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Review Article

Models of Developing an Empowering, Person-centred Approach to Recovery within Psychiatric and Mental Health Nursing

Nabil Lahrache* and Houda Akbour

Professor in the Higher Institute of Nursing and Health Technology, Health Ministry, Rabat, Morocco

Abstract

In the UK, psychiatric and mental health nursing places little emphasis on nursing theories and models. The theoretical and philosophical foundation of the Tidal Model, which resulted from a five-year investigation into the "need for psychiatric nursing," is discussed in this paper. Some of the conventional beliefs about the importance of interpersonal relationships in nursing practice are expanded upon and developed by the Tidal Model. Additionally, the model incorporates separate mechanisms for re-empowering individuals who have been disempowered by psychiatric services, mental suffering, or both. The ongoing assessment of the model in practice is briefly reported in the publication.

More Information

***Corresponding author:** Nabil Lahrache, Professor in the Higher Institute of Nursing and Health Technology, Health Ministry, Rabat, Morocco, Email: lahrachenabil2007@yahoo.fr

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Introduction

In recent years, mental health care has increasingly focused on individuals suffering from "severe and/or persistent mental disorders," particularly "schizophrenia" [1]. Simultaneously, there has been a growing acceptance of biological, neuroscientific, and genetic hypotheses as all-encompassing "explanations" for severe and persistent mental anguish [2,3].

Phil Barker's Tidal Model is a patient-centered paradigm for mental health rehabilitation that uses the metaphor of water to represent life's unpredictable path. Acknowledged as a mid-range theory, it substitutes a narrative approach in which the patient is the expert of their own story for the conventional medical model. This model is commended for its scientific clarity and philosophical consistency. It creates tangible concepts like autonomy (empowerment) and the therapeutic alliance. Despite the principles' clarity, their complexity could make them more difficult to apply. The plethora of metaphors (naufrage, océan, sauveteur) can sometimes be catastrophic for certain practitioners. The concept was initially created for serious mental health issues, but it has since expanded to include toxicomania, general health issues, and teens with little autonomy. According to the results, administering it lowers critical episodes (violence, automutilation) and boosts patients' self-esteem and hope.

Despite this popularity, much research has been conducted to challenge these presumptions [2,4-7]. This research has highlighted important differences in how people with mental disorders are perceived and treated. Furthermore, evidence exists for suitable substitutes for these biological conceptions of mental distress, recommending the possibility of more comprehensive psychosocial interventions [8,9]. There is also other evidence showing that there are viable alternatives to these biological conceptions of mental distress, suggesting the possibility of more holistic psychosocial interventions [8,9].

In conclusion, as Keen [2] pointed out, public and political concern about the "uncertainty" of identifying a single factor responsible for severe forms of mental illness (such as schizophrenia) has led to the creation of new theories that attempt to highlight unique biological causes.

These theories have been widely accepted as comprehensive explanations for severe and persistent mental

distress. Keen [2] pointed out that political and public anxiety over the "uncertainty" of ever being able to identify a single cause for severe mental illnesses (like schizophrenia) has led to a kind of pragmatism that could impede the continuous pursuit of a genuine comprehension of these issues of human existence.

Pragmatism in nursing, according to the acknowledgement of biological explanations and behavioral control, can "undermine fostering connections by stigmatizing or marginalizing those who suffer and by training a nursing workforce that is distant and possibly repressive " [2].

Similar presumptions to those stated in the book form the basis of the Tidal model. of Alanen et al. [8], according to which individuals, their families, and loved ones need help to perceive the circumstance (such as admission) as a result of the challenges that patients (sic) and their loved ones have experienced throughout their lives, as opposed to as an enigmatic disease that has afflicted the patient.

This approach, which respects the experiences of the individual and their loved ones, contrasts with the "psychoeducational" approach, which is based on an organic understanding of schizophrenia [10,11] and reinforces the general perception of mental illness as the result of a damaged or disorganized brain (largely beyond repair). The psychoeducational approach is often associated with stigmatization and the stigmatization of people with mental disorders.

This tidal model is based on the principle that, to cultivate heightened awareness or better education, people in extreme mental suffering require assistance. According to the Tidal model, the kind of assistance that those experiencing severe mental distress require is similar to the growth of a higher level of consciousness or education. According to Rowan [12], it assumes that a person cannot bring a level of understanding or personal knowledge to themselves.

The status of nursing models and theories

By defining the medical profession, patient care, and work structure, medical care models influence practice. They can be categorized as primary approaches, work-oriented approaches, functional approaches, or humanist approaches. Increasing the efficacy and caliber of care is their aim. are the primary care models:

- Service organization models (Prestation): Functional services: Concentrated on the clinics, each doctor carries out certain duties (e.g., prescriptions, pansements) for numerous patients.
- Promoting cooperation: Under the supervision of a chef d'état, a team of patients is led by staff (infirmiers, aides-soignants), promoting cooperation.
- Primary care (or primary care physicians): From admission until release, a patient's treatment is entirely under the control of a primary care physician.
- Taken care of worldwide (or by the patient): An infirmier attends to all of a patient's needs during their quarter of employment.

Although it has been the subject of controversy, the medical model has dominated mental health treatment for over 40 years [3,13-19]. A variety of disciplines are currently using the "biopsychosocial" model, which was inspired by Engel [16], as well as other "psychosocial" models, such as Foa [20], in their attempts to create more all-encompassing treatment plans.

However, maybe it is not surprising that no particular mental health and psychiatric model of nursing has emerged, or that conceptions of nursing have not been well understood by the caregivers themselves. However, it is perhaps not surprising that no particular model of mental health and psychiatric nursing has been developed [21,22]. In contrast to medicine, which has links to the physical sciences and disciplines derived from the social sciences, Nursing has long been viewed as an intellectually light field, with little research context and no true home in either the social sciences or the health sciences, like clinical psychology and social work [23]. Historically, nurses have been viewed as supporting characters in the therapeutic drama. According to Nightingale [24], nurses are similar to foot soldiers who execute the overarching strategies for combating illness.

The marginalization of the nursing profession may additionally explain why a lot of mental health nurses have tried to use more well-established therapeutic models to support their therapeutic status [25-28]. Perhaps the popular notion of the nurse therapist implies that nursing is not or never will be therapeutic [29].

However, although numerous criticisms have been made of the countless assumptions underlying according to medical and biopsychosocial conceptions of "mental illness" [2,4,5,30-35], several nurses accept a subservient position in a mental health service (sic) dominated by medicine [36-39] perceived as their traditional "support" function.

Concerns have indeed been raised regarding the relevance of certain mental health nursing models [40,41,], but there is no reason, in the context of this study, to question the validity of these models.

Despite the reservations expressed about the relevance of certain nursing models [41,42], no serious objection is raised, in principle, to the establishment of a discipline of psychiatric nursing based on theory, nor to the design of this model intended to support the implementation of practice.

In fact, creating a theoretical model of nursing practice could be considered a professional necessity [32]. The emphasis continues to be on multidisciplinary teamwork and

models, such as the biopsychosocial model [43], which would undoubtedly facilitate this work.

In clinical psychiatry, however, nurse practitioners are also aware that the medical model is more powerful than ever [4,5,44]. In clinical psychiatry, nurse practitioners are also aware that the medical model is more powerful than before [4,5,44].

These works show that any model of nursing practice in psychiatry and mental health should not only emphasize the "need for nursing care" but it should also align with other disciplines' reactions to individuals' medical and psychological requirements.

A radical, Catholic approach to mental health nursing

The Tidal model was created [45] following a five-year study conducted by Newcastle University on "nursing needs " [30,46,], to give rise to a substantial theory of practice in the field of mental care [47,48].

Many of Peplau's claims regarding the significance of interpersonal relationships in nursing practice were put into effect by the Tidal model, which also included a model of the empowerment process [49] developed in a parallel study [48]. These theoretical studies continued the tradition of research on nursing practice's interpersonal processes [50,51], which aimed to understand how interpersonal relationships influence nursing practice. These theory-generating studies continued the tradition of research on interpersonal processes in nursing practice [50,51], which sought to explain in more detail what nurses should do to provide good care for people.

Research on empowerment was conducted by nurses and published in nursing journals.

It could be said that the "right approach to nursing" [31] has gone out of fashion, as the emphasis is now on multidisciplinary teamwork.

This model is a radical and universal paradigm for practicing psychiatric nursing, based on the fundamental care processes in mental health nursing. It is radical because it focuses on essential nursing processes, and universal because of the distinct practices it includes.

Although this model is radical and universal, it is important to note that it is not a one-size-fits-all solution. It can be adapted to the specific needs of the patient and each care situation. This model is based on three fundamental principles:

1. Priority given to essential nursing processes.
2. Integration of essential nursing processes into all care contexts.
3. Adaptation of essential nursing processes to the needs of the patient.

The primary metaphor is water

The Tidal Model (also known as the Marβ Model) is a philosophical and practical approach to mental health care that focuses on rehabilitation. Developed by Dr. Phil Barker and Poppy Buchanan-Barker, it stands out for using the "aphorism" of water to describe human experience. Constructed at the end of the 1990s in the United Kingdom, it is the first interdisciplinary health care model co-constructed by healthcare professionals and consumers. It is based on the notion that health and illness are fluid phenomena. A journey on an "océan d'expésences" is compared to life. Originally intended for Aiguë psychiatry, it has expanded to various support contexts to help people navigate the "tempés" of their lives. The model is based on an active listening and development philosophy that is formalized by ten universal values: Respecting the voice: A person's history is the foundation of their care.

1. Respecting the voice: A person's history is the foundation of their care.
2. Respect language: Use the patient's own words instead of medical jargon.
3. Develop a genuine curiosity: by genuinely being interested in the other person's unique experience.
4. Become the apprentice: The doctor learns from the patient, who is the expert on his own life. Be transparent: Encourage a trusting and honest relationship.
5. Developing personal wisdom: Assisting the individual in recognizing their own internal resources.
6. Being open: Encouraging a relationship of trust and honesty. Donner le don du temps: Giving human interaction quality time.
7. Making use of the available tools: Focus on what works for each individual.
8. Making one step at a time: Giving priority to immediate and feasible changes.
9. Giving the gift of time: Assigning quality time to human contact.
10. Recognize that change is constant: Acknowledge that rehabilitation is a dynamic process.

This approach is used to change psychiatric units into dialogue-based settings where patients are assisted in "reprendre le gouvernail" through an emotional "naufrage." Comme il sert à la mise en oeuvre via des manuels de soins (disponibles en français via l'École de la Source) qui guident l'évaluation centrée sur le récit. Additionally, it serves to promote cooperation between medical professionals, social workers, and users for a worldwide approach to rehabilitation.

Drawing on chaos theory, Barker [30] recognized that the human experience is flexible and characterized by constant and unpredictable transformations.

The core metaphor of the tidal model that life is a voyage on an ocean of expériences is based on fluidity; insights throughout this voyage over this ocean of experiences are connected to human development, including the experience of health and illness. At certain critical moments during this journey, the person is subjected to storms or even acts of piracy (crises). At other instances, the ship can start to absorb water, putting the person in danger of drowning or experiencing a shipwreck (an anxious breakdown). The individual might then require guidance to a haven to make repairs or recover from the trauma (rehabilitation). The person may then need to be guided to a haven to make repairs or recover from the trauma (rehabilitation).

The Tidal model, in contrast to normative psychiatric models, is based on a limited number of presumptions on an individual's typical life trajectory. Instead, it focuses on the type of support people might need to get them out of a crisis or help them get back on track with their lives (development). It acknowledges that metaphorical language is always used to explain life experiences connected to mental illness. The Tidal model is an approach to life that emphasizes personal development and support for daily living. It is predicated on the idea that individuals can develop and flourish throughout their lives, and that it is possible to help them regain their balance and reintegrate into society.

Individuals going through existential crises feel as though they have been flung onto the rocks or are (metaphorically) in deep water and in danger of drowning. Similar to the pain connected to piracy, those who have endured trauma (such as abuse or injury) or more persistent issues in their lives frequently express a loss of "sense of self." They require a sophisticated type of rescue (psychiatric rescue), followed at suitable intervals by the kind of developmental work required to facilitate full recovery. This could be "refuge" in a hospital or crisis stabilization facility, or it could be crisis intervention in the community. After rescue (psychiatric nursing), the emphasis switches to the kind of assistance required to help the individual "get back on track" and resume a fulfilling life in the community (mental health nursing).

According to the Tidal model, people's "nursing needs" surpass these arbitrary distinctions as their demands change, frequently indiscernibly, and cannot be reduced to a choice between acute or continuous care, general or specialized care, or community or hospital. The focus on continuity of care seeks to advance the kind of "continuous" treatment that runs the risk of being reduced to empty language.

The nature of the needs expressed by individuals varies considerably from one person to another and from one moment to another. Care, as expressed through nursing, must follow the individual and adapt to their changing needs. The artificial divisions between the worlds of community care and institutional care are regrettable. The interconnectedness of many services to satisfy various requirements becomes evident if we keep the needs of the individual in mind, whether they are critical, transitional, or developmental care.

A range of distinct holistic (exploratory) and targeted (risk) assessments has been developed as part of the Tidal model. These assessments facilitate a person-centered approach and enable interventions that emphasize existing resources and the person's ability to find solutions. The goal of various intervention and assessment procedures is to enhance practice rather than limit it. These diverse assessment and intervention procedures, which were outlined in the model's training program [45], give nurses a better understanding of the patient and the care area. They also give them the flexibility they need to address the patients' and the care area's needs. The various techniques outlined in the model training program [45] help nurses better comprehend the patient and the care domain and offer them the flexibility they need to help someone in distress.

Re-conceptualizing the person as a patient

According to Reynolds and Scott [52], the Tidal model is predicated on a charitable idea that appears to be swiftly clouded by a plethora of therapeutic principles taken from various fields or areas of human research. Although the majority of therapy approaches, if not all of them, seek to alter the patient's presentation, the Tidal model has more modest objectives that can turn out to be more ambitious in the end. The Tidal paradigm emphasizes contact with the individual rather than the condition or illness [23].

Gaining insight into the individual's present circumstances, particularly their connection to health and sickness, is the aim of this interaction. The nurse shows interest in the patient rather than concentrating on the illness or disorder, but with the intention of learning more about the patient's internal processes. Understanding the individual's existing circumstances, particularly their relationship to health and illness, is the aim of this engagement. Even though the nurse shows interest in the patient, their goal is to comprehend how the patient perceives the world, themselves, and their coworkers, as well as the potential implications for providing critical care.

With regard to personal dimension, the emphasis is on the individual's need for both physical and mental security. The safety plan, a particular assessment format, was created to identify the kind of assistance required to guarantee personal safety and reduce the possibility of injury to oneself or others due to carelessness or direct action. For each of these dimensions, nursing staff seek to understand the construction of the story of an individual's experience [53-55], utilizing the notion of therapeutic connection [56]. Nurses emphasize

the person's full involvement in the assessment process and, to the extent possible, their contribution to interventions that may meet their needs. At each stage of the assessment and intervention, emphasis is placed on the person's full involvement in the process of identifying and, to the greatest extent feasible, assisting with initiatives that might address their needs.

A balance or fusion between the many constructs of the individual and their "loved ones" will always be part of the care that the person needs. The model's narrative foundation and empowerment principle recognize that an individual's "personal science" will play a significant role in determining what "needs to be done" [57]. The model also heavily relies on systemic and solution-focused approaches [58,59], which place an emphasis on identifying and utilizing one's own resources as well as solving personal problems, which place an emphasis on identifying and utilizing one's own resources as well as solving problems on one's own.

Because story plays a crucial role in self-expression [60], it is important to maintain the narrative's integrity through thorough collaborative research. A person's history and the various connotations attached to it are intimately related to how they see themselves and the world, including other people. The idea of evidence-based practice is very different from the discourse-based practice produced by the Tidal Model. Whereas the latter is based on population behavior, the former always deals with individual human cases. The narrative-based practice produced by the Tidal model is very different from the idea of evidence-based practice. The former is based on the behavior of populations whose components are only taken to be equal, but the latter is always dependent on particular human cases. Because the Tidal model is narrative-based, it makes use of the individual's life experience and related components rather than attempting to identify the root causes of their current issues. More significantly, the Tidal model's narrative approach tries to define the "next step" forward by drawing on the individual's journey and the meanings attached to it, rather than attempting to identify the root reasons of their present issues. As part of the collaborative investigation of the individual's "world of experience," narrative evaluation is a continuous activity. Instead of being translated into a third-person or formal language, the assessment report is written in the individual's own words. This makes it possible to emphasize the person's profound meanings and ideals. The assessment report is written in the individual's own words, not in a third-person or expert translation, as part of this collaborative investigation of the individual's "world of experience." This makes it possible to jointly create a narrative about the individual's experiences, which includes determining what the individual feels they require in terms of nursing care [47].

The necessity of re-empowering the individual

Mental illness is inherently dehumanizing [35]. A person may be perceived as impaired by their family or community if their mental health issues are persistent or recurrent. Even if mental health services are provided, they frequently just aim to reduce the harm that common issues known as mental illness can cause to an individual and to others [35]. Psychiatric care and therapy can "injure" a person by making their loss of autonomy worse [47].

This can include more covert constraints imposed by being "under observation" in the hospital [61] or deemed "uncooperative" by an "assertive intervention team," as well as overt restrictions imposed by involuntary hospitalization. The most prevalent type of disempowerment is not paying enough attention to the person's description of their life's challenges.

Origins and present-day progress

Between 1997 and 1999, the Tidal Model was first created at two trial sites in acute mental admission wards in Newcastle, UK. In May 2000, the updated model was fully implemented throughout the entire Adult Mental Health Programme, which includes eight admission wards and the community support teams that work with them. An interdisciplinary assessment of the model's practical use is being carried out using action research methodology.

A number of nations, including Australia, England, Ireland, Japan, New Zealand, Scotland, and Wales, have developed additional pilot locations. These locations span a variety of therapeutic contexts, including a medium-security facility in Cardiff, Wales, an acute ward in a private hospital in Tokyo, Japan, and a rural mental health service in Adelaide, Australia. These pilot sites, which at the time of writing numbered 15, will enable some cross-cultural and cross-national assessment of the model in operation [62].

Critical evaluation of the tidal model

This model stands out for its metaphorical and narrative approach to mental health rehabilitation. Instead of concentrating on diagnosis, it focuses on the individual's past.

This model is hard because of its abstract nature, and its "10 engagements" may seem difficult to implement without a solid foundation, and it might also be challenging to quantify the advancement of standardization when relying on narration. Additionally, it may be subject to the strict protocols and time constraints of traditional hospital environments.

Comparison with alternative methods

The Tidal Model represents a significant break from the traditional healthcare paradigm:

Traditional medical model: While the medical model focuses on finding the biological cause and treating symptoms (effective vision), the Tidal model focuses on navigating the "chaos" of the current experience (growth vision).

Model of beholds (V. henderson): Tidal prioritizes interdependence and co-construction of sense, whereas Virginia Henderson's model emphasizes independence through the fulfillment of basic needs.

Practices Based on Preuves (EBP): Tidal favors "preuves humaines" (individual results) in comparison to population statistics, which are frequently favored by EBP.

Psychoeducative approach: In contrast to psychoeducation, which educates the patient about their illness, Tidal believed that no one can help someone understand themselves if they haven't had the opportunity to do so.

Clarification conceptuelle: secours *vs* recuperation

It is helpful to view these two approaches as the two stages of a continuum of care rather than as opposites.

Psychiatric remedies: The focus is on crisis and security management, with the infirmier acting as a "garde-côte." The goal is to stabilize symptoms, prevent auto-aggressive or hyper-aggressive risks, and maintain basic vital and biopsychosocial functions.

Mental health infirmaries in Santé Mentale (La Récupỹ): Autonomy and rehabilitation are prioritized. Acting as a "guide de navigation" is the infirmier. L'objectif est de redonner du pouvoir d'agir (empowerment) au patient, de travailler sur le sens de la vie malgré les symptômes et de favoriser l'intégration sociale (Table 1).

Illustrative example: When a patient expresses that he is "in the middle of a storm", the nurse does not simply note the agitation. He/she uses this image to guide the intervention: instead of "repairing" (teaching long-term techniques), the nurse first focuses on the "haven" (offering a reassuring presence and a calm place) until the winds fall, allowing them to start the "repairs" (work on adaptation strategies).

To improve conceptual comprehension, it is essential to differentiate between the holistic and person-centered orientation of mental health services and the clinical/medical orientation of mental health services. They are philosophical approaches to health, despite the fact that they are often used interchangeably in professional titles.

Table 1: From Metaphor to Practice.

Metaphorical elements	Evaluation Analysis of Nursing	Infirmary Intervention (Action)
Storms	Identify crisis triggers, psychomotor agitation, or signs of acute psychological distress.	Apply the principles of psychological first aid: immediate security, verbal de-escalation, and crisis management.
Safe Haven	Assess the perception of environmental safety and the strength of the patient's social support network.	Create a calm therapeutic environment, establish a relationship of trust, and validate emotions to offer a secure recovery space.
Repairs	Analyze current coping mechanisms and identify gaps in self-care skills (sleep, nutrition, emotional regulation).	Teach stress management techniques (breathing, mindfulness) and promote resilience through therapeutic education.

Table 2: Psychiatric nursing: The "Rescue" (Clinical recovery)

Feature	Psychiatric Nursing (Rescue)	Mental Health Nursing (Recovery)
Model	Paternalistic and medical	Humanistic / Collaborative
Success Metric	Symptom elimination (Clinical)	Quality of life (Personal)
Nurse's Focus	"What is wrong with you?"	"What's wrong with you?"
Patient Status	Passive recipient of care	Active self-manager of health

Table 2 Psychiatric Nursing: The "Rescue" (Clinical Recovery).

This concept, which emphasizes pathology care and stabilization, is firmly grounded in the medical framework.

The main objective is clinical recovery, which is characterized by symptom remission, acute crisis stabilization, and restoration to baseline functioning.

Focus: acute, high-security, or inpatient settings where it is crucial to "rescue" patients from potentially fatal symptoms (such as psychosis or suicidal thoughts).

Nurse's role: Expert-driven or paternalistic, in which the practitioner "sets up" the patient's treatment plan to control the condition.

The "Recovery" (Personal recovery) in Mental Health Nursing

This concept places a strong emphasis on a humanistic perspective that sees the person beyond their diagnosis.

Primary goal: Personal recovery. It entails leading a fulfilling, optimistic, and meaningful life despite the constraints brought on by a disease.

Focus: Holistic well-being, which includes interacting with others, discovering purpose in life, and creating coping strategies.

Setting: Community services, outpatient clinics, and rehabilitation centers where the focus is on "getting back on track" in daily life.

Nurse's role: Collaborator or facilitator who encourages patient autonomy and collaborative decision-making.

The Relationship: A Care Continuum

Under the heading of Psychiatric-Mental Health Nursing (PMHN), both are typically integrated in modern practice.

Interdependence: A patient often enters a "mental health" phase (recovery/rehabilitation) after beginning in a "psychiatric" phase (rescue/stabilization).

The bridge: Effective care requires the nurse to move from managing the illness (psychiatric) to empowering the individual (mental health) as the crisis subsides.

Conclusion

The idea of providing care through interpersonal

relationships has a long history in nursing. However, calls for "evidence" on the part of their utility within a postpositivist research paradigm [63,64]. However, as Taylor [65] 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. According to the Tidal Model, nurses must develop a deep relationship with the patients they are caring for to jointly discover what it is like to be healthy and ill. Many persons with mental health issues are calling for care and therapy to re-emphasize the relationships between themselves and their caregivers, as health care is becoming more technological and emotionally detached (e.g., through the use of computers) [3,15]. It is noteworthy in this regard that Harry Stack Sullivan's biographer proposed that Sullivan's primary contribution to psychiatry and psychotherapy was his constant awareness of the necessity to uphold the patient's self-esteem and to demonstrate respect for them. Evans [66]. The Tidal Model, created by Phil Barker and Poppy Buchanan-Barker, is both potent and difficult to standardize in strict health systems because it is essentially philosophical and symbolic. The use of the Tidal model in modern healthcare systems, which are frequently characterized by cost rationalization and a lack of effectiveness, is an intriguing conundrum. The model is based on "real-world experience" and storytelling. In an environment where the patient-to-physician ratio is low, the management of urgency frequently relies on constructive discussion. Modern structures frequently favor symptomatic diagnosis above life narrative. The Tidal model calls for a paradigm shift toward "soin relationnel," which may result in a hospital culture focused on productivity. Without a thorough understanding of the model's ten engagements, the soignants run the risk of viewing it as an additional administrative burden rather than a tool for care. The Tidal model honors a person's humanity in the context of their past experiences rather than treating a pathology. It is based on the patient's understanding that they are the experts in their own lives. By focusing on recovery rather than just symptom relief, it gives people who are frequently "noyés" by health care a voice and a sense of dignity[67-84].

You can articulate your analysis around the shift from a paradigm of "maladie" to one of "experience véue" to unify these arguments and clarify the position of Phil Barker's model. The biological model is criticized for its tendency toward pathological reduction.

* Fragmentation: It treats the person as a passive "objet" of care, dividing them into symptoms and diagnoses.

* The "knowledge expert" relies on the patient's experience, creating a power imbalance whereby the patient receives treatment passively.

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