of experience – including experience of others – is inextricably tied to her/his life stories and their various associated meanings. The Tidal Model generates a narrative-based form of practice that differs markedly from the concept of evidence-based practice. The former is always about particular human instances, whereas the latter is based on the behaviour of populations, whose elements are merely assumed to be equivalent. More importantly perhaps, the narrative focus of the Tidal Model is not concerned to unravel the causative course of the person's present problems of living, but aims to use the experience of the person's journey and its associated meanings, to chart the 'next step' that needs to be taken on the person's life path. As part of this conjoint exploration of the person's 'world of experience', the assessment record is written in the person's own voice, rather than translated into third person, or professional language. This results in the co-creation of a narrative of the person's world of experience which includes an identification of what the person believes (s)he needs in the form of nursing (Barker *et al*. 1999a).

In giving precedence to the person's story the Tidal Model acknowledges that the narrative is the location for the person's enactment of life. The caring process begins and ends here as people invariably wish to develop (create) a coherent account of what has happened and presently is happening to them in the light of their experience of mental distress. In this context, the inquiry into the history of the person's difficulties and the emerging story of the changes that have occurred needs to be a patient and rigorous process. In a related context the poet Rilke wrote:

> Being an artist means . . . ripening like a tree, which doesn't force its sap, and stands confidently in the storms of spring, not afraid that afterward summer may

> not come. It does come. But it comes only to those who are patient, who are there as if eternity lay before them, so unconcernedly silent and vast. I learn it every day of my life, learn it with pain I am grateful for: *patience* is everything. (Mitchell 1998, pp. 186–187)

The need to re-empower the person

The experience of mental ill-health is fundamentally disempowering (Barker & Stevenson 2000). When mental health problems endure or recur frequently, the family or community may view the person as disabled. Although the person is offered a mental health service, often this is focused only on limiting the personal and interpersonal damage that can be caused by the problems of living called mental illness (Barker & Stevenson 2000). The processes of psychiatric care and treatment can add to the disempowerment of the person – adding 'insult to injury' (Barker *et al*. 1999a). This can range from the manifest restrictions imposed by confinement under the law to the more subtle limitations enacted by being placed 'under observation' in hospital (Barker & Cutcliffe 2000) or deemed 'noncompliant' by an 'assertive outreach team'. The commonest form of disempowerment involves the failure to afford a proper hearing to the person's story of the experience of problems of living. Traditionally, the medical model has served as a means of deflecting attention away from the lived experience of the person, translating this unique, subjective account, into the para-language of medicine. In this way the person's account is reduced to the level of its apparently commonly occurring parts. This is not a condemnation of psychiatric diagnosis *per se*, but acknowledges the limitations of this particular way of re-presenting the human experience of problems of living, especially where this is afforded primacy.

The three dimensions of the Tidal Model aim to avoid reducing the person to a 'patient phenomenon', whilst recognizing the impossibility of developing anything more than a provisional account of the person's life experiences, and the person's immediate need for nursing.

Origins and current development

The Tidal Model was originally developed across two pilot sites in acute psychiatric admission wards in Newcastle, UK between 1997 and 1999. The revised model was formally introduced across the whole Adult Mental Health Programme, comprising eight admission wards and their associated community support teams, in May 2000, where an interdisciplinary evaluation of the model in practice is being conducted, using action research methodology.

Additional pilot sites have been established in various countries – Australia, England, Ireland, Japan, New Zealand, Scotland and Wales. These sites extend across a range of clinical settings, from a rural mental health service in Adelaide, Australia, through an acute ward in a private hospital in Tokyo, Japan, to a medium secure facility in Cardiff, Wales. These pilot sites (numbering 15 at the time of writing) will allow a degree of cross-national, as well as cross-cultural comparison of the model in action (Narayanasamy 1999).

Conclusion

Nursing has a longstanding attachment to the concept of caring through interpersonal relationships. Increasingly, however, this has been usurped by demands for 'evidence' of their utility within a postpositivist research paradigm (Stevenson 1996, Barker 1999). However, as Taylor (1994) has demonstrated, the dynamic processes involved when nurses and the people in their care, encounter and negotiate (through narrative) the experience of illness, can ultimately engender healing, and are experienced as such by people receiving nursing care. The Tidal Model assumes that nurses need to get close to the people in their care, so that they might explore (together) the experience of health and illness. Health care is becoming increasingly technical and emotionally distant (e.g. through the use of computers) and many people with mental health problems are calling for care and treatment to re-emphasize the relationships between themselves and their carers (Newnes *et al*. 1999, 2000). In this context it is notable that Harry Stack Sullivan's biographer suggested that Sullivan's key contribution to psychotherapy and psychiatry was his:

> ever present awareness of the need to convey respect for the patient and to maintain the patient's own self-esteem. (Evans 1996)

In quite a different context, the Irish philosopher and theologian, John O'Donohue, has argued that contemporary culture possesses:

> an excessive concentration on the notion of relationships. It is a constant theme on TV, film and media. Technology and media are not uniting the world. They pretend to provide a world that is internetted, but in reality, all they deliver is a simulated world of shadows . . . 'relationship' has become an empty centre around which our lonely hunger forages for warmth and belonging. (O'Donohue 1997, p. 39)

In the early Celtic church, a person who acted as a teacher, companion and spiritual guide, was called an anam cara (a soul friend): someone 'to whom you confessed, revealing the hidden intimacies of your life' (O'Donohue 1997, p. 35). It is noteworthy that there are accounts, from over

1000 years ago, of Celtic monks caring for people with what might, now, be called mental illness (Nolan 1993). It is evident that the practice of psychiatric and mental health nursing is still predicated on a kind of confession (of trauma and physical and emotional vulnerability) within an intimate conversation (interview/assessment/therapeutic dialogue). Only our postmodern secular society feels uncomfortable about acknowledging that this process is 'spiritual', as it involves – as Frankl (1964) defined it – an exploration of the meanings which people have attributed to the experiences in their lives.

The Tidal Model acknowledges that the life problems which overtake and threaten to drown people described as suffering from mental illness can be construed, at a fundamental level, as spiritual crises (Hummelvoll & da Silva 1994, Morris 1996, Thomas 1997) in the sense that the disturbance (whatever we call it) involves a disturbance of the various meanings attached to and by the person, in relation to the experience of being human and being alive. The Tidal Model also acknowledges that the kind of care that nurses need to deliver, to respond effectively to such crises, may appear ordinary (Taylor 1994) but, given the context of care and the often-limited resources available, can represent acts of extraordinary courage and compassion.

References

Abbondanza D.M., Puskar K.R., Wilkinson B., Welch C., Rudert S. & Gallippi B. (1994) Psychiatric mental health nursing in a biopsychosocial era. *Perspectives in Psychiatric Care* **30,** 21–25.

Alanen Y., Lehtinen K. & Aaltonen J. (1991) Need-adapted treatment of new schizophrenic patients: experiences and results of the Turku Project. *Acta Psychiatrica Scandanavica* **83,** 363–372.

Altschul A.T. (1972) *Nurse–Patient Interaction: a Study of Interactive Patterns on an Acute Psychiatric Ward*. Churchill Livingstone, Edinburgh.

Antai-Otong D. (2000) The neurobiology of anxiety disorders: implications for psychiatric nursing practice. *Issues in Mental Health Nursing* **21,** 71–89.

Barker P. (1982) *Behaviour Therapy Nursing*. Croom-Helm, London.

Barker P. (1990) The philosophy of psychiatric nursing. *Nursing Standard* **5,** 28–33.

Barker P.J. (1996) Chaos and the way of Zen: psychiatric nursing and the 'uncertainty principle'. *Journal of Psychiatric and Mental Health Nursing* **3,** 235–243.

Barker P. (1997) *Assessment in Psychiatric and Mental Health Nursing: in Search of the Whole Person*. Stanley Thornes, Cheltenham.

Barker P. (1998) It's time to turn the tide. *Nursing Times* **94,** 70–72.

Barker P. (1999) *Qualitative Research in Nursing and Health Care. Nursing Times Clinical Monographs No 13*. NT Books, London.

Barker P. (2000) *The Tidal Model: from Theory to Practice*. University of Newcastle, Newcastle.

Barker P. & Cutcliffe J. (2000) Creating a hopeline for suicidal people: a new model for acute sector mental health nursing. *Mental Health Care* **3,** 190–193.

Barker P., Baldwin S. & Ulas M. (1989) Medical expansionism: some implications for psychiatric nursing practice. *Nurse Education Today* **9,** 192–202.

Barker P. & Fraser D. (1985) *The Nurse as Therapist: a Behavioural Model*. Croom-Helm, London.

Barker P., Jackson S. & Stevenson C. (1999a) What are psychiatric nurses needed for? Developing a theory of essential nursing practice. *Journal of Psychiatric and Mental Health Nursing* **6,** 273–282.

Barker P., Leamy M. & Stevenson C. (1999b) Nurses empowerment of people with enduring forms of mental illness. Report to the Northern and Yorkshire Regional Research Committee, Newcastle.

Barker P. & Reynolds B. (1994) A critique: Watson's caring ideology. The proper focus of psychiatric nursing? *Journal of Psychosocial Nursing and Mental Health Service* **32,** 17–22.

Barker P.J. & Reynolds B. (1996) Rediscovering the proper focus of nursing: a critique of Gournay's position on nursing theory and models. *Journal of Psychiatric and Mental Health Nursing* **3,** 76–80.

Barker P. & Stevenson C. (2000) *The Construction of Power and Authority in Psychiatry*. Butterworth Heinemann, Oxford.

Bulmer C.A. (1994) Maximum insight with minimum dependence. Brief therapy in psychiatric nursing. *Professional Nurse* **9,** 621–625.

Callahan A.M. & Bauer M.S. (1999) Psychosocial interventions for bipolar disorder. *Psychiatric Clinics of North America* **22,** 675–688.

Chafetz L. & Ricard N. (1999) The biopsychosocial perspective in psychiatric nursing: myth or future reality? *Canadian Journal of Nursing Research* **31,** 17–23.

Clarke L. (1997) Schizophrenic patients fare badly in the company of scientists. *Journal of Advanced Nursing* **25,** 429–430.

Clarke L. (1999) Nursing in search of a science: the rise and rise of the new nurse brutalism. *Mental Health Care* **2,** 270–272.

Dawson P.J. (1994) Contra biology: a polemic. *Journal of Advances in Nursing* **20,** 1094–1103.

Dawson P.J. (1997) A reply to Kevin Gournay's 'Schizophrenia: a review of the contemporary literature and implications for mental health nursing theory, practice and education'. *Journal of Psychiatric and Mental Health Nursing* **4,** 1–7.

DeHowitt M.C. (1992) King's conceptual model and individual psychotherapy. *Perspectives on Psychiatric Care* **28,** 11–14.

DoH (1994) Working in Partnership. Au, London.

Doncliff B. (1994) Putting Peplau to work. *Nursing New Zealand* **2,** 20–22.

Engel G.L. (1977) The need for a new medical model: the challenge for biomedicine. *Science* **196,** 129–136.

Evans F.B. (1996) *Harry Stack Sullivan: Interpersonal Theory and Psychotherapy*. Routledge, London.

Falloon I., McGill C. & Boyd J. (1984) *Family Care of Schizophrenia*. Guilford Press, New York.

Flaskerud J.H. (2000) Shifting paradigms to neuropsychiatric nursing. *Issues in Mental Health Nursing* **21,** 1–2.

Foa e (2000) Psychosocial treatment of post-traumatic stress disorder. *Journal of Clinical Psychiatry* **61** (Suppl. 5), 43–48.

Frankl V. (1964) Man's search for meaning. Penguin, Harmondsworth.

Gamble C. (1993) Working with schizophrenic clients and their families. *British Journal of Nursing* **13** (2:17), 856–859.

Gordon J.S. (1990) Holistic medicine and mental health practice: towards a new synthesis. *American Journal of Orthopsychiatry* **25** (60:3), 357–370.

Gournay K. (1995) What to do with nursing models. *Journal of Psychiatric and Mental Health Nursing* **2**, 325–327.

Group T.M. & Roberts J.I. (1974) Exorcising the ghosts of the Crimea. *Canadian Nurse* **70**, 31–35.

Hamera E.K., Peterson K.A., Young L.M. & Schaumloffel M.M. (1992) Symptom monitoring in schizophrenia: potential for enhancing self-care. *Archives of Psychiatric Nursing* **6**, 324–330.

Holdsworth N. (1995) From psychiatric science to folk psychology: an ordinary-language model of the mind for mental health nurses. *Journal of Advances in Nursing* **21**, 476–486.

Hopton J. (1996) Reconceptualizing the theory–practice gap in mental health nursing. *Nurse Education Today* **16**, 227–232.

Hummelvoll J.K. (1996) The nurse–client alliance model. *Perspectives in Psychiatric Care* **32**, 12–21.

Hummelvoll J.K. & da Silva A.B. (1994) A holistic-existential model for psychiatric nursing. *Perspectives in Psychiatric Care* **30**, 7–14.

Jackson S. & Stevenson C. (1998) The Giff of Time from the Friendly Professional. *Nursing Standard* **12**, 31–33.

Jones A. (1996) The value of Peplau's theory for mental health nursing. *British Journal of Nursing* **5**, 877–881.

Kavanagh D. (1992) Recent developments in expressed emotion and schizophrenia. *British Journal of Psychiatry* **160**, 601–620.

Keen T. (1999) Schizophrenia: orthodoxy and heresies. A review of alternative possibilities. *Journal of Psychiatric and Mental Health Nursing* **6**, 415–424.

King M. (1994) Nursing theories outdated. *Journal of Psychosocial Nursing and Mental Health Service* **32**, 6.

Kinsella P. (1993) Practical skills to overcome emotional problems. Developing a model of cognitive behavioural therapy nursing for acute inpatient psychiatric care. *Professional Nurse* **9**, 98–100.

Lacey D. (1993) Using Orem's model in psychiatric nursing. *Nursing Standard* **7**, 28–30.

Lehtonen J. (1994) From dualism to psychobiological interaction: a comment on the study of Tienari and his co-workers. *British Journal of Psychiatry* **164** (Suppl. 23), 27–28.

Mahoney M.J. (1974) Cognition and behaviour modification. Ballinger, Cambridge, Mass.

Markowitz J.C. (1999) Developments in interpersonal psychotherapy. *Canadian Journal of Psychiatry* **44**, 555–561.

McIntyre A. (1981) *After Virtue*. Notre Dame University Press, Notre Dame.

McKenna H. (1993) The effects of nursing models on quality of care. *Nursing Times* **89**, 43–46.

McMinn B. (1995) Diagnostic classification systems and nursing diagnosis of collaborative problems. *Australian and New Zealand Journal of Mental Health Nursing* **4**, 124–131.

Michael S. (1994) Invisible skills. *Journal of Psychiatric and Mental Health Nursing* **1**, 56–57.

Miller F. (1991) Using Roy's model in a special hospital. *Nursing Standard* **5**, 29–32.

Mitchell S. (1998) *The Enlightened Mind*. Harper Collins, New York.

Morris LE.(1996) A spiritual well-being model: use with older women who experience depression. *Issues in Mental Health Nursing* **17**, 439–455.

Murphy K., Cooney A., Casey D., Connor M., O'Connor J. & Dineen B. (2000) The Roper, Logan and Tierney (1996) model: perceptions and operationalization of the model in psychiatric nursing within a health board in Ireland. *Journal of Advances in Nursing* **31**, 1333–1341.

Musker M. & Byrne M. (1997) Applying empowerment in mental health practice. *Nursing Standard* **11**, 45–47.

Narayanasamy A. (1999) Transcultural mental health nursing. 1: Benefits and limitations. *British Journal of Nursing* **8**, 664–668.

Newnes C., Holmes G. & Dunn C. (1999) *This is Madness: a Critical Look at Psychiatry and the Future of Mental Health Services*. PCCS Books, Ross-on-Wye.

Newnes C., Holmes G. & Dunn C. (2000) *This is Madness Too: a Further Look at Psychiatry and the Future of Mental Health Services*. PCCS Books, Ross-on-Wye.

Nightingale F. (1969) *Notes on Nursing: What it is and What it is Not*. Dover Publications, New York.

Nolan P. (1993) *The History of British Mental Health Nursing*. Chapman & Hall, New York.

O'Donohue J. (1997) *Anam Cara: Spiritual Wisdom from the Celtic World*. Bantam Press, New York.

Peplau H.E. (1952) *Interpersonal Relations in Nursing*. Putnam, New York.

Pylkkanen K. (1997) The Finnish National Schizophrenia Project. In: *Psychotherapy of Psychosis* (eds Mace, C. & Margison, F.). Gaskell, London.

Reynolds W. & Cormack D.F. (1991) An evaluation of the Johnson Behavioural System Model of Nursing. *Journal of Advances in Nursing* **16**, 1122–1130.

Reynolds W.J. & Scott B. (1999) Empathy: a crucial component of the helping relationship. *Journal of Psychiatric and Mental Health Nursing* **6**, 363–370.

Rowan J. (1993) *The Transpersonal: Psychotherapy and Counselling*. Routledge, London.

Saunders J. (1997) Walking a mile in their shoes. . . Symbolic interactionism for families living with severe mental illness. *Journal of Psychosocial Nursing and Mental Health Service* **35**, 8–13.

Stevenson C. (1996) The Tao, social constructionism and psychiatric nursing practice and research. *Journal of Psychiatric and Mental Health Nursing* **3**, 217–224.

Szasz T.S. (1961) *The Myth of Mental Illness*. Hoeber, New York.

Szasz T.S. (2000) The case against psychiatric power. In: *The Construction of Power and Authority in Psychiatry* (eds Barker, P. & Stevenson, C.). Butterworth Heinemann, Oxford.

Tarrier N. (1991) Some aspects of family interventions in schizophrenia: I. Adherence to treatment programmes. *British Journal of Psychiatry* **159**, 475–480.

Taylor B.J. (1994) *Being Human: Ordinariness in Nursing*. Churchill Livingstone, Melbourne.

Thomas P. (1997) *The Dialectics of Schizophrenia*. Free Association Books, London.

Thompson J.E. (1990) Finding the borderline's border: can Martha Rogers help? *Perspectives in Psychiatric Care* **26,** 7–10.

Tienari P., Wynne L., Moring J., Lahti I., Naarala M., Sorri A., Wahlberg K., Saarento O., Seitman M., Kaleva M. & Lasky K. (1994) The Finnish adoptive study of schizophrenia: implications for family research. *British Journal of Psychiatry* **164** (Suppl. 23), 20–26.

Tilley S. (1995) Notes on narrative knowledge in psychiatric nursing. *Journal of Psychiatric and Mental Health Nursing* **2,** 217–226.

Warner S. (1993) The Milieu Enhancement Model: a nursing practice model, Part I. *Archives of Psychiatric Nursing* **7,** 53–60.

Webster D.C., Vaughn K. & Martinez R. (1994) Introducing solution-focused approaches to staff in inpatient psychiatric settings. *Archives of Psychiatric Nursing* **8,** 254–261.

Webster D.C., Vaughn K., Webb M. & Playter A. (1995) Modeling the client's world through brief solution-focused therapy. *Issues in Mental Health Nursing* **16,** 505–518.

Williams R. (1996) From modernism to postmodernism: the implications for nurse therapist interventions. *Journal of Psychiatric and Mental Health Nursing* **3,** 269–271.

