What Do Psychiatric Advanced Practice Nurses Know About Trauma Treatment?
A National Survey of Psychiatric Advanced Practice Nurses

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Abstract

BACKGROUND: According to the National Comorbidity Survey, trauma exposure is common in the U.S. This exposure can result in posttraumatic stress disorder or significant sub-threshold trauma-related symptoms. Physical and mental illnesses, functional disability, and high health care utilization results from untreated psychological trauma. OBJECTIVE: The main purpose of this study is to explore psychiatric advanced practice nurses’ (APRNs) educational preparation to treat psychological trauma. RESULTS: A convenience sample of 118 APRNs answered a questionnaire. Responses were analyzed using descriptive and inferential statistics, and content analysis. The majority of respondents stated their graduate program did not adequately prepare them to provide psychotherapy for patients suffering from psychological trauma. Additionally, just over 40% of respondents stated instruction on principles of trauma informed care, medical diagnoses associated with trauma, stabilization skills, and education in evidenced-based models for trauma treatment was not provided in their graduate curriculum. Those who did receive education on trauma treatment in their graduate program and through post-graduate training found their education to be helpful in treating patients. CONCLUSION: APRNs have identified the need for psychotherapy training to treat psychological trauma. APRN graduate programs should evaluate their curriculum and increase content on the treatment of psychological trauma using evidenced-based psychotherapy models.

Keywords: advanced practice psychiatric nurse, education, psychotherapy, trauma
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Introduction

Psychological Trauma

Large scale community surveys have found that the majority of people have experienced at least one traumatic event and that on average, five traumatic events are reported (Centers for Disease Control and Prevention [CDC], 2010). Psychiatric advanced practice nurses (APRNs) often work with patients who suffer from psychological trauma as a result of experiencing traumatic events. Patients suffering from psychological trauma are seen in the emergency room by psychiatric liaison APRN nurses, and by psychiatric APRNs in outpatient clinics, inpatient settings, and private offices.

A confluence of events has converged to suggest an urgent need for trauma training for all nurses and especially for advanced practice psychiatric nurses. These events include terrorist attacks, devastating natural disasters, the large number of veterans returning from the Iraqi and Afghanistan conflicts, and the growing body of research documenting the emotional and physical deleterious sequelae incurred from adverse life experiences (Felitti & Anda, 2010). Trauma and its consequences have been identified as a high priority public health risk (Shonkoff & Gardner, 2012; U.S. Department of Health and Human Services, 2003; World Health Organization, 2013).

The current Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) describes a traumatic event in Criterion A as “a direct or indirect exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence”, and outlines types of traumatic events in Criterion A which may result in PTSD (APA, 2013, p. 271). Psychological trauma can result in posttraumatic stress disorder (PTSD), a complex disorder comprised of intrusive recollections, avoidance of the trauma, and anxiety and mood symptoms. The lifetime prevalence of PTSD is estimated to be
7–12% in the general population (Kessler, 2000; Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) and is more widespread among individuals with severe mental illness (SMI) such as schizophrenia, bipolar disorder, and major depression, and those who have served in combat. The lifetime prevalence of PTSD among individuals with SMI is 29% to 47% (Mueser, Bolton, & Rosenberg, 2007) and 21.8% for veterans who served in Iraq or Afghanistan (Seal et al., 2009).

Those who suffer from PTSD are known to have high rates of disability, including increased likelihood of unemployment, deficient physical health, low quality of life, and high rates of health care utilization (Rosenberg et al., 2000; Sareen et al., 2007; Sareen, Houlahan, Cox, & Asmundson, 2005; Stein, Walker, Hazen, & Forde, 1997; Zayfert, Dums, Ferguson, & Hegel, 2002). These outcomes contribute to the economic burden of PTSD, which is estimated at $3 billion per year (Kessler, 2000).

It is not just Criterion A events as described by the DSM-5 that predispose people to physical and emotional illness but also adverse life experiences or stressful events that happen to most people. In fact, Mol et al. (2005) found that PTSD symptoms were more prevalent following significantly stressful life events not specified in the DSM-5 as Criterion A events. PTSD symptoms in the absence of the full disorder, or sub-threshold PTSD, can still result in significant functional impairments (McLaughlin et al., 2015; Stein et al., 1997).

The Adverse Childhood Experiences (ACE) study found that in the case of childhood trauma, the greater the childhood stress, the more likely an individual will experience physical and mental health problems, unstable and abusive relationships, and substance use disorders (Felitti et al., 1998). Additionally, Xie et al. (2010) demonstrated a link between a childhood adversity and later development of PTSD. A theoretical model has been proposed by Subica,
Claypoole, and Wylie (2012) demonstrating the complicated relationship between early life trauma, serious mental illness, PTSD, and functional impairment. In this model, trauma begets more trauma, resulting in increased physical, mental, and social impairments.

**Interventions**

Fortunately, evidence-based therapies (EBT) for psychological trauma exist and include pharmacotherapy and psychotherapy (Berg, Breslau, & Goodman, 2008). While PTSD treatment guidelines differ somewhat in their recommendations for pharmacotherapy, all guidelines strongly support the use of specific psychotherapy-based interventions for the treatment of adults with PTSD (Forbes et al., 2010). Two recent meta-analyses of PTSD treatments identify cognitive and exposure-based therapies and eye movement desensitization and reprocessing as effective, evidence-based psychotherapeutic treatments (Jonas et al., 2013; Watts et al., 2013).

It is imperative that patients who suffer from psychological trauma receive EBTs to maximize the probability of positive treatment outcomes; however, research has demonstrated that EBTs are underutilized in the clinical setting (Becker, Zayfert, & Anderson, 2004; Rosen et al., 2004). One potential contribution to underutilization is training inexperience with EBTs for psychological trauma (Becker et al., 2004). Trauma assessment and training is not included in the curricula of most mental health provider graduate programs (Courtois & Gold, 2009; DePrince & Newman, 2011).

**APRN Nursing Education**

Since the inception of APRN psychiatric nursing education in 1954 there have been several major curricular revisions made to APRN training. Initially, Hildegard Peplau’s (1991) “interpersonal model” of psychiatric nursing care strongly influenced curricula, and psychiatric APRNs considered psychotherapy a central part of their practice. As biological models of care
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and managed care developed, health care delivery emphasis shifted to prevention, cost
containment, and the delivery of psychiatric care in the primary care setting (Delaney, 2005). By
the end of the 1990s, psychiatric nursing curricula added a primary mental health care focus,
pharmacology, physical assessment, and pathophysiology content (Delaney, Chisholm, Clement,
& Merwin, 1999).

In 2000, the American Nurses Credentialing Center (ANCC) began credentialing
Psychiatric Mental Health Nurse Practitioners (PMHNP), reflecting the changing mental health
care environment. Discussion in the psychiatric nursing community regarding the educational
prioritization of psychotherapy versus pharmacotherapy ensued (Delaney, 2005). One study
found that practicing psychiatric APRNs wanted more psychopharmacology content in APRN
curricula (Delaney, Hamera, & Drew, 2009). Another study found that although psychotherapy
was still emphasized in curricula, there was no consistency in types of psychotherapy taught,
textbooks utilized, or standardized number of clinical hours required in psychotherapy for
psychiatric APRN programs (Wheeler & Delaney, 2008).

In the midst of this debate, ANCC proposed another curricular change, the Consensus
Model for APRN Regulation: Licensure, Accreditation, Certification, and Education (L.A.C.E).
A large group of nursing organizations worked together to produce the L.A.C.E. APRN
educational model (APRN Joint Dialogue Group Report, 2008). The model sought to unify
aspects of APRN education across nursing specializations, with core requirements for all APRNs
seeking certification. Many APRN programs are now shifting to doctorate of nursing practice
programs (DNP), adding even more curricular requirements to an already crowded program of
study. This has created enormous burdens for the psychiatric nurse educator. Burgeoning
curricular requirements mean psychiatric nurse educators must make choices about specialization
content, leading to a debate within the psychiatric APRN community as to how much time
gradient programs should devote to teaching evidenced-based psychotherapy skills versus other
interventions.

Purpose

While the debate ensues, psychiatric APRNs often treat patients with PTSD, acute stress
disorder, and other manifestations of exposure to adverse life experiences. It is unknown if
PMHNPs and clinical nurse specialists (CNSs) are adequately prepared to meet this demand. To
date, no known assessment of the preparation of psychiatric APRNs to treat psychological
trauma has been undertaken. The purpose of this survey research was threefold:

1. To determine psychiatric APRNs’ perceived preparedness to treat patients who have
   suffered disabling psychological trauma using evidenced-based therapy skills;

2. To compare perceived preparedness with years of experience as a psychiatric APRN;

3. To determine the reported content in graduate nursing education preparing psychiatric
   APRNs to treat psychological trauma using evidenced-based therapy skills.

Methods

A descriptive survey design was used for this study. The institutional review board at
Brigham Young University approved the study prior to data collection. A brief survey was
constructed with content experts to explore APRN perceived confidence in providing treatment
for patients suffering from psychological trauma, and the role of graduate education in preparing
APRNs to provide psychological therapy for trauma. Three psychiatric APRNs and three non-
psychiatric nurse practitioners completed an initial survey to obtain feedback on ease of use and
interpretation of questions. Questions were slightly modified based on feedback from the pilot
group of respondents.
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Participants

Participants were recruited from the American Psychiatric Nurses Association (APNA) website online discussion forums and from APRN attendees at the APNA 2014 Annual Conference in Indianapolis, Indiana. Individuals were invited to participate if they had graduated from a psychiatric APRN program.

Data Collection

The online survey was constructed using REDCap, a licensed, Web-based research tool that collects and compiles data input. A total of 71 individuals initially submitted the online survey, which was accessed from a direct link on a recruitment message sent to the following APNA online forums: General Discussion Board, Advanced Practice Council, Education Council Advisory Panel, Nurse Educators, and Nurse Practitioner groups. A second reminder message was sent through the General Discussion Board.

An identical hard copy survey was distributed at the 2014 APNA annual conference in between APNA conference sessions to those APRNs willing to receive the survey from the researcher. Stamped, addressed envelopes were provided with the survey but no incentives were offered to complete the survey. An additional 48 persons completed and returned the hard copy survey. A research assistant, supervised by a member of the research team, entered hard copy survey responses into the REDCap online survey tool. The response rate on the hard copy survey was 32.6%. One hard copy survey was discarded because the respondent neglected to complete most of the survey. A total of 118 surveys were completed.

The survey consisted of two separate sections. The first section was a combination of closed and open-ended questions and Likert scale ratings. All of the 118 APRN participants were queried regarding their graduate program instruction on psychological trauma, the perceived
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adequacy of the instruction (if it was received), level of confidence in treating trauma patients, and what percentage of patients in their practice suffered from psychological trauma. Participants were also asked if they had pursued training in treating psychological trauma beyond their graduate program, what this training was, and how often they used skills gained from this training. The second section focused on practice history and demographic information of respondents.

Data Analysis

Quantitative data analysis was accomplished using two methods: (a) REDCap was utilized to generate descriptive statistics and SPSS was used for inferential comparisons. And, (b) two members of the research team analyzed the qualitative data for major themes. They used qualitative content analysis principles set forth by Fink (2013).

Results

Section 1: Instruction, Preparation, Confidence, Trauma Patients, Continuing Education

Instruction on trauma-related topics. Respondents were asked whether they received instruction on several topics. If they indicated “Yes,” they were then asked to rate the instruction from 1–5 (with 1 being “not at all helpful” to 5 being “extremely helpful”) in treating patients with psychological trauma. Respondents reported they were most likely to have received instruction in their graduate program on the topics of (a) specific mental health diagnoses associated with the experience of significant psychological trauma (84.5% said “Yes,” they had received instruction on the topic); (b) physiologic responses to events triggering significant psychological trauma (80.3%); and (c) the identification of populations at risk for experiencing psychological trauma (78.6%). In all, 55.6% said they had received instruction in their graduate program on topics related to providing trauma informed care. Fewer than 60% of respondents
stated they had received instruction on medical diagnoses associated with psychological trauma, evidenced-based treatment models, principles of trauma informed care, and stabilization for trauma treatment. (See Table 1) When instruction was received, all the topics were viewed by respondents as “helpful” on the 1 to 5 scale, with 1 being “not at all helpful,” to 5 being “extremely helpful.” The highest “helpful” mean scores were as follows: instruction on specific mental health diagnoses associated with the experience of psychological trauma ($\bar{x} = 3.99$); medical diagnoses associated with the experience of significant psychological trauma ($\bar{x} = 3.94$); and physiological responses to events triggering psychological trauma ($\bar{x} = 3.88$). These were followed by helpfulness of instruction on trauma-informed care ($\bar{x} = 3.80$); stabilization skills for trauma treatment ($\bar{x} = 3.75$); identification of populations at risk for experiencing psychologically traumatic events ($\bar{x} = 3.73$); and finally, helpfulness of instruction on evidenced-based models for trauma treatment ($\bar{x} = 3.45$).

The data on instruction topics and helpfulness of instruction were then analyzed to determine if the year in which the respondents graduated from their psychiatric APRN program of study significantly influenced the instruction topics taught and the perceived helpfulness of the topics. Two groups were compared: those who graduated between 1966 and 2006, and those who graduated between 2007 and 2014. Chi-square analysis was used to look for significant difference between the two groups on instruction topics, and independent sample $t$-tests were used to look for mean difference between groups on the helpfulness of each topic.

When it came to the frequency of instruction topics covered in graduate education programs, there was no significant difference ($\alpha = .05$) in the receipt of instruction topics for those who graduated between 1966 and 2006 and those who graduated between 2007 to 2014 on
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the following topics: (a) identification of populations at risk for experiencing psychologically traumatic events; (b) physiologic responses to events triggering significant psychological trauma; (c) specific mental health diagnoses associated with the experience of significant psychological trauma; and (d) delivery of patient care using evidenced-based models for trauma treatment, such as EMDR (eye movement desensitization and restructurung), cognitive re-structuring, exposure therapy, or others.

Those graduating from 1966–2006 reported significantly higher average helpfulness scores than graduates from 2007–2014 for the following topics (\( \bar{X} \) and \( SD \) respectively): (a) principles of trauma-informed care 4.11 (0.85) vs. 3.56 (1.08), \( t(61) = 2.21, p = 0.03 \); (b) stabilization skills 4.19 (0.94) vs. 3.43 (1.21), \( t(60) = 2.80, p = 0.01 \); and (c) delivery of patient care using evidenced-based models 3.86 (0.91) vs. 3.23 (1.29), \( t(54) = 2.24, p = 0.03 \).

**Graduate program preparation.** All 118 survey participants responded to the question, “Do you feel your graduate program adequately prepared you to provide care for patients suffering from psychological trauma?” The majority (52.5%) said “No,” their program did not adequately prepare them, whereas 47.5% said “Yes,” it did prepare them to care for such patients. When invited to make comments, 75% offered opinions. Three major categories emerged from the comments: “Inadequate graduate training”; “Adequate graduate training”; and “Continuing education and practice to obtain further training.”

Those who believed their programs were inadequate to prepare them mentioned their exposure to trauma education was “limited,” “minimal,” “generalized,” and/or “brief.” Some mentioned that when they received their education, little was known about trauma and its effects. Typical of comments in this category were, “Although I felt that I received an introduction to trauma informed care and treatment, I did not have the opportunity to move beyond just brief
exposure when it came to evidenced-based models,” and “I felt my training was superficial. Frankly I can remember only a few slides on it.”

The major thrust of comments for those who believed their trauma education was “Adequate” was that although basic trauma skills were taught in lecture classes, clinical practicum gave exposure to the skills and supplemented the didactic teaching. For example, “I got decent knowledge at the time of my program. Much of it was in clinical at the VA [Veterans Administration],” and, “My preceptor was excellent. She had a strong interest in treating patients with history of trauma.” Words to describe the trauma training included “great,” “decent,” “basic,” “general,” and “adequate.”

The third category of comments related to seeking further education in trauma training and the role of clinical practice in securing trauma skills. Respondents mentioned attending conferences and workshops as well as acquiring “on the job” training in trauma treatment. For example, one respondent stated, “I have since learned more about trauma by being certified as a sex addiction therapist.” Another stated, “I have educated myself since graduation, but they began it. I have learned more about trauma from continuing education courses and from trial and error working in the field.”

Confidence in treating patients with psychological trauma. Respondents reported high confidence levels in treating patients suffering from psychological trauma. In all, 60.6% of the 117 respondents rated their confidence 4 or 5 on the 5 point scale (with 1 being “not at all confident” to 5 being “extremely confident”). Another 29.9% rated their confidence as a 3 on the 5 point scale, and 9.4% rated their confidence low (1 or 2 on the 5 point scale). The average confidence rating was 3.76 ($SD = .962$).
Respondents were invited to comment on their response to the confidence-rating question and 83 did so. Most comments about confidence in treating patients suffering from psychological trauma centered on having years of clinical experience, as well as receiving additional education (post-graduation) in the form of continuing education, attending workshops, reading current literature, and receiving ongoing training. Other comments included having confidence in using medications and knowing the “basics” in order to refer patients for therapy. Eleven comments indicated a lack of confidence in treating patients, particularly as it related to providing therapy.

**Perception of patients in APRN practice who suffer from psychological trauma.** Respondents \((n = 115)\) indicated the “Percent of patients in their APRN practice who suffer from psychological trauma.” The mean percent of patients who suffer was 51.05 \%(SD = 28.57)\) and the median percent was 50. Table 2 shows the number of respondents grouped by quartile indicating the percent of their patients who suffer from psychological trauma.

**Continuing education received.** A total of 115 respondents answered the question, “Following completion of your graduate program, have you sought continuing education opportunities to learn psychological therapy skills for the treatment of significant psychological trauma?” Just over 77 \%(n = 89)\) of respondents said “Yes,” they had sought continuing education opportunities. When asked what training they received to gain skills for the treatment of psychological trauma, responses varied greatly. A content analysis of comments from this open-ended question revealed that major training came in the form of conferences (e.g., APNA, Veteran PTSD conferences), continuing education offerings, seminars, workshops, and specific training courses. Specific training courses in the following modalities were mentioned by respondents: “cognitive behavioral therapy,” “eye movement desensitization,” “dialectical behavioral therapy,” “cognitive processing therapy,” “emotional freedom techniques,” “energy
psychology,” and “holographic memory resolution.” In addition, 20 respondents indicated they were active in self-directed learning such as reading the literature, books, and seeking out self-study training opportunities.

When asked how often they use the treatment of psychological trauma skills learned outside their graduate education, on the scale of 1 to 5 with 1 being “very rarely” to 5 being “very often,” 62.5% of the 88 respondents who answered this question rated their frequency of use as 4 or 5 on the 1–5 scale. The mean score was 3.84% ($SD = 1.133$). Only 12.5% indicated they very rarely use the trauma treatment skills learned outside their graduate education.

Section 2: Demographics, Certification, and Practice

Age of respondents. A total of 105 respondents indicated their age at last birthday. The mean age was 52.32 ($SD = 12.268$). The median age was 56, with a range of 47 (27–74 years). Although the respondents tended to be older, many reported receiving their psychiatric APRN graduate education later in their careers.

Graduation date, states, and years of practice. Participants graduated from their psychiatric APRN program of study between 1966 and 2014. About 50% graduated between 1966 and 2006, and another 50% between 2007 and 2014. A total of 117 respondents indicated the state where they received their psychiatric education. Thirty-two states and the District of Columbia were represented in the sample.

Respondents also reported the number of years they have been practicing in a psychiatric APRN role. Of the 117 respondents to this question, the mean number of years in practice was 11.98 ($SD = 11.77$), and the range was 44 (0–44) years. A total of 115 respondents indicated the state where they currently practice. In all, 40 states and the District of Columbia were noted, including all regions of the United States. (See Table 3).
Certification. The most common certification was psychiatric nurse practitioner (adult and family), followed closely by clinical nurse specialist in psychiatry (adult and child/adolescent). A significant number of respondents listed certification as both a clinical nurse specialist and psychiatric nurse practitioner.

Current practice environment. Respondents were asked to identify their current clinical practice environment by selecting from a list of possible clinical practice sites. In all, 32.2% of the 118 respondents checked “private practice,” 30.5% checked “community mental health,” and 16.1% checked “inpatient psychiatry.” “Integrated primary psychiatric care clinic,” was checked by 9.3% of the respondents, followed by 7.6% who checked “Veterans Health Administration,” and 5.1% who checked “inpatient psychiatric liaison.” A total of 29.7% (or n = 35) of respondents wrote “other” as their practice environment. The most common responses in the “other category were “outpatient clinic” (n = 10) and “academic setting” (n = 7), followed by “health care center (or hospital)” (n = 2) and “nursing home (or long-term care)” (n = 2).

Other respondent comments. A total of 29 of the 118 respondents added comments at the end of the survey when invited to do so. These additional comments focused on (a) the need for and the importance of the current study; (b) the differences about what was taught in past graduate studies and what is needed today in treating patients with psychological trauma; (c) the difficulty in providing ideal treatment to patients when visits are very short in length; (d) a recognition of how the APRN role has evolved over the past years, particularly related to medication management and psychotherapy; and (e) the importance of trauma treatment skills.
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Discussion

This survey cast a wide net for participants with 118 respondents representing advanced practice psychiatric nurses across the United States from various practice settings. Approximately half were PMHNPs and slightly less than half were psychiatric clinical nurse specialists. The majority of respondents said they had received instruction on mental health diagnoses associated with psychological trauma (84.5%), physiological responses to trauma (80.3%) and identification of populations at risk for experiencing trauma (78.6%). However, fewer than 60% of respondents stated that they had received instruction on medical diagnoses associated with psychological trauma, evidenced-based treatment models, principles of trauma informed care and stabilization for trauma treatment and more than half (52.5%) did not feel that they were adequately prepared in their graduate programs to provide care for patients suffering from psychological trauma.

Even though there has been a growing body of literature and research on trauma in recent years, there was no significant difference in the receipt of instruction topics for those who graduated between 1966 and 2006 and those who graduated between 2007 to 2014 in the following content areas: (a) identification of populations at risk for experiencing psychologically traumatic events; (b) physiologic responses to events triggering significant psychological trauma; (c) specific mental health diagnoses associated with the experience of significant psychological trauma; and (d) delivery of patient care using evidenced-based models for trauma treatment, such as EMDR (eye movement desensitization and restructuring), cognitive reprocessing, exposure therapy, or others. In fact, those graduating earlier reported significantly higher helpfulness scores for this content in their programs than those who graduated later with respect to principles of trauma informed care, stabilization skills, and delivery of patient care using evidence-based
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models. Perhaps the older cohort reflects those who attended psychiatric clinical nurse specialist programs where more emphasis was placed on psychotherapy than the later cohort who were more likely to have attended PMHNP programs.

It is indeed curious that as the body of knowledge and awareness of the deleterious consequences of trauma for physical and emotional health has expanded, this knowledge has not been widely disseminated through graduate psychiatric nursing programs. Judith Hermann’s seminal book *Trauma and Recovery* (1992) noted that repression, dissociation, and denial are social phenomena and that a parallel process occurs when working with traumatized patients. That is, studying psychological trauma requires one to come face to face with our own vulnerability and the nature of evil. Nurses bear witness to psychological trauma in all settings, medical and psychiatric, and much has been written about vicarious trauma in nursing. However, the deeper, pervasive psychological trauma of those with mental health problems are encountered daily in advanced psychiatric nursing practice and a collective denial may account for the lack of this content in graduate programs.

The integration of trauma-informed care transcends clinical interventions and evidence based trauma treatments, and implies that organizations and systems recognize the pervasive consequences of trauma. “These effects can range from sensory sensitivities, (to harsh noise, light for example) stemming from a sensitized nervous system, to more existential challenges, like distrust of others, despair, a damaged sense self or powerlessness” (Acharya, 2015). Surely this is essential for all psychiatric advanced practice nurses in any setting. Through active engagement, the APRN cultivates dignity, respect, hopefulness, choices, empowerment, and recovery, yet fewer than 60% of respondents reported gaining this knowledge in their graduate program.
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There are specialized skills and knowledge that are needed when working with trauma survivors in order to avoid re-traumatization (Cook & Newman, 2014). The psychiatric APRN may inadvertently create boundary violations through insensitive questions, or misunderstand the patient’s phobia of traumatic memory as an issue to explore in therapy rather than understand the nature of dissociation as an effect of trauma. Traumatized people find it difficult to participate in treatment and are frequently labeled as “resistant” or “noncompliant.” Problems with trust and emotional regulation are the norm with this population and the psychiatric APRN should be educated to understand, recognize and address these characteristics and competently work toward stabilization. Again, fewer than 60% of respondents received instruction on stabilization strategies.

It is well established in the literature that evidence-based trauma treatments result in better outcomes than generic treatments or medications (Ehlers et al., 2010). Researchers report that guiding patients to face and process previously avoided emotional experiences results in profound changes (Ecker, Ticic, & Hulley, 2012). Foundational to some evidence based psychotherapies for PTSD is the process of memory reconsolidation, which goes beyond simply symptom relief. This sequential approach involves reactivating the traumatic memory and subsequent negative beliefs while creating a mismatch or/contradiction to the traumatic memory, thus allowing new and healing perspectives to emerge. Although these therapies are complex, training can and should be integrated into graduate psychiatric nursing curriculum so psychiatric APRNs are able to engage their patients in healing, not just provide temporary symptom relief through psychopharmacology or supportive psychotherapy. Ecker and colleagues (2012) assert that most therapy approaches are counteractive in that the focus is to manage or over-ride the emotional reactivity and associated symptoms. Approaches such as supportive or cognitive
therapy that rely on the frontal cortex to damp down amygdala response tend to be slow, incremental, and subject to relapse because the underlying emotional reactivity remains. Research that demonstrates that when effective therapy is combined with medication, better, longer-lasting positive outcomes occur than with medication alone (Rothbaum et al., 2006; van der Kolk, et al. 2007). Although limited trauma content is included in graduate psychiatric nursing programs, 60.6% respondents rated their confidence in treating patients with psychological trauma a 4 or 5 on a 5 point scale. One respondent stated that serendipitously s/he learned from a preceptor who had an interest in trauma. Some of the comments from participants noted that further trauma training education was obtained through conferences, workshops, trainings, and continuing education programs. Obviously the need for continuing education for trauma treatment was felt, with over 77% of respondents seeking such opportunities. This indicates that psychiatric APRNs do perceive a need for more trauma training and seek out opportunities to learn about therapy skills for this population. In addition, the majority of those who did learn these skills said they used these skills “very often”. This finding attests to the need for such skills in clinical settings.

Of concern is that the respondents identified only 51% of their patients as suffering from trauma. This is far short of estimates from epidemiological studies (CDC, 2010) and research has found that adults receiving treatment for severe and persistent mental illness, substance abuse, eating disorders, anxiety, and depressive disorders are highly likely to be survivors of trauma (Brown et al., 2009; Chu, 2011; Read, 2010; Teicher, 2012). The incidence of trauma is even greater for those served by public health mental health and substance abuse service systems (Grubaugh, Zinzow, Paul, Egede, & Frueh, 2011). It is likely that psychiatric advanced practice nurses encounter many more patients who are survivors of trauma than they recognize.
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Future Directions

This survey highlights the critical need to develop trauma competencies for graduate psychiatric nursing education with the majority of respondents (52.5%) reporting that their graduate program did not prepare them adequately to provide care for patients suffering from psychological trauma. Both the PMHNP Competencies (National Panel, 2003) and our Scope and Standards of Practice (American Nurses Association, 2013) include psychotherapy skills as essential for the PMHNP role. Graduate programs are accredited by CCNE if they meet the 2003 PMHNP Competencies, so programs are at risk of losing their accreditation by not including psychotherapy content. At present, the Competencies do not specify specific modalities for psychotherapy or trauma training.

Evidence-based psychotherapies for trauma should be included in the curricula of our programs. These competencies can provide the foundation for future training of a vibrant, effective psychiatric nursing workforce. Identification of trauma content, skills and competencies for advanced practice psychiatric nurses can lead the way for our colleagues in other specialties towards truly integrative care without the silos of medical vs. psychological care. Because PTSD has been linked to cardiovascular disease (Roy, Foraker, Girton, & Mansfield, 2015) and life threatening medical disorders, especially in children (Stuber & Shemesh, 2006), and there is a high incidence of medical illness in those who have suffered childhood trauma (Felitti & Anda, 2010); the integration of traumatology should include both undergraduate and graduate nursing programs. Leveling this content would ensure an enlightened workforce so that proper assessment and treatment can be delivered.

One such effort toward a trauma competency model for graduate level curricula for mental health providers is the New Haven Trauma Competencies, developed by the Yale New
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Haven Department of Psychiatry in collaboration with the National Center for PTSD (Cook & Newman, 2014). This evidence-based model consists of five broad competencies that include scientific knowledge about trauma, psychosocial trauma-focused assessment, trauma-focused psychosocial intervention, trauma-informed professionalism, and trauma-informed relational and systems. The consensus model might serve as a compass for psychiatric APRN trauma competencies.

Although there is growing interest in offering courses in traumatology in graduate courses for mental health practitioners, there are few references exploring how to teach graduate students about trauma. A search of the literature found one article describing a model for teaching trauma based on the principles of trauma treatment for patients: resourcing, titrated exposure, and reciprocal inhibition (Black, 2006). Specific pedagogical strategies were designed to prevent the vicarious traumatization that can occur when exposed to traumatic material. This important model illustrates not only how to deliver trauma content, but how to take care of oneself in a future practice that inevitably will include working with traumatized people.

Teaching about trauma and trauma treatment affects students through exposure to disturbing content. Exposure to trauma in the classroom is necessary when one is learning how to treat psychological trauma. A co-author (Kathleen Wheeler) often passes out an excerpt from the book, When Bad Things Happen to Good People (Kushner 1978) to her students. This is because the collective mood of the class becomes predominately sad after a semester centered on trauma-focused care. The challenge is how to teach this content without the accompanying vicarious traumatization that so often occurs for those who work with these patients.

In addition to integrating trauma into graduate psychiatric nursing programs, CEUs for trauma and psychotherapy skills could be required for PMHNP recertification by the ANCC just
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as pharmacology CEUs are required. This would ensure that graduate PMHNPs would increase their knowledge of psychotherapy skills. Research documents that the best results are obtained when therapy is provided as well as medication; that positive outcomes last longer when psychotherapy is offered; and that people adhere to medication better when there is a therapeutic relationship.

This survey provides valuable information about psychiatric APRNs’ perception of their knowledge about traumatology and psychotherapy for trauma and points to the need for future studies. A survey of the directors of graduate psychiatric nursing programs would yield more specific information about trauma content and skills in working with this population. There were only seven respondents who reported working in the academic arena. Their most common practice environment associated with this work was identified as “private practice.”

Limitations

This research relied on a convenience sample of 118 APRNs of various education, certification and experience. The mean age of the respondents was 52, perhaps reflective of the demographics of advanced practice psychiatric nurses who participate in the APNA on-line professional discussion boards and attend the annual APNA conference. While the mean age of respondents is older, the cohort is actively involved in their profession, as evidenced by their participation in APNA and large number who completed their graduate education (50%) between 2007 and 2014.

Because of the use of convenience sampling and limited sample size, the views expressed in this survey research may not reflect the opinions and experience of advanced practice psychiatric nurses in general. Research using a larger sample size and more diverse age
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representation could yield additional helpful information on the question of APRN preparation to treat psychological trauma.

Conclusions

The results of this research indicate the majority of APRNs responding to this survey received inadequate education on treating psychological trauma in their graduate program. Given the ubiquity of traumatic events, the pervasive physical and emotional sequelae of trauma, and the existence of evidenced based psychological treatments, there is a critical need to provide core curriculum instruction in psychological treatment of trauma. Psychiatric APRNs have an ethical mandate to provide safe, effective care for all individuals, including highly vulnerable, traumatized patients.
References


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Subica, A. M., Claypoole, K. H., & Wylie, A. M. (2012). PTSD’s mediation of the relationships between trauma, depression, substance abuse, mental health, and physical health in
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### Table 1

**Instructional Topics and Helpfulness**

<table>
<thead>
<tr>
<th>Question: Did you receive instruction on:</th>
<th>Valid n</th>
<th>No %</th>
<th>Yes %</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The identification of populations at risk for experiencing psychological trauma?</td>
<td>117</td>
<td>21.4</td>
<td>78.6</td>
<td>3.73 (SD = .973)</td>
</tr>
<tr>
<td>Physiologic responses to events triggering significant psychological trauma?</td>
<td>117</td>
<td>19.7</td>
<td>80.3</td>
<td>3.88 (SD = .993)</td>
</tr>
<tr>
<td>Medical diagnoses associated with the experience of significant psychological trauma?</td>
<td>118</td>
<td>41.5</td>
<td>58.5</td>
<td>3.94 (SD = .906)</td>
</tr>
<tr>
<td>Specific mental health diagnoses associated with the experience of significant psychological trauma?</td>
<td>116</td>
<td>15.5</td>
<td>84.5</td>
<td>3.99 (SD = .979)</td>
</tr>
<tr>
<td>Principles of “trauma informed care” (i.e., understanding the impact of trauma, promoting safety for the traumatized client, supporting patient choices and autonomy, maintaining personal boundaries, and avoidance of re-traumatization)?</td>
<td>117</td>
<td>44.4</td>
<td>55.6</td>
<td>3.80 (SD = 1.003)</td>
</tr>
<tr>
<td>Stabilization skills to prepare patients for trauma treatment, such as progressive muscle relaxation, imagery, safe place, relaxation, breathing, grounding, dual awareness, and mindfulness?</td>
<td>118</td>
<td>45.8</td>
<td>54.2</td>
<td>3.75 (SD = 1.155)</td>
</tr>
<tr>
<td>Delivery of patient care using evidence-based modules for trauma treatment, such as EMDR, cognitive restructuring, exposure therapy or others?</td>
<td>117</td>
<td>43.6</td>
<td>56.4</td>
<td>3.45 (SD = 1.199)</td>
</tr>
</tbody>
</table>

*On a scale of 1 to 5, with 1 being “not at all helpful” to 5 being “extremely helpful.”*
### Table 2

**Percent of Patients in the APRNs’ Practice Who Suffer Psychological Trauma**

<table>
<thead>
<tr>
<th>% of patients</th>
<th>n</th>
<th>% of patients</th>
<th>n</th>
<th>% of patients</th>
<th>n</th>
<th>% of patients</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>30</td>
<td>11</td>
<td>51</td>
<td>1</td>
<td>80</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>35</td>
<td>4</td>
<td>55</td>
<td>1</td>
<td>85</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>40</td>
<td>3</td>
<td>60</td>
<td>4</td>
<td>90</td>
<td>8</td>
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<tr>
<td>5</td>
<td>2</td>
<td>45</td>
<td>3</td>
<td>65</td>
<td>5</td>
<td>95</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td>6</td>
<td>49</td>
<td>1</td>
<td>67</td>
<td>1</td>
<td>99</td>
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<tr>
<td>15</td>
<td>4</td>
<td>50</td>
<td>11</td>
<td>70</td>
<td>6</td>
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<tr>
<td>25</td>
<td>7</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>Total</td>
<td>33</td>
<td>Total</td>
<td>26</td>
<td>Total</td>
<td>26</td>
</tr>
</tbody>
</table>

*Note. \( \bar{X} = 51.05\% \), median = 50%; SD = 28.566; range = 100*
### Table 3

*State Where Respondents Practice (Valid n = 115)*

<table>
<thead>
<tr>
<th>State of Practice (n = 5–9)</th>
<th>State of Practice (n = 4)</th>
<th>State of Practice (n = 2–3)</th>
<th>State of Practice (n = 1)</th>
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</thead>
<tbody>
<tr>
<td>State</td>
<td>n</td>
<td>State</td>
<td>n</td>
</tr>
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<td>CA</td>
<td>7</td>
<td>MA</td>
<td>4</td>
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<tr>
<td>FL</td>
<td>5</td>
<td>NC</td>
<td>4</td>
</tr>
<tr>
<td>IL</td>
<td>7</td>
<td>OR</td>
<td>4</td>
</tr>
<tr>
<td>MI</td>
<td>6</td>
<td>PA</td>
<td>4</td>
</tr>
<tr>
<td>OH</td>
<td>9</td>
<td>TN</td>
<td>4</td>
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<tr>
<td>UT</td>
<td>3</td>
<td>TX</td>
<td>4</td>
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<tr>
<td>WI</td>
<td>5</td>
<td>VA</td>
<td>4</td>
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