The Service Theories and Healing Leadership of Florence Nightingale and Hildegard Peplau: Their Central Importance for Military Psychiatric Nurse Practitioner Education

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The authors are solely responsible for the contents of this article and have no conflicts of interest to declare. There was no funding for this manuscript. The view(s) expressed herein are those of the author(s) and do not reflect the official policy or position of the Department of Defense, the Department of Veterans Affairs or the U.S. Government. All correspondence should be directed to the first author, Dr. JoEllen Schimmels.

Author Contributions: Drs. Schimmels, Gebara, Owen and Lewis used the model and determined the methodology. Three authors collected and analyzed the data. Dr. Schimmels took the lead in writing and organizing the manuscript. Drs. Schimmels and Gebara wrote the introduction and conclusion. Dr. Owen wrote the background and foundations section. Dr. Lewis wrote the command section and Ms. Wallace wrote the journey through the program section. All authors reviewed the final manuscript before submitting for publication.

Abstract

Nursing theory should guide nursing curriculum development. Teaching military psychiatric mental health nurse practitioner (PMHNP) learners to respond in the complex, multi-domain advance combat support for their wartime mission is no exception. Florence Nightingale and Hildegard Peplau both served in the military and the Uniformed Services University PMHNP program has adopted their Environmental and Interpersonal Relationship Theories to explore foundational didactic content, classroom, simulation and field environment learning outcomes for individual, group, and unit level interactions in a PMHNP program. PMHNP program outcomes for individual, group, command and unit level interactions align with the theories and practical application of these different areas will be discussed. Advanced nursing practice education should pay tribute to the guiding lights in nursing while applying evidence-based practice to improve the future of PMHNP practice to focus on the nursing model of care.

Keywords: behavioral health, nursing, readiness, nursing education, psychiatric nurse practitioner

Introduction

Although Florence Nightingale began her foundational nursing work in the 1850s during the Crimean War, nursing, specifically advanced practice nursing, is still considered a developing profession. The idea of advanced practice nursing began in the 1950s with a mental health clinical nurse specialist program started by Dr. Hildegard Peplau at Rutgers University with a grant from the National Institute of Mental Health. The vision was to use nurses with expert theoretical and practical knowledge to improve patient outcomes. These initial advanced practice mental health nurses focused on psychotherapy and milieu management, continuing Nightingale's work using the environment to support positive patient outcomes (Spray, 1999). Similarly, Drs. Loretta Ford and Henry Silver developed the first nurse practitioner (NP) program at the University of Colorado in the 1960s based on identified needs in primary care (Pulcini & Wagner, 2002). Today, in order to streamline nomenclature, advanced practice nurses in the psychiatric mental health field are also called nurse practitioners (PMHNP) (APRN Consensus Workgroup, 2008). According to the American Academy for Nurse Practitioners,

there are now over 290,000 nurse practitioners across the U.S. today with over 15,000 of them specializing in psychiatric mental health (AANP, 2020).

Nightingale and Peplau were not only instrumental in laying the groundwork for nursing and advanced practice nursing, but they both also served in the military and both focused on factors that impact health of patients: Nightingale emphasized environmental conditions whereas Peplau emphasized relational conditions. The Uniformed Services University PMHNP program provides doctoral-level education to nurses who, like Nightingale and Peplau, serve in the military. This program uses these nursing theorists to guide teaching/learning processes and evaluation methods. In this article, the authors describe the use of their theories in the development of didactic course content, pre-clinical simulation learning activities, clinical and field practicums, as well as learner assessments throughout the program. Also presented are some lessons learned in the program's journey and recommendations for further refinement of this endeavor.

Background

DNP PMHNP Education

As healthcare providers strive to improve access to care in a fragmented health care system, there is an increasing need for clinicians who hold an exceptional set of skills as flexible leaders, independent clinicians, and autonomous health care decision makers (DHA, 2019). In 1992, Congress appropriated funding to implement a training program for nurse practitioners (NPs) at the Uniformed Services University of the Health Sciences (USU). After receiving operational authority in 1993, Dr. Faye Glen Abdellah, founding Dean of the Graduate School of Nursing (GSN), began recruiting faculty and staff, developing curricula, and the first three NP students matriculated in August 1993. In 1996, the Assistant Secretary of Defense (Health Affairs) approved the GSN as a funded School of the Department of Defense (DoD) and in 2008 the GSN received dedicated classroom and faculty space in a separate building on the USU campus. Students in the Masters of Nursing (MSN) and Doctor of Nursing Practice (DNP) Advanced Practice Nursing (APN) programs are all commissioned officers in one of the Uniformed Services. Students receive full pay and allowances, free medical care, tuition, books and lab fees while at USU and upon graduation, all graduates complete a service obligation determined by their sponsoring Service or Agency.

USU matriculates the only military and federal graduate school of nursing's learners. The program is Commission on Collegiate Nursing Education (CCNE) accredited and prepares graduates for credentialing as a PMHNP across the lifespan. This rigorous, full time three-year program is composed of a total of 97 graduate credit hours and 1640 supervised clinical hours with 31 credits of PMHNP specific content. This unique program has an additional simulated military field experience in which learners, who are all active duty military officers, train and perform combat and operational stress control activities to enhance the program's curriculum on readiness and operational (deployment) related topics (USU, 2020).

The scope of privileges for the PMHNP allows for continuous and comprehensive mental health care to *individuals across the life span and across settings*. These privileges allow for the assessment, diagnosis, and treatment of behavioral, psychiatric, addictive, and emotional disorders. PMHNPs practice focuses on comprehensive psychiatric and mental health care to include biopsychosocial assessment, treatment, education, health promotion and disease

prevention to patients, families, groups, and the community. PMHNPs provide acute, crisis-oriented assessment and treatment, therapeutic counseling/psychotherapy, psychoeducation and holistic care. They provide pharmacologic and non-pharmacologic therapies. PMHNPs may collaborate and/or provide consultation to other healthcare professionals, units and commanders, and military legal system. They may perform special military evaluations in accordance with DoD/service policy to determine risk for harm, fitness/suitability for duty, including command-directed evaluations, disability evaluations, and narrative summaries. PMHNPs may also assess, stabilize, and determine disposition of patients with emergent conditions to include admitting privileges in accordance with military treatment facility policies.

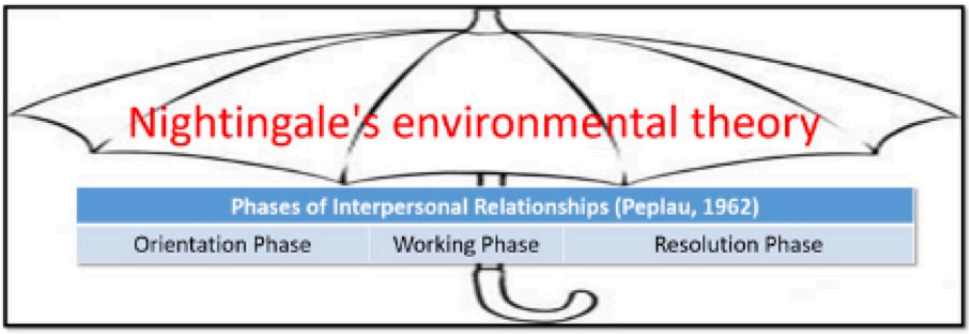
PMHNP role requirements have evolved over time. Entry level for PMHNPs has been proposed to shift from the master's to the doctoral level; and USU's program is focused on the doctoral option. Endorsement by recognized accreditation bodies is one way of measuring quality in nursing programs. Accreditation bodies specifically evaluate nursing programs' approximation to a set of essential criteria in DNP nursing education. Metrics such as program length, credit hours, and clinical hours are based on the ability to map to practice essentials related to the PMHNP track, learner's experiences, and program outcomes. Learner learning objectives throughout the program can be mapped to the DNP Essentials (AACN, 2006) related to: scientific foundation, leadership, quality/use of evidence, practice inquiry, technology and information literacy, policy, health delivery system, ethics, and independent practice PMHNP specific competencies as outlined by NONPF (2016). Guidelines also recommend use of innovative teaching strategies, methodologies for hybrid and distance learning education, support of the DNP project, implementation of quality improvement processes, and interprofessional education and practice. The scope of practice for PMHNP includes the evaluation, diagnosis, treatment, disposition, and referral for patient of all ages with acute and chronic mental health symptoms, illnesses, injuries, conditions, or reactions.

Nursing Theory Influence on Education

A main goal of nursing education is to maintain the continued advancement of the discipline's contributions to health and healthcare systems. Nursing theories organize the science and practice of nursing and are crucial because they constitute the unique language of nursing education, practice, and research (Barrett, 2017). Using nursing theoretical frameworks as a scaffold for DNP nursing education is key in allowing the nursing discipline to continue to provide its distinct and unique impacts within the healthcare environment. However, a 2018 integrative review of nurse practitioner education models found a lack of clarity and paucity in the area of theory development in current NP education (Kostas-Polston, Rawlett, Miedema, & Dickins, 2018). This can hinder advancement of the nursing discipline as it renders it difficult to articulate the distinctiveness of APRN practice from medical practice or other related disciplines (Reed, 2017). This highlights the importance of using nursing theories to guide APRN educational programs.

Florence Nightingale was the first nursing theorist. Her seminal work and writings forever impacted nursing practice, education, and research. Her Environmental Theory was groundbreaking for its time in its description of the integral interrelationships between patients and their environmental conditions that impact patients' health (Nightingale, 1992). Hidegard Peplau was the first published nursing theorist after Nightingale and the pioneer in developing

the theory and practice of psychiatric-mental health nursing. In her Interpersonal Relations Theory, she describes the essence of the nurse-patient relationship and how that relationship is what helps patients make sense of their experiences in health and illness. She also describes the three phases of the nurse-patient relationship-the orientation, working, and termination phases-as essential elements that consist of important tasks to be accomplished in each (Peplau, 1962).



Aligning with Nursing Theory

The focus on interpersonal relationships and their impact on health are very applicable in any healthcare context, especially more so in a military setting where advanced practice nurses have to work under austere and often dangerous conditions, including dealing with their emotional responses to death and injury of colleagues. Peplau's theory explicates that it is during the therapeutic nurse-patient relationship that the patient processes their dilemmas and experiences to reach a greater sense of health and healing. Thus, in content teachings, faculty stress therapeutic communication skills that can be used during each of the orientation, working, and termination phases to encourage patient self-exploration as facilitated by the learner. An example highlighting the importance of matching the appropriate communication skills with the right phase of the relationship in the context of the military patient is when the learner specifically uses open-ended questioning to inquire about the patient's reintegration experience post-deployment or to inquire about concerns regarding an upcoming deployment and separation from family during the working phase of the relationship. The clinical evaluation tool used for the assessment of learner learning in the pre-clinical simulation labs also specifically lists therapeutic communication skills and the phases that the learner needs to use and skillfully navigate throughout an encounter.

A well-rounded approach needs to be multi-faceted; and no one theory is going to fit all situations, and nursing theories used together with other disciplines' theories help propel the science of nursing. This is especially true in the field of mental health, where environmental and relationship factors are of utmost importance in the care of this vulnerable patient population. A number of theories provide synergy for learning in the PMHNP program, as there is a large overlap in skills for behavioral health care providers but using nursing theory ensures a nursing model of care is taught at this level.

Learning: Constructivism

Since the learners come into the program with an average of five years of RN experience, many of which have previously deployed, the program also uses constructivism principles as a foundation for its curriculum design. In constructivism, Jean Piaget (1976) referred to learning as an active process, which occurs on both the individual and social levels. He describes constructivism as a process during which learners combine what they have previously learned with what new information is presented leading them to cognitively construct and make sense of their learning before applying it back to their world. Using schemas, learners assimilate and make sense of experiences to fit them into the rest of what they already know, rendering the focus to be more on the interpretation of information rather than the content of the information. Information is then consolidated into ideas that assist the acquisition of new information. This theory has a lot more focus on the learner having more control over what is learned and their interpretation of learning and thus is very fitting with the learner population (Beck, 2011; Ormrod, 2012). Using reflection at the end of simulation experiences, constructivism principles for learning were solidified.

Peplau and Nightengale's theories are also used as a learning philosophical foundation of the PMHNP DNP program. The curriculum and learning outcomes are supported with these learning principles because learning is active and interactive. In order to help patients understand their problems, relate to something that would be helpful, formulate goals, and achieve those goals eventually without the assistance of the nurse takes the ability to translate learning into action. In Peplau's Interpersonal Relations Theory, the interaction leads to growth from the nurse and the patient, and learning involves promoting growth in others through teaching and interacting (Peplau, 1962). Nightingale's theory augments this by reinforcing the holistic approach to learning, to consider the patient's environment and their interaction with the nurse in this environment in order to move towards recovery (Nightingale, 1992). In the learning process, these theories can both complement and conflict with one another to help students understand both the environment and the interaction between nurse and patient simultaneously. It can be challenging to incorporate both the process and content of these ideas as will be demonstrated.

PMHNP learners need to move to the individual provider level where they are responsible for their critical thinking and clinical decision-making process in the care of complex psychiatric clients. Without a holistic, active and interactive learning model, it would not be possible to take in all of the information needed to be clinically present as the therapeutic tool in client encounters (Weber, Delaney, & Snow, 2016). Providing feedback should reflect this dynamic educational process to assess outcomes of the courses and to assess learners' synthesis and application of theoretical information in patient care situations that they will most likely encounter. This would be challenging without the use of nursing theory to guide faculty and learners on this journey.

Curriculum Applications

Infiltrating these theories into classroom pedagogy, simulation, clinical experiences, patient assessments are many levels, and with learner feedback, offered a more streamlined approach to the structure of curriculum (Hagerty, Samuels, Norcini-Pala, & Gigliotti, 2017). Peplau's Phases of Interpersonal Relationships were used to provide feedback through phases in their

patient encounters: orientation phase, working phase and resolution phase with a focus on the therapeutic use of self and learning through thinking and interacting. Being a good learner practitioner means being able to not just learn from faculty but from each other, peers, and patients. Learners were evaluated on these phases in their clinical interactions and used the phases for active engagement through critical reflection to question assumptions, expectations, and context to change understanding of self, belief system and behaviors. Reflection is a process used to assess the validity of meaning to think more critically and adapt to change more readily to empower autonomy and make meaning in a constructivist way.

Classroom Didactic

The classroom setting provides an exclusive opportunity to begin learner curiosity and growth. At the didactic level, providing immediate integration by developing and embedding the comprehension of therapeutic relationships and therapeutic skills from these three angles, participant observation, therapeutic use of self and the environment. After familiarization with the theories, the learners are expected to connect various learning activities that are intended to link learners' knowledge and application of the theories. This constitutes major learning activities to include lectures, case study activities, peer-to-peer vignettes, and self-reflection write-ups.

In the case study activities, learners observe provider-patient interviews and identify the phases. This provides an opportunity for thorough review and discussion in the classroom. During the peer-to-peer vignettes, learners are given a brief scenario to role play in pairs. Learners are expected to use and identify each of the phases while identifying the therapeutic techniques used throughout their activity. When completing their self-reflection write-ups, learners identify and describe their interactions in these scenarios using participant observation. This allows the learner to reflect on their communication styles, identifying their own behaviors throughout the encounter. The integration of these learning activities in the didactic content aims for learners to achieve a deeper and more complex understanding, preparing them for additional adaptation and utilization in the curriculum.

Clinical and Simulation

Use of standardized patients for developing both content and process evaluation components in a PMHNP DNP program specifically has not been studied well. First of all, there are few published studies of the use of standardized patients in psychiatric nursing simulation and these focus on the physical and procedural skills, history taking, and the assessment of psychopathology (Goodman & Winter, 2017; MacLean, Kelly, Geddes, & Della, 2017; Williams, Jaramillo, & Pesko, 2015). The same phases were used to guide PMHRN learners to provide feedback to PMHNP learners. Post learner-standardized patient encounters, faculty use a debrief format for feedback and case review that focuses on both content and process of the encounter. Content was evaluated by examining the learner's thoroughness and accuracy in conducting a thorough and individualized assessment and treatment plan negotiation with the patient. The process was evaluated by examining how well the learner was able to work through the phases in the here and now environmental context of the encounter to further enhance the therapeutic nurse-patient alliance. For examples of the tools used for learner self-reflection see Tables 1, 2 and 3 in Appendix A at the conclusion of this article.

Graduated PMHNP student Major Rebecca Briones (left) interviews a service member in a simulation lab.

Group Education and Therapies

The theories translate well to group education and therapies. The group process along with therapeutic factors of group (Yalom & Leszcz, 2005) are taught in the context of the theories with consideration of environmental factors include the content and process of the group. Peplau's theory is additionally applicable to group to help learners understand that the importance of consideration of the same phases in a group as well. In the orientation phase, there is a welcome, rule review, introductions, purpose, and objectives for the group. If it is an ongoing group, then there is review of any homework and what has happened since the last time they met. If the group is not a closed group, then introductions of any new group members may also occur. In the working phase, there is discussion about the content with a focus for the learner on both the explicit and implicit content, and group elements such as the emotion, interactions, norms, emotion, and interactions among members and the facilitator. In the resolution phase, summary/wrap up occurs along with any additional information, homework, next meeting, and any feedback for the facilitator.

Operational Environment: Command and Unit Interventions

In the complex world of military medicine, mental health is often an underestimated and underrepresented course of disability and combat and operational stress includes all the physiological and emotional pressures encountered as a direct result of dangers and mission demands of combat and other military operations. Combat and operational stress control

are any number of programs and actions taken to prevent, identify and manage reactions. Historically, combat and operational stress reactions account for up to half of all battlefield casualties (OTSG, 2011) and in 2018, accounted for 34% of evacuations, with reactions to severe stress/adjustment disorder as the number one condition both male and female service members evacuated from theater for (AFHSB, 2019). Exposure to PTSD—probably among learners who have been deployed also—thus the importance of paying attention to the unique aspect of military culture and their unique practice and training environment—they are primarily military officers and secondarily healthcare practitioners. PMHNP learners, who are all military officers, "deploy" to develop, organize, and provide combat and operational stress principles to medical platoons supporting offensive operations in the notional country of Atropia. This exercise called "Behavioral Health at Bushmaster" is the perfect environment for interprofessional education. Learners and clinical faculty from nursing, psychiatry, psychology, medicine, social work, chaplains, occupational therapy, and mental health and occupational health technicians, all work together to create an austere learning experience in a complex, multi-domain combat support role for wartime capabilities. Educating learners on the mission critical competencies to the downrange mission while focusing on patient, unit and population needs, teamwork, and collaboration creates an optimal learning environment for these nursing theories.

As part of the experience, learners work in field conditions and set up and perform personnel surveillance, consultation, traumatic event management, prevention activities and education, command consultations, and unit mental health needs assessments in order to provide feedback to leadership. Focus is put on teaching about the environment and exploring the external factors and how they affect their lives. Mental wellness and psychological prevention are taught throughout this exercise. Learners interact with commanders, encouraging the use of psychological prevention principles to provide descriptions of the mental health of their units, potentially traumatic events, and the management of different interactions. Much of the training and education involves discussing the underestimated mental impact of war

Current PMHNP student Major Yosef Fufa (right) talks to a service member experiencing a stress reaction at Operation Bushmaster.

to include the stigma of mental illness among some service members and their commanding officers. Getting buy-in from the command is often the most challenging aspect of behavioral health care outside of the hospital and helping with crisis leadership is an instrumental piece of the education and consultation interventions taught in the field environment. Traumatic event management includes a number of adaptable interventions aimed at folks experiencing potentially traumatic events. The intent of combat and operational stress principles as well as traumatic event management are to encourage post-traumatic growth and warrior resiliency (OTSG, 2019).

Learners apply Peplau's theory to a multitude of exercises. They respond to line commanders in the orientation phase by introducing themselves and their team, providing information on what their mission is and how combat stress acts as a force multiplier. The working phase includes any number of these interventions and the resolution phase includes surveillance and assessment data, formal treatment of service members and recommendations. In psychological first aid exercises, they respond to crises and potentially traumatic events beforehand with getting to know the unit, personnel, and situation, hopefully before something "bad" happens. Environmental safety is included in this phase as part of the assessment, along with an awareness of other incidents that the unit personnel have been involved with. The working phase involves any number of interventions and the identification, and management of combat and operational stress reactions in the unit and with individuals. Resolution involves ongoing support and evaluation for the unit. Interventions are expected to follow combat stress principles of "BICEPS"-brevity, immediacy, command contact/involvement, expectancy to return to duty, proximity to the unit, and simplicity (reassure normality, rest, replenish, restore confidence, remind (of warrior mindset), resume routine) (OTSG, 2019).

Feedback and Self-Reflection

The theories are used to have learners self-evaluate and receive feedback from peer observers, standardized patients, and faculty. Clinical reasoning is a culmination of knowledge, skills and behaviors across cognitive, psychomotor and affective domains (Bloom, Engelhart, Furst, Hill, & Krathwohl, 1956; Harrow, 1972; Krathwohl, 1964). Evaluating the interaction between the learner and patient in the context of their environment is a vigorous and challenging process. Other evaluations have described these amorphous clinical skills as subjective, inconsistent, ambiguous, and inequitable (Amicucci, 2012; DeBrew & Lewallen, 2014; Hughes, Johnston, & Mitchell, 2019; Hughes, Johnston, & Mitchell, 2018; Oermann & Gaberson, 2017; Oermann, Yarbrough, Saewert, Ard, & Charasika, 2009; Watts & Walker, 2018); negative, stressful and of poor quality (Hughes, Johnston, & Mitchell, 2018; Hughes, Mitchell & Johnson, 2019; Oermann & Gaberson, 2017; Watts & Walker, 2018) with inter-rater reliability discrepancies on checklist items ranging from 33.3-100% (Dunbar, 2018).

Observation is the primary strategy for evaluating clinical and simulation performance (Oermann & Gaberson, 2017). There is a great deal of uncertainty and ambiguity in the complex concepts evaluated in clinical practice such as communicating, building rapport, analyzing and interpreting information, synthesizing and evaluating data and applying theoretical principles to other situations (Billings & Halstead, 2012; Oermann, Yarbrough, Saewert, Ard, & Charasika, 2009). Teaching students both self-assessment and peer observation skills in addition to faculty feedback has been helpful. Students receive and provide feedback to others and are able to additionally learn what feedback patients would provide them thought

structured feedback in classroom and simulated exercises. This also helps students learn and experience having difficult conversations with others, which is a vital skill as a behavioral health provider, being able to have conversations with patients about topics such as psychiatric diagnoses, medications, and suicide prevention.

Learner Journey

Learners in the program are introduced to Nightingale and Peplau early on. There is an overall orientation phase of the program that starts with the admission process, where the interview and discussion of written instrumental experiences in nursing; to better understand past experiences and future career goals. Once the learners arrive on campus, they are acclimated to the academic environment with two years of classroom, simulation, and clinical experiences as part of their working phase to prepare them for independent practice. During the third and final year in the program, learners move to a military treatment facility for their final site where over 1000 additional clinical hours are completed, requiring a total for the program of almost twice as much as is required for certification exam (ANCC, 2020); and didactic content is significantly less. Learners work with only online content and on their DNP projects at their clinical sites with preceptors and site directors. Learners work towards the resolution phase of their own ability to perform independently as practitioners. As part of this phase, work is out briefed at the university research week and complete requirements for graduation and board certification. Nurses are given an opportunity to reflect on their nursing experiences throughout these experiences with portfolio entries each semester detailing this journey.

Outcomes

Since the start of the program, outcomes such as learner satisfaction as well as learner self-, peer-, SP- and faculty feedback have been used for formative, longitudinal progress as well as summative evaluations, moving beyond only faculty assessment for grading purposes. Learners have reported satisfaction with the consistency of the expectations across the program over different years and many different courses. Many learners have also implemented the model in many of their DNP capstone projects and have referred to the theories in assignments in courses outside of the PMHNP program. Some have even taught the model to patients in clinical practice. Because the tools utilized for evaluation are still being tweaked, no formal outcome data was available at the time of publication.

The use of Peplau and Nightingale's nursing theories also link directly to the program terminal competencies (see Appendix B, Table 4), specifically related to healthcare delivery, managing the needs of the unique military population and using theory and concepts from nursing sciences in the application of best practices to the field. Unique military needs include combat and operational stress control principles and psychological first aid not only in the war zone, but also peace keeping assignments, humanitarian missions and most recently, in response to the COVID-19 pandemic and social unrest across the nation. These experiences cause a great deal of stressor-induced behavioral health and non-behavioral health conditions that nurse practitioners are educated and trained to respond to (Morganstein, West, Schimmels, & Benedek, 2020). Additionally, the theories help guide consideration for the environmental stressors of deployment on the families by anticipating and addressing the impact of deployment on spouses, partners, children and/or parents, family, and friends. The impact of family stress on the active duty force is another large consideration in the environment.

Conclusion

Nursing theory provides a unique nursing language. The authors contest that keeping nursing as a profession means keeping nursing as a science and using nursing's distinctive theoretical background to guide nursing education, especially in advanced practice DNP education, nursing practice, and nursing research. Theories are necessary to tie together concepts to improve patient care and predict patient outcomes. Advanced practice nursing is not medical practice, and show pride making advanced practice nurses, not mini-psychiatrists. PMHNPs are full partners in the healthcare team; a unique military situation, and it is important to apply foundational work, so the nursing contributions made to the organization are clear. Recognizing the unique and overlapping interprofessional roles without losing the nursing lens to provide optimum care for patients is vital. Sometimes nurses lead, sometimes they support, but always as a professional nurse.

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Appendix A: Examples of Program Feedback

Table 1: Interpersonal Process Recording Example

Phase	Patient Statements	Patient Observed Behavior	Student's Feelings/ Thoughts	Therapeutic Concept Used	What you'd do different
Orientation	*"I'm glad to meet you, always glad to meet new people"*	*Started seated in chair then transitioned to standing and writing things down in notebook, pacing the room and playing with paper gowns*	*Concerned about getting the patient seated for the interview. Was wondering if I should just continue observing or interrupt and begin interview*	*Suggestion- offered that she might be more comfortable for the interview if she were seated*	*Instead of emphasizing a requisite to be seated I could inquire if she felt more comfortable standing or sitting*
Working	*"Medicatio ns are bad for my spirit and body, nothing is wrong with me"*	*Standing continuing to move around the room and shake head side to side regarding medication use*	*Cautious in proceeding with interview Was thinking that it will be difficult to promote medication if medical cause is ruled out to stabilize patient if she is against taking them*	*Suggestion- offered medication to help regulate sleep though patient's complete lack of insight prevented a connection*	*I could have maybe used observation focusing more flight of ideas and how medications could help her collect her thoughts*
Resolution	*"If we can hold hands I can feel your energy and you can feel my energy then you can understand "*	*Standing in close proximity to interviewer with arms and hands out offering to hold hands with interviewer*	*Uneasy with holding patients hands. I avoided explaining my future recommendation for inpatient admission thinking that getting the husband and command involved would be helpful in getting buy in*	*Information giving- I thanked her for the offer but recommended we continue with interview so we would have time to discussed tx plan*	*Would have used same technique with further review of how a better understanding of her current state is needed along with safety and inpatient hospitalization would be the best venue for that to occur*

Table 2: Peer Observation Feedback Example

	Positive Examples		Missed Opportunities	
Phase	Technique	Evidence	Technique	Evidence
Orientation	*Rapport building*	*Good introduction, layout of appointment expectations*	*Trust/rapport building*	*Did not address confidentiality*
Working	*Validation* *Education*	*Praised the patient for seeking treatment* *Demonstration of mindfulness technique*	*Exploration*	*Did not ask any more questions about drinking*
Resolution	*Goal setting* *Recap*	*Patient expectation management, involve them in their care/goals* *Verified information collected at end*	*Continuity*	*No therapy follow up appointments scheduled*

Table 3: Standardized Patient (SP) Feedback Example

Please rate this student by the following scale (Keep in mind that "3" is average, safe practice)						
		1 poor	2 fair	3 good	4 very good	5 excellent
Orientation Phase	*1. For building a relationship, I would rate the learner as:*			*X*		
	2. For understating the patient's perspective, I would rate the learner as:				*X*	
Working Phase	*3. For gathering information, I would rate the learner as:*				*X*	
	4. How would you rate the student's ability to focus on your needs:				*X*	
Resolution Phase	*5. How would you rate the student's ability to engage you in treatment:?*			*X*		
	6. For providing closure, I would rate the learner as:				*X*	
Feedback on opening the encounter/building a relationship: *When you said that in our last encounter you had failed to mention that the medication could increase my anxiety, I felt disbelief. I felt acceptance when you were up front about these types of side effects in today's encounter.*						
Feedback on gathering information and understanding patient's perspective/goal setting as a team: *I felt worried when you said Suzie should take me to the ER if I exhibit suicidal ideation. The thought of medical situations is an anxiety trigger for me. Although I understood the rationale, perhaps a moment here to acknowledge my perspective regarding such situations might have contributed to my sense of well being.*						
Feedback on closure and overall experience: *Overall I felt supported when you exhibited a sense of urgency and desire to see me improve. I felt glad that our next appointment was in one week rather than two.*						
List two strengths and two areas of improvement: *A strength for this encounter was sharing information such as side effects. I feel engaging me in therapy could be an area of improvement.*						

Appendix B: Program Terminal Competencies

Table 4: Key USU DNP PMHNP Program Terminal Competencies

Manage the unique healthcare needs of military beneficiaries across the lifespan.
Provide adaptive leadership in joint service environments within multidisciplinary teams.
Deliver healthcare in unique and dynamic settings including military operational, austere, disaster, and humanitarian and civic aid environments.
Synthesize theories and concepts from nursing sciences in the use of an appropriate framework.
Develop and sustain therapeutic collaborative relationships.
Identify indications of client motivation and readiness to change during the therapeutic process.
Apply best practices in the selection and implementation of specific interventions.
Implement principles of psychiatric nursing assessment, diagnosis, and psychotherapy recommendations.
Analyze the application of psychiatric advanced practice nursing.
Evaluate outcomes of advanced psychiatric nursing practice.