Military Culture Implications for Mental Health and Nursing Care

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Abstract

With over 13 years of war and military combat operations, the number of veterans, military families, and service members with mental health needs continues to increase across civilian and federal healthcare services. Knowledge about severe battle wounds, traumatic brain injury, and traumatic stress has influenced the delivery of healthcare. The invisible wounds of war associated with brain injury and traumatic stress will increase clinical care challenges into the foreseeable future. The purpose of this article is to describe two interrelated concepts, military cultural competence and stress injuries. The authors also differentiate stress reactions versus stress injury. Nurses with military cultural competence and knowledge about stress injuries will be better able to deliver patient-centered care to patients with military culture experiences.

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The Global War on Terrorism (GWOT) officially began on September 11, 2001 (U.S. Department of State, 2009) and continues more than 13 years later with a shift in focus from direct combat mission to support and training in often dangerous areas of the world. There is yet another American generation whose adolescence and young adulthood has been influenced, and arguably, defined by military culture and war. As of 2012, over 2.5 million women and men have served in GWOT combat with 1.56 million (78%) having left active duty and qualify for government care (Bilmes, 2013).

Only 41% of veterans who qualify for benefits from Veterans Health Administration (VHA) are enrolled in VHA care (Kang, 2008). The remainder of veteran’s healthcare occurs in civilian healthcare facilities. Understanding how military culture, policies, and research may influence mental health behaviors, help-seeking, and therapeutic relationships is important to nursing practice in a wide range of settings. Healthcare practices are one area where military culture and military healthcare policies have a direct impact on care and treatment across the continuum of care for both veterans and non-veterans.
As in past wars, medical discoveries and knowledge have progressed tremendously over the past decade. This knowledge comes with a significant cost in lives, quality of life, and resources. The mental health impact on post 9/11 veterans alone includes post-traumatic stress (49% for combat veterans); family life strain (48%); anger management problems (47%); and readjustment problems (44%) (Pew Research Center, 2011).

In 2007, the U.S. Congress appropriated over $600 million to focus on traumatic brain injury (TBI) and posttraumatic stress disorder (PTSD) for military personnel (U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007). Annual Congressional funding for research, treatment, mental health promotion programs, and hiring clinical professionals remained near that level for over four years (Institute of Medicine [IOM], 2014). Long-term goals for this funding were to improve access to care and quality of clinical services, and to promote innovations to improve the quality of life for injured and wounded service members and veterans. These efforts have produced volumes of new data, concepts, and clinical interventions to further understanding and improve the mental health and neurological care of service members and their families.

The purpose of this article is to describe two interrelated concepts that are important for understanding the mental health needs of service members, veterans, and their families. The first concept is military cultural competence. As with other forms of cultural competence, nurses need to identify and understand the needs, help-seeking behaviors of our clients and tailor services that are culturally relevant.

Understanding military culture was critical to the development of the second concept; stress injury. Most people recognize that trauma exposure is an occupational hazard for military members. This focus on trauma created a discourse about post-traumatic stress disorder and traumatic brain injury as the signature wounds of the Iraq and Afghanistan veterans (Tanielian & Jaycox, 2008). Unfortunately, when healthcare professionals, health policy leaders, and the public look for disorder and illness there are missed opportunities to prevent mental illness and support mental health promotion. Nurses working with veterans and their families in a wide range of clinical environments need to be able to assess early signs of stress injury, create opportunities to address stress related functional changes, and account for the impact of stress injuries in treatment planning.

Military Cultural Competence

Nurses are expected to communicate and interact effectively with a broad range of clients with varied cultural origins and to work within a patient’s cultural context (Camphinha-Bacote, 2011). Cultural competence training tends to focus on people with ethnic and language influences that impact healthcare literacy and health practices. Military culture includes patterns of beliefs, language, and cultural practices that impact use of healthcare services and health practices.

The need to develop healthcare professional training and awareness specific to military culture was identified from an unintended consequence of expanding mental health services. From 2007 through 2010, the Veterans Health Services (VHS) and Department of Defense (DoD) hired over 10,000 mental health and neurocognitive professionals. Most of these new hires had little to no military experience. Many of the new hires adapted quickly and integrated military culture skills into their practice based on trial and error; but many did not. Skilled clinicians who did not incorporate military cultural competencies into practice created an additional barrier to care and help-seeking.

Military culture includes patterns of beliefs, language, and cultural practices that impact use of healthcare services and health practices.

The need for providers with military cultural competence has been identified by service members who received quality, evidenced-based care (e.g., manualized cognitive behavioral therapy), but felt the delivered therapy was not relevant or that their provider did not actually understand the context of military trauma (Acosta et al., 2014). A young military spouse described, “Sometimes, depending on the situation, it was too difficult to try to take the time to teach them [provider] when we are going to them for help, there were a couple of times where we changed providers because it was frustrating and they did not have an understanding.” (Center for Deployment Psychology, 2014; available: www.deploymentpsych.org/faces-of-military-culture, select “On Cultural Competent Care”, Play Video 96). A recent survey of behavioral health and primary care providers in Maryland identified
Military culture shapes a shared set of behaviors, beliefs, and values that are learned and reinforced through the lived experience of military service. Nurses need to understand that military cultural influence includes people beyond those who have worn a uniform. People who are directly influenced by military culture include: uniformed service members, civilian defense employees, veterans, and their families (Convoy & Westphal, 2013). "Military culture can be defined as the sum total of all knowledge, beliefs, customs, habits, and capabilities acquired by service members and their families through membership in military organizations" (Center for Deployment Psychology, 2014; Select "Take the Course" then select Module 1, p. 21). Military culture shapes a shared set of behaviors, beliefs, and values that are learned and reinforced through the lived experience of military service. People who have not directly experienced the military culture often see the explicit representations of military culture; uniforms and other clothing, customs, training, weapons, media images; and infer how military culture influences service members, veterans, and their families. It is important for nurses and other healthcare professionals to recognize explicit representations of military culture and learn about implicit representations, values, and beliefs, on the health behaviors of those who are members of the military culture.

One area in particular that can be problematic is the tension between the public discourse of military service as heroic and the experience military members and their families have in their daily lives and across their careers. Military service members are often referred to as “heroes” in our public discourse. For those outside of the military culture, many of the characteristics of the military ethos are consistent with the Greek concept of heroes. The rhetoric of heroism often simplifies and misses the complexity of military culture and military ethos.

Military ethos is sometimes called the warrior ethos. The term "warrior ethos" is used most often when referring to those trained in the combat arms specialties; military roles that engage an enemy in combat. The term “military ethos” applies to all those who serve in the military and includes diverse roles ranging across many specialties such as, logistical support, medicine, and intelligence. The military ethos reinforces and rewards selflessness, courage, loyalty, stoicism, and commitments to excellence, living by a moral code, and defending the social order (Coker, 2007; French, 2003; Pressfield, 2011). For some service members, the military and warrior ethos becomes a permanent part of their self-identity and worldview. Figure 1 depicts a U.S. Army soldier’s tattoo of the Army Warrior ethos.

Figure 1. U.S. Army Soldier with Warrior Ethos Tattoo

Figure 1. Inscription:

Warrior Ethos
I will always place the mission first
I will never accept defeat.
I will never quit.
I will never leave a fallen comrade.
Stigma regarding mental illness related behaviors, labels, and behavioral health treatments is strongly influenced by the military ethos.

It is important to recognize that learning about and understanding military culture begins with self-reflection and self-assessment regarding one's own experiences and beliefs about the military, military culture, and those who choose to serve in uniform or as civilian employees of military and veteran organizations. It is important to recognize that learning about and understanding military culture does not mean that nurses must agree with or support the how the U.S. Government engages the military role.


In many ways, the military ethos is an unattainable ideal that influences daily lives of those who work, live, and have experienced military culture. Someone outside of the military culture may see striving to live by military ethos ideals as heroic, while the person living within the military culture may be acutely aware of their failings to meet those ideals.

Culturally competent care for service members and veterans may hinge on understanding the extent to which individuals identify with the military ethos. The military ethos values and beliefs have a powerful influence on recognizing and interpreting symptoms, help-seeking behavior, and engagement with healthcare services (Tanielian & Jaycox, 2008). Stigma regarding mental illness related behaviors, labels, and behavioral health treatments is strongly influenced by the military ethos (Ben-Zeev, Corrigan, Britt, & Langford, 2012; Hoerster et al., 2005; Vogt, 2011).

The military ethos can be a strength and vulnerability for service members, veterans, and military family members when facing life stress and mental illness symptoms (Center for Deployment Psychology, 2014; Module 1 Slide 47). Military ethos is a source of strength and resilience when it helps individuals, families, and groups engage resources and leverage emotional and instrumental supports, and promotes hope. Military ethos can be a vulnerability when beliefs act as a barrier to resources, supports, and hope. Table 1 presents some of the strengths and vulnerabilities associated with military ethos traits.

### Table 1. Military Ethos Strengths and Vulnerabilities

<table>
<thead>
<tr>
<th>Strength</th>
<th>Trait</th>
<th>Vulnerability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placing the welfare of others above one’s own welfare</td>
<td>Selflessness</td>
<td>Not seeking help for health problems because personal health is not a priority</td>
</tr>
<tr>
<td>Commitment to accomplishing missions and protecting comrades in arms</td>
<td>Loyalty</td>
<td>Survivor guilt and complicated bereavement after losing friends</td>
</tr>
<tr>
<td>Toughness and ability to endure hardships without complaint</td>
<td>Stoicism</td>
<td>Not acknowledging significant symptoms and suffering after returning home</td>
</tr>
<tr>
<td>Following an internal moral compass to choose “right” over “wrong”</td>
<td>Moral Code</td>
<td>Feeling frustrated and betrayed when others fail to follow a moral code</td>
</tr>
<tr>
<td>Meaning and purpose when defending societal values</td>
<td>Social Order</td>
<td>Loss of meaning or betrayal when rejected by society</td>
</tr>
<tr>
<td>Becoming the best and most effective professional possible</td>
<td>Excellence</td>
<td>Feeling ashamed of (or not acknowledging) imperfections</td>
</tr>
</tbody>
</table>

DVA (2014). Module 1

Developing military cultural awareness begins with self-reflection and self-assessment regarding one’s own experiences and beliefs about the military, military culture, and those who choose to serve in uniform or as civilian employees of military and veteran organizations. It is important to recognize that learning about and understanding military culture does not mean that nurses must agree with or support the how the U.S. Government engages the military role.
Nurses and other healthcare professionals do need to be able to recognize, assess, and understand the degree to which military culture influences a patient or family and how strongly the patient relates to or rejects the military ethos.

Fortunately, many resources related to developing military cultural awareness have been developed over the past few years. One resource in particular is designed to assist nurses and healthcare professionals to move beyond awareness toward cultural competence in clinical practice. Table 2 provides information about a no fee, eight contact hour online course designed to provide core military cultural competencies (DVA, 2014).

Table 2. Military Culture Training Course

| Sponsor: Department of Veterans Affairs and the Center for Deployment Psychology |
| Continuing Education: 8 ANCC Contact Hours. 2 contact hours for each module. |
| Fee: None |
| Expires: November 8, 2015 |
| Module 1: Self-Assessment and Introduction to Military Ethos |
| Module 2: Military Organization and Roles |
| Module 3: Stressors and Resources |
| Module 4: Treatment, Resources, and Tools |
| Weblink: www.deploymentpsych.org/military-culture |

DVA (2014)

Stress Injury

TBI and PTSD have been called the invisible wounds of war mainly because there are minimal physical deformities or obvious scars. These wounds are far from invisible, if one knows where to look. The evidence of the wounds is found in diminished quality of life, impaired occupational functioning, loss of family integrity, and myriad physical and cognitive impairments. These invisible wounds can impact the context of care. Combat deployments are associated with increased risk of posttraumatic stress disorder, depression, suicide, substance abuse, and eating disorders that impact between 12% and 23% of those deployed (Wells et al., 2011). Prevalence rates of mental disorder diagnoses do not capture the broader range of mental health impact that is associated with the military occupation that includes combat deployments; non-combat and humanitarian operations; family separation for training; and international peace keeping roles and reintegration challenges for service members, their families, and military communities. The broader context of behavioral health impact associated with military service can include stress reactions such as impaired sleep, cognitive functions, and relationships; and drug use (SAMSHA, 2012).

Part of the goal to shift the discourse toward injury was to decrease diagnostic stigma, while increasing recognition that stress injuries were similar to physical injuries in needing immediate care to reduce risk of further harm.

To address broader issues of behavioral health impact versus focusing on impairment, the military services developed various programs that focused on stress injury and resilience. These programs were consistent with individual military branch culture. Initially, stress injuries were referred to as combat and operational stress reactions (COSR) or injuries (COSI). Part of the goal to shift the discourse toward injury was to decrease diagnostic stigma, while increasing recognition that stress injuries were similar to physical injuries in needing immediate care to reduce risk of further harm. Nurses working with service members, veterans, and families need to listen for and be ready to use the concept of stress injury. Stress injuries are defined as:

More severe and persistent distress or loss of functioning caused by disruptions to the integrity of
Stress Reactions Versus Stress Injury

Hans Seyle’s (1956) work on the Global Adaptation Syndrome (GAS) provided knowledge and insights that everyone responds to stress as a human physiological event. Stress reactions have both physiological and psychological components. In stress reactions, the stress response will diminish and the person returns to baseline behaviors when the stressor is removed or when the person uses additional coping resources. Stress reactions are normal, expected, and transient.

Typically, people with stress reactions do not need helping interventions or have long-term health issues. A tree branch bending in the wind is one of the metaphors used for teaching patients about the differences between stress reactions and stress injury (Nash, 2011). Like the prevailing wind, a stress reaction causes a branch to bend but not break. The bending of the branch helps to make it stronger and more resilient. If the force of wind is too strong or the tree already has a vulnerability, there is risk of the branch breaking.

Stress injuries are different from stress reactions in that the stress response stays active after the stressor is removed or does not diminish when additional coping resources are used. Stress injuries are often associated with sustained GAS response that is further activated by routine life stressors and often associated with cardiovascular, respiratory and GI system reactivity. Changes in role functions such as difficulty in intimate relationships, decreased work or school performance, and diminished competency in coping skills begin to create additional sources of stress that can exceed in immediacy the original stress injury stressor.

Key behaviors that signal potential stress injury include persistent functional impairment in any of several areas including: sleep, emotions, cognitions, self-calming, anger, memory, enjoyment, moral/ethical decision making, personal safety (Nash, 2011). Common metaphors used to understand stress injury include a scar from a wound or a tattoo. Scars represent the remnants of a wound that will fade over time but will never disappear. The tattoo as metaphor for stress injury has been useful for helping patients and family members understand stress injury behaviors. The ability to see stress injuries is like seeing tattoos. Some tattoos are hidden and only can be seen by trusted others. Some tattoos peek out from under the edge of clothing to indicate something is there, but not clearly what. Other tattoos vividly declare an image for all to see.

While there are hundreds of different types of stressors that can cause stress reactions, there are four classes of stress exposures identified as sources of stress injury. The four sources of potential stress injury are life threat; loss; wear and tear; and inner conflict (USMC & USN, 2010; Nash, 2011). A demand-resource imbalance is proposed as the primary pathway from stress reaction to stress injury (Bates et al., 2010). Demands are stressors that require biological, psychological, social, and spiritual resources to be engaged to meet coping challenges.

Acute demand stressors that have the potential to rapidly exhaust or overwhelm coping resources include life threat, loss, and inner conflict. Chronic stressors require that resources be replenished regularly; exhausting resources over time leads to wear and tear. Nursing burnout is an example of a wear and tear stress injury. Most people have adequate coping resources to meet significant stress demands. However, when the sources of stress injury begin to overlap, there are additional demands that may lead to stress injury or stress related illnesses. It is important for nurses to understand that trauma is not the only pathway to stress injury.
It is important for nurses not to assume that a traumatic exposure may be the patient’s most problematic experience.

**Life Threat – Trauma**

Perceiving that your life or the life of someone you care about deeply is at risk, witnessing trauma in person, or repeated exposure to traumatic event details are stressors that place immediate demands on coping resources. This can result in a traumatic stress injury if resources are overwhelmed. The exposure is a potentially injurious event. Functional impairment related to the exposure is the injury. Functional impairment plus intrusion symptoms, avoidance, impaired mood or cognitions, or marked reactivity would be the stress illness of PTSD. Not everyone who experiences any given exposure will develop trauma stress injury or go on to develop PTSD. The concept of exposure, injury, illness can help explain why not everyone who experiences a traumatic event will experience functional impairment or disorder. It is important for nurses not to assume that a traumatic exposure may be the patient’s most problematic experience.

**Loss — Grief Injury**

Loss is the experience of separating from a person, a cherished object, or an ideal before being ready to let go. In many ways, it is the substantial emotional penalty for an early withdrawal. One of the most profound loss experiences is the traumatic death of a loved one. Death as a loss often produces an intense grief response. Grief is the physical, psychological, and spiritual reaction to the perception of loss (Rando, 1984). Intense grief often results in somatic distress, preoccupation with the deceased, guilt, diffuse anger, and loss of functions in daily living (Lindemann, 1944). Loss is the potentially injurious event and grief is the stress injury.

...that the traumatic loss of a military buddy, a brother or sister in arms, can be as powerful as the loss of a spouse, parent, or a sibling.

In many ways, traumatic loss is one of the clearest examples of a stress injury that is not immediately considered an illness. There is an identifiable stressor that creates an overwhelming demand on coping resources that often results in immediate functional impairment. The common peer response is to immediately provide additional physical, psychological, and spiritual resources. The activation of instrumental social supports is an often used response, depending on the social context of the loss. The expectation is that by augmenting resources the person will be able to “work through” the grief and regain functional skills. Yet, the loss experience has left a scar, an experience that is sensitive to sights, sounds, smells, or a memory that may produce future episodes of functional impairment.

People with grief injuries are often afforded time, resources, and socially sanctioned expectations to facilitate healing. It is important for nurses to understand that the traumatic loss of a military buddy, a brother or sister in arms, can be as powerful as the loss of a spouse, parent, or a sibling. Service members whose role is to deploy in combat will often talk about the bond of love that is forged through training and facing an enemy.

**Inner Conflict — Moral Injury**
Moral and ethical challenges can create inner conflict. Inner conflict as a potentially injurious experience occurs by, "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009, p.700). The process of aspiring to live in accordance with military ethos and the harsh reality of combat and disaster experiences are fraught with inner conflict. Inner conflict increases the demand on moral, ethical, and existential resources needed for renewal and reconciliation.

Moral injury occurs when individuals are unable to separate the implications of an event from their own identity. Poor integration leads to guilt, shame, and anxiety and persistent psychological distress, intrusive thoughts, and avoidance of potential triggers (Litz, et al. 2009). Mental health implications from moral injury include increased risk of self-harm behaviors, ranging from poor self-care though active self-injury; self-handicapping behaviors; undermining successes or feelings of joy and happiness; and demoralization, ranging from persistent sense of hopelessness through active self-loathing (Litz et al. 2009).

Assessing the presence of moral injury is challenging. Key words that may indicate the presence of moral injury are: could’ve, should’ve, ought’of, and only if. Nursing practice implications for recognizing moral injury include understanding that patients may not believe that they deserve care and compassion and may behave in a manner that ensures rejection. For example, a service member who was randomly pulled off of an assignment where his or her replacement was killed may believe that he or she should be dead instead. Additionally, the shame and guilt that can accompany moral injury often requires the development of a trusting therapeutic relationship over time, time that may not be available in many clinical encounters (Staal, 2004).

Wear and Tear – Fatigue Injury

Long-term exposure to ongoing stressors from multiple sources without adequate renewal of coping resources is a potentially injurious experience. A single event may not rise to the level of creating functional impairment or injury. Yet, over time, the accumulation of daily hassles, sleep deprivation, poor nutrition, strained social relationships, occupational stress, and loss of self in monotonous daily routines takes a steady toll on physical and psychological health (Staal, 2004). The demands of repeated deployments; navigating multiple deployment cycles of pre-deployment training and anticipation; deployment strain and worry; and post-deployment reintegration until the next pre-deployment cycle create a baseline of sustained stress for many service members and military families.

A fatigue stress injury is identified when there are sustained functional changes in important roles, activities of daily living, or reactivity to new stressors. A fatigue stress injury is similar to other forms of chronic occupational stress including burn-out and work-related stress illness. One of the challenges for people who have a fatigue stress injury is to recognize that their behavior is injured. The onset is slow and insidious with subtle changes over time, making it difficult to identify a point where their stress reactions and tolerance changed. In high stress organizations and jobs, the presence of stress injury may be endemic, reducing further the ability to see one’s behavior as out of sync.

Principles of nursing care have long recognized the impact of chronic stress on health, illness, and recovery. The nursing implication for working with service members, veterans, and families is to understand that they may not recognize multiple simultaneous stressors as being unusual or problematic. Additionally, it is important to remember that the presence of a fatigue stress injury can reduce the availability of coping resources when trauma, loss, or inner conflict events occur.

The fatigue stress injury can play an important role in delayed responses. For example, the first deployment may have traumatic exposure and loss events. A second deployment experience may have moral injurious events. However, it was the third deployment with seemingly minor or few stressful events that brought all four sources of stress injury into a focus that severely impacted function and quality of life.

Conclusion
Proper diagnosis and the delivery of quality care does not change because a patient or family has military culture related experiences, injuries, or health problems. What does change is the context that those who have lived and worked within the military culture may bring to the healthcare experience and the therapeutic relationship. It is important that nurses be able to recognize the influence of military culture, given the potential strengths and vulnerabilities that the military ethos can interject in expression of symptoms, help-seeking behaviors, or the willingness to stay engaged in treatment.

The language of psychological health and mental disorders has been shifting within the military services since 2007 (USMC & USN, 2010; Meredith, et al., 2011). To assess and understand potential mental health issues for patients influenced by military culture, it is important to be knowledgeable about the concept of stress injury. Identifying the presence of one or more sources of stress injury, and knowledge about which source of stress injury is dominant in the patient current life experience, has potential to improve diagnostic accuracy and facilitate true patient-centered care versus diagnosis-centered services.

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