

# The recovery alliance theory of mental health nursing

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The recovery alliance theory (RAT) is a mid-range theory of mental health nursing based on humanistic philosophy. The conception of the RAT was the outcome of collaboration among service users, practising mental health nurses, educationalists and managers and was developed in the context of a number of political and social changes as well as changes in the mental health field. The theory is composed of six constructs: humanistic philosophy, recovery, partnership relation, strengths focus, empowerment and common humanity. The derivation of three concepts from these constructs, namely coping, self-responsibility/control and working alliance, forms the basis for the translation of the constructs into a system of mental health nursing practice [Partnership in Coping system (PinC)]. The constructs underpinning the RAT were clearly demonstrated in a preliminary trial of the PinC system.

**Keywords:** mental health nursing, partnership in coping, recovery alliance theory, recovery, theory of nursing, working alliance

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## Introduction and the scope of the theory

Hildegard Peplau, the first theorist in mental health nursing (Peplau 1952), had a considerable impact on psychiatric nursing (McNaughton 2005). However, while Peplau has been considered a pioneer, in the intervening 55 years there has been a sea change in the treatment of people with mental health problems. Even though this change is significant, there has been only a limited amount of research, particularly in the acute care setting (Veitch 2007), undertaken in the area of the development of mental health nursing models to guide practice based on a theoretical framework.

Changes that have occurred in the treatment of service users include a move away from a psychoanalytic interpretation of an individual's experiences to a greater emphasis

on the 'here and now' with many interventions involving the use of cognitive and behavioural approaches, such as brief solution-focused therapy and cognitive behaviour therapy. Other changes involve further development of our understanding and expansion of the meaning of the therapeutic relationship, e.g. Bordin's conception of the working alliance (Bordin 1994). Nevertheless, in this paper describing the recovery alliance theory, Peplau's influence, while lessening, may be seen in the importance attributed to the relationship between the service user and the nurse.

This paper describes the elements of the recovery alliance theory, ranging from the general scope and constructs to the more specific concepts, before examining its practical application. The paper consists of four sections, each describing an aspect of the recovery alliance theory. The first section, '*Societal changes and changes in the mental*

*health field*', looks at the political, social, mental health and personal context in which the theory was developed. The second section, '*Scope and constructs of the recovery alliance theory*', identifies the range of nursing that the theory covers and the constructs underpinning the theory. Each of these constructs – humanistic philosophy recovery, partnership relation, strengths focus, empowerment and common humanity – is examined. The third section, '*Concepts of the recovery alliance theory*', is concerned with working alliance, coping and self-responsibility/control. The concepts of person, mental health concerns, mental health nursing and environment as seen within the recovery alliance theory meta-paradigm and the relationship between them are discussed. The final section addresses the practical application of the theory to practice in describing a system of mental health nursing practice, Partnership in Coping (PinC), which was developed as an outcome of the theory.

### **Societal changes and changes in the mental health field**

For centuries, the dominant model of mental health remains the traditional medical model (Dawson 1997, Horsfall 1997, Cole & Shanley 1998, Cutcliffe 2000, Horsfall & Stuhlmiller 2000). Laungani (2002) stated that the medical model, despite its continued usage, is, to a large extent, unreliable and invalid, in that it tends to pathologize any unusual form of psychological and behavioural phenomena not in keeping with the dominant culture. Airhihenbuwa (1994) sees the use of the traditional medical model as having an emphasis on finding a universal solution, not recognizing the different methods of health communications in different cultures.

The formulation of the recovery alliance theory in this paper has been influenced by the authors' experiences of mental health services in Australia and refined by their experiences in Ireland. Both these countries, in tandem with other developed countries, have been undergoing major changes in the liberalization of legislation, decentralization of decision making and adoption of the recovery-orientated approach.

### **Political changes**

More liberal mental health legislation have been introduced in a number of developed countries (United Kingdom, Ireland, New Zealand and Australia). In Ireland, the Irish Mental Health Act (Government of Ireland 2001) was operationalized in 2006. This Act brings Ireland into line with international human rights standards and offers respect for the rights of the person to dignity, bodily integrity, privacy and autonomy by such means as establishing

an automatic independent review of people who have been detained involuntarily in hospital. An Irish government report, *A Vision for Change* (Department of Health and Children 2006), was commissioned to update the mental health policy framework defined in the health policy document *Quality and Fairness: A Health System for You* (Department of Health and Children 2001). The report recommended a community-based focus with a recovery orientation, including greater involvement of service users and their carers. It recognizes the importance of the clients' understanding of their experiences based on their cultural norms, and incorporates their understanding of these experiences in the provision of mental health nursing practice. The emergence of an alternative approach to the traditional medical model in the mental health field, namely the recovery-orientated approach, occurred as a result of the aim to provide a more client-centred service. The recovery-orientated approach is currently the approach advocated by mental health policy makers in the Australia, Ireland, United Kingdom, New Zealand and Canada. These changes in the cultural, legislative and government policy context in which mental health services operate necessitate appropriate changes in mental health nursing practices to reflect the changes of the different philosophy. Mental health nurses are therefore faced with the task of modifying their practice to accommodate these changes.

### **Social changes**

The initial development of the philosophy and approach of the theory was based on Australian state and federal mental health standards, which recommended a consumer-centred approach to determine management of those experiencing mental health concerns (Mental Health Consumer Outcomes Taskforce 1991, Commonwealth Department of Health and Aged Care 1996, Health Department of WA, Mental Health Division 1998). In addressing these standards, the recovery alliance theory accounted for the variety of mental health settings that exist in Australia, as well as the diversity of cultures. For example, in Western Australia, one-third of the population was born outside of Australia (Australian Bureau of Statistics 1996), bringing with them a range of differing value systems and social norms. The recovery alliance theory was developed taking into consideration cultural and geographical diversity across mental health settings in metropolitan, rural and remote areas of Australia. Cultural diversity has also been a recent phenomenon in Ireland, where approximately one in 10 people is a non-national, with most of the immigrants coming from Eastern Europe (Ruhs 2003), where English is not their first language.

### Consequences of the changes for mental health nurses

As with other groups facing changes in the philosophy of the organization in which they work, there is invariably a time of uncertainty and role ambiguity among mental health nurses which contributes greatly to stress and adversely affects job performance (Breugh & Colihan 1994). Mental health nurses have experienced a degree of conflict and confusion over their future role. Some nursing academics (Gournay 1995a,b, Burnard 2002, Mutsatsa & Rinomhota 2002) feel that mental health nurses should retain their old role of focusing on the administration and monitoring of medications, including side effects. Others advocate that mental health nurses need to move away from the biological sciences (Horsfall 1997, Cutcliffe 2000, Clarke 2002, Barker 2003). Morrall (1998), on the other hand, feels that mental health nurses should cooperate with the medical and social work professions by returning to a position where mental health nursing dominates through enforcing social control. Practising mental health nurses also have trouble describing their role. Some see the main aspects of their work involving caring, counselling, advocacy, alleviation of distress and 'being there' for patients, while others talk more of maintaining control, monitoring and administration of medications (O'Brien & Cole 2004). According to Cody (1996, p. 87), 'nurses continue in the traditional role of Jack- or Jill-of-all trades and master of none. The lion's share of what nurses who work in non-nursing theories know and do is known in greater depth and done better by members of other disciplines . . .'. Mental Health nurses are required to work closely with other disciplines. Indeed, the report *A Vision for Change* (Department of Health and Children 2006, p. 59) recommends that 'Effective multidisciplinary working . . . depends on mental health professionals changing how they practise and work together, so that they work as a team'. However, Hague *et al.* (2002) highlight that nurses risk playing only a limited function within the multidisciplinary team if their role is not clearly defined.

In a study by E. Shanley & M. Jubb-Shanley (unpublished) of mental health nurses' perception of their role, there was no common understanding among participants of what or how mental health nurses went about their work. The closest respondents came to identifying a single encompassing term for what mental health nurses did was 'eclectic'.

Given the current environment of change and the criticisms of current mental health nursing practices (Human Rights and Equal Opportunity Commission 1993, Shanley *et al.* 2003, E. Shanley & M. Jubb-Shanley unpublished), the creation of a new theory is timely. The recovery alliance theory was developed by service users, carers, clinicians

and academics. Agreement on the philosophy and principles of recovery alliance theory included the nature of human rights, the relevance of recovery principles and the focus for mental health nursing practice. The philosophy and principles that emerged facilitated the development of a comprehensive and easy-to-use system of mental health nursing practice. The prime movers, Eamon Shanley and Maureen Jubb-Shanley, were greatly influenced by their involvement with the service user movement and working in and with non-government organizations, for example, Schizophrenia Fellowship (Western Australia), WAAMH, Workright, Disability Services and the Health Consumers Council. Their thinking was also moulded by their experiences in the use of a bottom-up managerial model establishing and running a Nursing Practice Development Unit in a psychiatric hospital. Here the approach used was that people who are most affected by those decisions (nurses and service users) were involved in the decision-making process. This view has been consistently reflected in their work in practice, in education and seen in their publications. Maureen Jubb-Shanley came from a background of mental health and general nursing while Eamon Shanley's background is that of mental health and intellectual learning disability nursing and social psychology.

### The scope and constructs of the recovery alliance theory

#### The scope of the theory

The recovery alliance theory is termed a mid-range explanatory nursing theory in that it is more concrete and narrow than a grand theory and was designed to relate directly to the practice of mental health nursing.

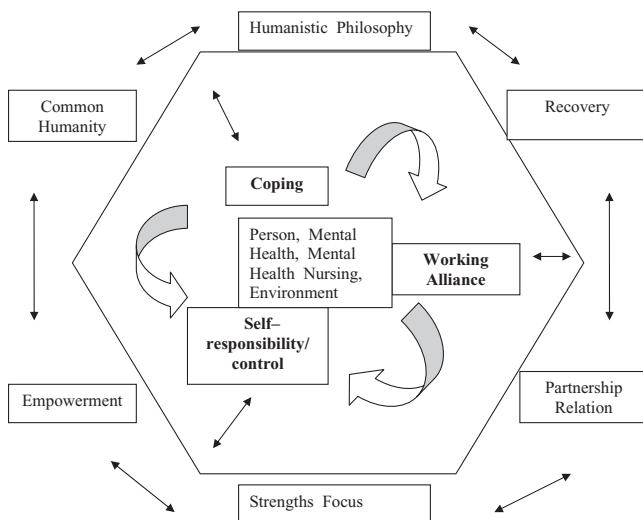
The scope of the recovery alliance theory in practice is comprehensive in its applicability across people (different ages, socio-economic groups, cultures, etc.), across mental health concerns and across different situations, e.g. inpatient and community settings.

Its name reflects the synergy between the philosophy of the recovery-orientated approach (Anthony 1993) and the use of the working alliance (Bordin 1994) in the interactions of the mental health professional with the service user (Fig. 1).

Six outer constructs underpin the theory:

- humanistic philosophy;
- recovery;
- partnership relation;
- strengths focus;
- empowerment;
- common humanity.

And from which three main concepts are derived:



**Figure 1**  
Diagrammatic representation of the recovery alliance theory

- coping;
- working alliance;
- self-responsibility and control.

## The constructs of the recovery alliance theory

### *Humanistic philosophy*

The philosophy of the recovery alliance theory constitutes a move away from the basis for current practice of mental health nursing, namely the traditional medical model, to the humanistic philosophy, which has its roots in existentialist thought (Kierkegaard, 1813–1855, Nietzsche, 1844–1900, Heidegger, 1889–1976 and Sartre, 1905–1980).

The characteristics of the philosophy underpinning the recovery alliance theory are as follows:

- Individuals are social animals and share a common humanity.
- Individuals have the potential for growth through awareness of and interaction with self and others.
- The individual's growth is enhanced by a respectful approach in validating the person's ability to deal competently with his or her own life experiences.
- Individuals have the ability to make choices and to exercise control in decisions affecting their lives.
- Individuals cannot be categorized in that they are composed of many different facets of which none stands alone.

The humanistic philosophy is exemplified at its widest point by the view that human beings are social animals possessing a common humanity. Being a social animal means that the individuals' well-being depends on the nature of their relationship and interaction with others. The construct of common humanity is taking another person's perspective and identifying with him or her similar life

experiences and applying the sentiments expressed in the adage 'do unto others as you would have them do unto you'.

Mental health concerns are viewed as a normal part of human life and human development. Individuals are seen to develop strengths and can identify resources that help them grow towards their psychological potential and cope with their mental health concerns. The mental health nurse helps guide individuals in applying their existing strategies to cope with their mental health concerns. This approach contrasts with the current mainstream philosophy of mental health nurses whose practice is based on the traditional medical philosophy (Dawson 1997, Horsfall 1997, Cole & Shanley 1998, Cutcliffe 2000, Horsfall & Stuhlmiller 2000).

This philosophy is seen in the application of medical concepts and methods shown to be useful in the physical illness domain. As a consequence, all disorders are seen in principle as diseases for which the cause will eventually be found in the form of an anatomical, physiological or biochemical abnormality. An important characteristic of medical philosophy is an emphasis on establishing the correct diagnosis of an individual patient and creating an accurate diagnostic or classificatory system on which to base a clear, distinct, treatment and prognostication (Grof 1985). The effect of the adoption of the medical philosophy in nursing has included the development of the nursing diagnosis leading to an increased focus on problems that are defined by the nurse (Crowe 2000). Clinical judgements are made from the nursing diagnosis. These diagnoses, like the medical diagnoses, are not necessarily confirmed or endorsed by the service user and often have widely disparate goals (Mitchell *et al.* 1983, Lynch & Kruzich 1986, Ruggeri 1994). Service users are forced to accept the problem or label as identified by the nurse. Because of this, the diagnosis may create a variance between the nurse's verdict and the service users' judgement about their problems (Hall 1996). The philosophy of the recovery alliance theory applied to mental health service delivery, on the other hand, avoids the concept of diagnosis, thus avoiding conflict between the nurse and the service user as there is no predetermined category assigned by the nurse. Instead, the recovery alliance theory advocates that individuals experiencing a mental health concern use their own understanding of their mental health concerns as a starting point. This change in paradigm effects a change not only in how mental health nurses and service users relate to each other but also in their roles.

### *Common humanity*

Humans have the capacity to understand each other. The principles of the recovery alliance theory give service users and mental health nurses a great opportunity to develop a

deeper understanding of each other. Their encounters, in which the nurse is open to the other's narrative, can help the nurse to think past her own familiar concerns and identify parallels in her life experiences with those of the service user. This process leads to a greater understanding of the others' perspective and world view and as a consequence the nurses become more conscious of human frailties, pleasures, happiness and sorrows that we have in common rather than focusing on those aspects that make us different. The construct of common humanity involves mental health nurses and service users sharing a basic understanding of what it is to be human.

George Orwell (1970) illustrates this well when during the Spanish War he expressed his awareness of a common humanity experience, explaining why he could not shoot an enemy soldier who was running holding up his trousers.

I have come here to shoot at 'Fascists' but a man who is holding up his trousers isn't a Fascist: he is visibly a fellow creature similar to yourself and you don't feel like shooting at him.

### *Recovery*

As emphasized above, the recovery alliance theory values the importance of the participation of service users in their own recovery and de-emphasizes the curative medical-based nature of services provided. The service users' belief that recovery is possible is a key condition leading to recovery (Anthony 2000). Part of this belief is their use of a problem-solving approach, namely recognition and acceptance of a problem, willingness to change, use of their strengths in dealing with the problem, looking forward to and acknowledging each small step, reviewing priorities and experiencing optimism (Jacobson & Greenley 2001). Parallel with this process is the requirement that clinicians adopt the view that every service user can achieve hope, healing and empowerment and that they are able to successfully play roles in the world by focusing on themselves as a whole person and their goals, not on their illness. The service user is seen as an active participant who has the right to choose from a range of options even when an element of risk is involved (Jacobson & Greenley 2001).

### *Partnership relation*

The recovery alliance theory operates within the dynamics of the partnership between the mental health nurse and the service user. This partnership relation is based on power-sharing and negotiation between the mental health nurse and the service user. Partnership is defined as 'the negotiated sharing of power between . . . partners (who) agree to be involved as active participants in the process of mutually determining goals and actions that promote health and well-being' (Courtney *et al.* 1996, p. 181). Thus, the part-

nership is seen as a process in which both the nurse and the service user join forces in a working alliance in problem solving to achieve common goals.

Within the recovery alliance theory, the strength and resilience of the service user are acknowledged and the experience of hope, empowerment and connection is valued. Service users are seen as possessing the skills, or having the ability to develop skills, to cope with their mental health concerns. The characteristics of the partnership distinguish the work of mental health nurses from other professionals in this field. These characteristics include the use of everyday speech and narrative, the ordinariness of the relationships they develop with service users, the use of self-disclosure, the use of unscripted dialogue and a holistic perspective.

Within this partnership each person is seen as bringing his or her own expertise. Each acknowledges the other's contribution, e.g. nurses have knowledge of general features of mental health issues and their effects. Service users are in the best position to know their own experiences, concerns, resources and abilities. Nurses have the skills to help people cope with their concerns, whereas service users have the skills to cope with their own concerns. Nurses have the skills to promote behavioural, cognitive and emotional change, while service users are the arbitrators of whether they want to change.

### *Strengths focus*

A strengths focus concentrates on the person's ability rather than their disability in attending to other competencies rather than their shortcomings and using the resources and assets that the client has access to, e.g. tenacity and determination, resilience and resources. This construct emphasizes that service users have the ability to recover from mental health problems and mental health nurses are expected to accept as true that service users have the ability to use these strengths in order to recover. The construct respects the uniqueness of the individual and sees the service user as capable of acting in a purposeful and coping way.

It emphasizes what is right with people rather than what is wrong with them. This philosophy contrasts with that of clinical psychology and psychiatry whose focus is on negative aspects of anxiety, depression and stress, typified by the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 2000), which is a systematic categorization of mental illnesses.

### *Empowerment*

The empowerment construct enables people to enhance the positive aspects of their lives. Within the recovery alliance theory, the concept of diagnosis, which is assigning the

service user to a predetermined category, is considered unhelpful in achieving this end. The service users are empowered by the acceptance that their own understanding of their mental health concerns is the starting point – not the medical diagnosis.

Empowerment is further extended within this theory by the active participation of the person in the decision-making process that is related to their care, and this is facilitated by mental health nurse accepting as true that service users have the ability to use their strengths in order to recover.

## The concepts of the recovery alliance theory

Three concepts, namely working alliance, coping and self-responsibility/control, describe the translation of the constructs of the recovery alliance theory to the dynamics of mental health nursing practice. Other concepts mentioned in this section, namely person, mental health, mental health nursing and environment, make more explicit the transition of the theory to practice.

### Working alliance

Within the recovery alliance theory, the partnership relationship is operationalized as a working alliance. The working alliance is based on a high level of collaboration and mutuality (Bordin 1994). The alliance is not seen as a specific therapy. It is a vehicle for the operation of therapeutic approaches, e.g. the PinC system of mental health nursing. It is a framework within which a clinician and service user work towards their mutually agreed goals within a positive relationship (Bordin 1994). Findings from research into the working alliance have supported its positive contribution to successful outcomes for service users (Kokotovic & Tracy 1990, Mallinckrodt & Nelson 1991, Al-Darmaki & Kivlighan 1993, Horvath 1994, Connors *et al.* 1997, Goering *et al.* 1997, Kivlighan & Shaughnessy 2000).

The authors have identified distinguishing characteristics of mental health nursing that separate the work of mental health nurses from other professionals, and these characteristics can be seen as assisting the working alliance that develops between the nurse and the service user. These characteristics include the use of the following:

#### *Everyday speech*

The use of everyday speech and narrative minimizes the inequality in the power relationship, improves communication and helps develop a helping relationship. Reclassifying what service users say and do into predetermined categories is excluding of them. The ordinariness of the

relationship and the ability of the mental health nurse to be friendly and approachable go a way in demonstrating a common humanity with service users (Shanley 2001).

#### *Variable context and times*

Mental health nurses often engage with service users in variable context and times. These encounters may be impromptu or planned. For example, they may meet at the individual's house or at public places such as the cafe or local park. This gives the nurse the opportunity to obtain an insight into the service users' environment.

#### *Self-disclosure*

The use of self-disclosure to facilitate the service users' understanding of their own thoughts, emotions, behaviour and circumstances, instead of the use of challenges or interpretations by the clinician, is recommended by Rogers (1961). Self-disclosure can enhance the therapeutic relationship which has a positive effect in helping the service user feel understood (Burkard *et al.* 2006).

#### *Unscripted dialogue*

Communication skills exist in the use of unscripted dialogue dealing with unpredictable behaviour and situations ranging from social exchanges to the service user's expression of intense anger. Planned and unplanned encounters may occur in variable contexts and at variable times, e.g. inside and outside the regular 9–5 schedule in the hospitals or in the community. They may engage in conversations in corridors, hospital grounds, the person's house, in cafes or other public places. Nurses encounter ambiguous situations that may offer service users a window of opportunity for change.

#### *Holistic perspective*

Mental health nurses take a more holistic perspective of the client's experiences than other professionals. Both mental health nurses and service users recognize that issues outside the remit of the traditional medical model are a legitimate concern of mental health nurses. Other mental health professionals have a much narrower perspective in focusing on the application of their expertise to service users' health, such as prescribing medication and the use of a form of talk therapy, e.g. cognitive behaviour therapy. The greater access to information about the person's life experiences can accommodate a sense of common humanity.

### Coping

Coping is defined by Folkman & Lazarus (1988) as a person's constantly changing cognitive and behavioural efforts to manage specific internal or external demands that

are appraised as taxing or exceeding the service user's resources. People either manage or alter the source of stress or they regulate their emotional response (problem-focused and emotion-focused coping respectively). Individuals with mental health problems have been shown to use their own strategies to cope with voices, self-harm behaviour, etc. (Carr 1988, Nelson *et al.* 1991, Carter *et al.* 1996, McNally & Goldberg 1997). The application of the recovery alliance theory helps service users tap into the strategies they had developed to cope with their particular mental health concerns.

### Self-responsibility/control

The recovery alliance theory accepts the service users' own understanding of their mental health concerns and is in contrast to the use of formal diagnosis. Consequently, service users have the prime responsibility for their own well-being.

Right from the beginning of the application of recovery alliance theory to practice, the language used in describing the service users' health concerns is the service users' language. This minimizes the inequality in the power relationship and hands back control to the service user.

Control is also exercised when individuals believe their health is the result of their own actions (internal locus of control) (Wallston 1992). The traditional medical model promotes the adoption of the belief that the service user's health is a result of external agencies such as health professionals and pathology (external locus of control). For example, a service user under the traditional medical model described how she was constantly attempting to convince mental health clinicians how unwell she was. This strategy hindered her in dealing with or managing the illness herself (Jubb-Shanley & Shanley 2007).

### Concepts within the recovery alliance theory's meta-paradigm

According to Fawcett (1995), general and abstract concepts and propositions reflect a distinctive perspective of the four concepts of nursing's meta-paradigm. The concepts of person, mental health concerns, mental health nursing and environment are seen within the recovery alliance theory meta-paradigm as more immediately relevant to the practice of mental health nursing.

#### *Person*

The person has the potential for growth and development towards realizing a valued sense of self and of purpose. People are described as:

- possessing humanistic characteristics (Bugental 1964);
- having the potential for growth and development towards realizing a valued sense of self and of purpose;
- learning from experiences and developing repertoires of strategies that enable them to deal with difficult situations;
- their well-being being greatly affected by the influences of other people;
- being in a position to know more about their subjective experiences than other people;
- making decisions and playing an active part in decision making about matters affecting them;
- having a right as others do, to have their own ways of interpreting their experiences being taken into consideration by others.

#### *Mental health concerns*

The concept of mental health that is relevant to mental health nurses is the psychological state experienced by people that promotes their ability to cope with events in their lives. Conversely, mental health concerns are disruptions in this psychological state that adversely affect people's ability to cope with events in their lives. Most people with a mental health concern learn to cope with it, and only periodically are unable to cope, and only then may be in need of mental health services.

#### *Mental health nursing*

Mental health nursing promotes health by encouraging service users to use their coping strategies. The main aspect of mental health that is relevant to mental health nurses are the difficulties experienced by the service user in coping with disruption in their mental health. These difficulties in coping are the main focus of mental health nursing rather than the disruption itself. Other areas of mental health, such as diagnosis, signs and symptoms, are the province of other clinicians such as psychiatrists and not the primary concern of mental health nurses. However, activities involving collaborating with colleagues are an important part of the mental health nurse's role.

The mental health nurses' role is to help the service users to recognize and use their existing coping strategies to deal with their concerns and, if need be, to help service users develop new coping strategies. To do so, mental health nurses must

- recognize and build on the strength and resilience of service users;
- promote the experience of hope, empowerment and connection;

- focus on helping service users use their skills to cope with their mental health-related concerns and not necessarily to help cure them;
- value and use each other's contributions (nurses and service users);
- use the stages of the PinC system (Shanley *et al.* 2003) which promotes these activities.

### Environment

The environment is the context in which the service user lives. The environment is made up of situations, events and internal factors that exercise influence over the person and to which the person modifies and adapts using his or her coping strategies.

The environment, particularly the social environment, can have a positive or a negative effect on the service user's mental health. Within the recovery alliance theory, service users use positive resources in their environment (least related to mental health services) that they have used in the past. Alternatively, service users may wish to relate differently to aspects of the environment that have previously had a negative effect on them.

### Propositions within the recovery alliance theory

The relationship between these four concepts can be seen in that the person's potential for growth and development is enhanced by mental health nursing processes which assist individuals to cope with potential or actual disruptions in their mental health.

Through the use of nursing processes the individual is assisted to use positive resources in their external and internal environments and to minimize the effects of their negative influences.

These processes involve building on the strength and resilience of service users; promoting hope, empowerment and connection; the valuing of nurses'/service users' contributions; and the application of the individuals' existing strategies to cope with their mental health concerns.

## Theory integrated with clinical practice

### Partnership in coping

As indicated previously, the PinC system (Shanley *et al.* 2003) is the result of the translation of the constructs and concepts of the recovery alliance theory into the practice of mental health nursing. While the six constructs – humanistic philosophy, recovery, strengths focus, partnership relation, common humanity and empowerment – are integral to the operation of the whole system, some constructs play a more obvious role in particular stages of the PinC. For

example, in stage one, the partnership relation is created through the recognition of a common humanity by the service user and the mental health nurse and forms the basis of the working alliance which permeates the other stages of the PinC system. In taking responsibility for identifying and prioritizing their concerns in stage two and in establishing goals (stage three), the service users are empowered through the application of recovery principles. Stages four and five particularly highlight the strengths focus in that service users use their own coping strategies to achieve their goals in accepting self-responsibility and control of their well-being. The concepts of partnership relation and coping are seen in all aspects of the operation of the PinC system.

From the trial of the PinC system (Jubb-Shanley & Shanley 2007), statements made by participants can be related to the constructs of the recovery alliance theory.

The constructs recovery, empowerment, strengths focus and the concept coping are reflected in the statement '(PinC) helps me to help myself. Now I stop wasting my energy and start using my energy to look at how I can cope with things'.

The construct strength focus can also be seen in the statement 'I can look at the positive aspects of how the client is going or their strengths rather than focus on the negative side of things – if you work on the positive side of things it helps to sort out the negative. Things are changing for me now because I am doing something positive about it'.

The construct empowerment permeated the language of the participants of the trial. One example was a statement by a service user: 'Partnership in Coping has changed my whole outlook to my disability looking more at managing my illness than just trying to get others to understand how bad it is for me.' 'I have a plan and I know what I am doing – instead of mental health imposing itself on me, telling me what is best for me.'

The overall effect of the use of the PinC system was that it changed the role of both the service user and the nurse to one with a greater affiliation with the recovery-orientated approach.

Participants in the trial talked about how the PinC system helped to promote the idea that both the client and the nurse are the experts in their respective fields.

It reverses the role, when the clinician works with the client to document their concerns, the client is in control not me.

I typed up the forms for the client and then gave the paperwork to the client to read and they give their approval.

I liked sitting down with the client and using their own words in the document, their concerns, their goals and strategies.

## Conclusion

The development of the recovery alliance theory can be traced through the expansion of the authors' thinking as well as those of other stakeholders about mental health nursing, with their ideas and values brought together in a single, cohesive whole or framework. Since Peplau's (1952) model was developed, there have been few frameworks created specifically to guide mental health nursing practice. Mental health nursing practice has been informed largely by the traditional medical model and by various psychological techniques, e.g. cognitive behaviour therapy, brief solution-focused therapy, with little modification on the original formulation to accommodate its use by nurses. With the exception of the Tidal model, whose architect claims it works in 'virtually any setting' (Veitch 2007), there have been no attempts to formulate a cohesive system for mental health nursing practice based on a theoretical framework. The recovery alliance theory is the first integrated formulation from which a system of mental health nursing (PinC) was derived that is applicable across all areas where mental health nurses work.

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