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A Clinical Practice Guideline to Reduce Behavioral Outbursts in Veterans with Posttraumatic Stress Disorder

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Mary Badru

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2017

Abstract

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MSN, Kean University, 2007

RN, Helen Fuld College of Nursing, 1999

Project Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Nursing Practice

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Abstract

In a Department of Veterans Affairs hospital on the East Coast of the United States, behavioral outbursts result in 2 out of 10 veterans dismissed from a posttraumatic stress disorder (PTSD) unit prior to completing the 6-week program. The purpose of this evidence-based quality improvement project was to create a clinical practice guideline (CPG) based on social cognitive theory (SCT) to provide new strategies for managing veterans with PTSD and to improve the confidence of the nurses in managing outbursts. The Star Model guided the project development with the Delphi method to achieve participant consensus, the AGREE II to assess the CPG quality, and the Generalized Self-Efficacy (GSE) scale to measure the change in participant knowledge and confidence. The literature was searched, compiled, assessed, and shared with 10 participants, registered nurses on the PTSD unit. Through the Delphi process, the participants achieved consensus (8/10) for the CPG, with two neutral participants. The GSE was administered pre- and post-test and analyzed using a paired t test to measure the mean differences of the GSE scores. The data was normally distributed to different scores to gauge the impact of the CPG development process on improving nursing knowledge and confidence was normally distributed [$t(9) = -4.188, p < 0.05, \&, t(9) = -2.714, p = 0.003$]. The data indicated a significant increase in participant knowledge about role of SCT, and confidence toward implementing the CPG into clinical practice. This project contributes to positive social change as nurses identified a clinical practice problem, transferred evidence about strategies from the literature into their clinical practice through a CPG, and implemented the CPG with the knowledge and confidence to impact patient care.

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Section 1: Nature of the Project

Introduction

The Department of Veterans Affairs (VA) hospitals offer specific services for veterans who have been diagnosed with posttraumatic stress disorder (PTSD). The success of the program has been marred by a percentage of veterans who either do not complete the program or require readmission to complete the program. According to Giardino (2009), PTSD is a psychiatric disorder due to combat exposure, which manifests with physical and emotional distress. The *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*) definition of PTSD is that it is an anxiety disorder that develops from traumatic events that can occur after childhood sexual abuse or a life-threatening trauma (Seides, 2010). The VA hospital involved in this project offers a PTSD program that includes therapy, education, support, and housing for 6 or 12 weeks. About 80% of the veterans complete the program without returning; however, 20% return to the program within 6 months (VA, 2010).

The current evidence-based method used for treatment is called trauma-focused behavior group therapy (TFBGT). The current treatment method did not address behavior crises occurring among participants during group activities. Hence, the purpose of this DNP project was to develop an evidence-based clinical practice guideline (CPG) based on social cognitive theory (SCT) to guide nursing practice for providing orientation as veterans enter the PTSD unit. The goal of incorporating SCT as part of the education provided by the nurses is to improve veteran outcomes, including improving the completion rates for the 6-week program. The project supported a nursing revision of the

existing veteran orientation package, which included provision of education. The star model of knowledge transformation (STAR) was utilized for this project.

PTSD can manifest following several physical and emotional traumas (Giardino, 2009). Because PTSD is one of the most visible and debilitating psychiatric disorders among soldiers in combat who receive their medical care from the VA, it has become a serious concern for VA hospitals and staff members (Foa, Keane, Friedman, & Cohen, 2008). Any treatment changes that improve the lives of veterans with PTSD contribute to positive social change.

Problem Statement

There are both cognitive and behavioral therapies available for treatment of PTSD. These treatments are primarily exposure-based. VA hospitals use several treatment approaches for PTSD: (a) cognitive therapy (Bisson, Roberts, Andrew, Cooper, & Catrin, 2013), (b) behavior modification (Sloan, Unger, & Beck, 2015), (c) family and group therapy (VA, 2013), (d) exposure therapy (VA, 2013), and (e) eye movement and desensitization (Greenwald & Shapiro, 2010a, 2010b). The goal for PTSD therapy is to identify the behavioral outburst triggers to effectively alter behavioral responses. This VA hospital uses TFBGT, an evidence-based method that includes therapy, education, support, and housing for 6 or 12 weeks as treatment. Eighty percent of veterans complete the program. However, 20% of those who complete the program return to the program within 6 months (VA, 2010). This method has limited effectiveness in addressing behavior crises occurring among participants during group activities. Hence, there is a need for an improved approach for veterans with PTSD.

More than 1,500,000 Americans participated in combat operations in Iraq and Afghanistan between 2002 and 2009 (Giardino, 2009). Between fiscal years 2009 and 2011, nearly 613,000 veterans accessed Veterans Health Administration (VHA) services. These veterans were relatively young (31.9 years \pm 9.6), and 29.3% of those veterans were diagnosed with PTSD (Cifu et al., 2013). The National Center for PTSD (2010) confirmed that 65% of military personnel who identified as having PTSD were exposed to high-intensity terrorist warfare and the chronic threat of roadside bombs and improvised explosive devices. Crum-Cianflone, Powell, LeardMann, Russell, and Boyko (2016) concluded that combat deplorers had the highest incidence rates of PTSD (25 cases per 1,000 person-years).

Nationally, the VA provides 6 weeks of inpatient PTSD treatment to about a half million veterans from Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn. The selected VA hospital for this project is located in the eastern United States. The facility has a 25-bed inpatient residential PTSD treatment program with a greater than 90% occupancy rate. Participants aged 19 to 69 come for therapy to either the 6-week PTSD program or 12-week PTSD with addiction program. The multidisciplinary staff includes psychiatrists, nurse practitioners, registered nurses, social workers, psychologists, recreation therapists, addiction therapists, chaplains, and dietitians. The major presenting diagnoses are PTSD, drug and alcohol, or drug or alcohol addiction. Major medical diagnoses include chronic pain, traumatic brain injury, hypertension, diabetes, and dental caries. Therapeutic activities include a range of

addiction programs, recreational and sleep therapy, and therapeutic and family meeting groups.

One evidence-based treatment method used at the VA is TFBGT. This treatment embeds exposure in a group context that includes psychoeducation, cognitive restructuring, relapse prevention, and coping skills training (Bisson et al., 2013). This was developed specifically for patients who might not otherwise tolerate or comply with individual exposure therapy. No evidence exists that these therapies support participants in gaining the self-confidence and self-control necessary to participate in or complete the program.

Behavioral outbursts continue to be an issue in this unit. Even though mental health practitioners at the PTSD unit are familiar with current evidence-based approaches, and though they are skilled at adapting these approaches to the needs of the veterans, 2 out of 10 veterans admitted for the 6-week PTSD program are expelled without completing the program. One out of 5 veterans who complete the program return within 6 months. These statistics indicate that a change may be needed in the protocol for treatment.

The creation of a CPG based on SCT and the education of the nurses on the use of the CPG may help the nurses in the PTSD unit to develop confidence in incorporating knowledge gained into the orientation process they present to program participants. Patient education is a fundamental competency in nursing care. Lahl, Modic, and Siedlecki (2013) discussed a relationship between patient education and positive patient outcomes. The rationale for introducing SCT, as defined by Benight and Bandura (2004),

into the orientation program is that the belief in one's capability to exercise some control over traumatic adversity is determined by self-confidence. As the nurses in the PTSD unit become confident in providing the proposed evidence-based education to veteran participants, veterans will become more self-assured and confident in group therapy, remain in the program, and benefit from the group therapy sessions. This will result in the reduction of a "revolving door" and irregular discharges, as well as save the VA millions of dollars.

According to the American Association of Colleges of Nursing, or AACN, (2006), doctoral-prepared clinical nurses should develop and evaluate new practice approaches based on theories from nursing and other disciplines. The practice question asks whether participating in the process of developing a new CPG will improve the knowledge and confidence of the nursing staff. Ultimately, the development of an evidence-based CPG based on SCT may have the impact of improving care for veterans with PTSD. Evidence from the literature has provided guidance on incorporating newer therapies into current practices. The nurses provide new program participants' orientation and set the stage for nursing care during their 6- or 12-week stay.

Purpose Statement

Even though mental health practitioners in this PTSD unit are familiar with current evidence-based approaches and are skilled at adapting these approaches to the unit's cultural and contextual conditions, there are still some unresolved clinical issues during group therapy. According to the nursing staff in the PTSD unit, issues include being distracted from the groups, disregarding other participants' expressions of trauma,

and offering unwelcome suggestions to group members. Furthermore, behavioral outbursts are a daily occurrence on this unit, and as a result, 20% of admitted veterans are expelled without completing the 6-week program. In addition, 20% of the veterans who complete the program return to the program within 6 months to ask for mental health assistance. After interacting with the PTSD staff, program participants, and therapists, it was suggested that the current TFGT is not as efficient as expected in keeping veterans in the program due to behavioral issues arising from group therapy.

The purpose of this project is to develop new guidelines for nursing practices that incorporate SCT, as this has shown notable success in other programs. Participation in this process may result in improving the knowledge of the nurses and their confidence in incorporating the guideline into the orientation process in a PTSD unit. Evidence from the literature has provided guidance for incorporating newer therapies into current practices. Doctoral-prepared nurses should develop and evaluate new practice approaches based on theories from nursing and other disciplines (AACN, 2006). With the nurses gaining confidence in their abilities and performance, they will effectively use the orientation package with new program participants and propose additional ways to incorporate SCT into nursing practices. The current orientation process conducted by the nurses upon entrance into the program includes the rules and regulations of the PTSD unit. The inclusion of new techniques using SCT may reduce the number of veterans who are unable to complete the program due to behavioral outbursts.

This practice change is based on the theory that as veterans become more self-assured and confident in group therapy, they will remain in the program and benefit from

the group therapy. This may result in reducing the “revolving door” cycle and eliminate unplanned discharges, as well as save the VA millions of dollars. The implementation and evaluation of the evidence-based orientation and practice updates is beyond the scope of this project.

Nature of the Doctoral Project

The proposed practice change is to revamp the orientation program that nurses provide to all participants during their first week of the program. Currently, the orientation package contains information about the two tracks of the program: PTSD treatment and the addiction program. The treatment approach is based on the needs of the participants. At the beginning of these programs, nurses explain the rules and regulations of staying in program. By incorporating the principles postulated by SCT into a CPG, nurses will acquire self-efficacy and self-confidence in incorporating principles into the orientation process. The nurses will then be able to change the approach from setting the rules and regulations of the program to transforming the knowledge they have gained through evidence-based theory. Bandura (1997, 1986a) has variously described self-efficacy as a mechanism, a construct, a facet, a generative capability, an outcome, and a mediator of behaviors.

Bandura’s (2004) social learning theory of change is referred to as *operant conditioning*, with the positive consequences outweighing negative. By using the proposed evidence-based orientation package, the nurses will help the participants develop confidence in themselves, and by developing coping self-efficacy, they will be

able to successfully participate in the program. This approach has emerged as a focal mediator of posttraumatic recovery (Bandura, 2004).

SCT (Bandura, 1986b) proposes that knowledge, behavior, and environment employ direct and common influence over each other and the individual. Benight and Bandura (2004) concluded,

Corroboration of the social cognitive theory of change's independent contribution to posttraumatic recovery across a wide range of traumas has lent support to the centrality of the enabling and protective function of belief in one's capability to exercise some measure of control over traumatic adversity. (p. 17)

Belsher, Ruzek, Bongar, and Cordova (2012) theorized that adjustment following trauma depends, in part, on interpersonal processing with supportive others, which is the foundation of group therapy. The clinical practice issue identified is behavioral outbursts, which may result in removal from the therapeutic group. Bandura (1986b) identified that for effective participation in group therapy and positive psychological outcomes, an individual needs coping self-efficacy or the perceived ability to manage the psychological and environmental demands associated with traumatic events.

The underlying concept of SCT is reciprocal determinism, which asserts that a behavior arises from the continuous, bidirectional interactions of people and their environments, and that resulting behavior, in turn, affects people and their environments (Bandura, 1986b). SCT postulates confidence in one's ability to engage in a specific behavior, goal, expectation, and that the behavior will have positive outcomes; these are the main contributors to health behavior. Program participants need to have confidence in

themselves. Glanz and Rimer (2005) explained that if individuals have a sense of self-efficacy, they can change behaviors, even when faced with obstacles.

STAR, a framework for the systematic integration of evidence into practice, will guide this project (Steven, 2012). STAR is composed of five major stages: knowledge discovery, evidence summary, translation into practice recommendations, integration into practice, and evaluation. STAR is one of the most commonly used frameworks that has influenced nursing practice (Stevens, 2012).

Transformation of evidence into practice requires two stages: the translation of evidence into practice recommendations and the integration into practice (Stevens, 2012). The aim of translation is to provide a useful and relevant package of summarized evidence to clinicians in a form that suits the time, cost, and care standard. The providers in turn integrate the evidence into their daily practice. Recommendations are generically termed CPGs and may be represented or embedded in care standards, clinical pathways, protocols, and algorithms. CPGs are tools to support informed clinical decisions for clinicians, organizations, and clients (Jaeschke et al., 2008). The strongest CPGs are developed systematically using a clear process that is reproducible. Stevens (2012) further stressed that summarized research evidence is interpreted and combined with other sources of knowledge (such as clinical expertise and theoretical guides) and then contextualized to the specific client population and setting. Evidence-based CPGs explicitly articulate the link between the clinical recommendation and the strength of supporting evidence or strength of recommendation.

The first step is a knowledge-generating stage where new knowledge is discovered through traditional research methodologies and scientific inquiry. This stage of development constructs the corpus of research about clinical actions. The literature review focused on the impact that SCT has in managing behavior in PTSD patients. Stevens (2013) suggested that the next step is to synthesize the body of research knowledge into a single, meaningful statement of the state of the science. The most advanced evidence-based practice (EBP) methods to date are those used to develop evidence summaries (i.e., evidence synthesis, systematic reviews). The systematic review method, according to Stevens (2013), is outlined in the Cochrane Handbook. This stage is also considered a knowledge-generating stage, which occurs simultaneously with the summarization. Evidence summaries produce new knowledge by combining findings from all studies while identifying bias and limiting chance effects in the conclusions. The systematic methodology also increases the reliability and reproducibility of results.

The summary of the literature and suggestions for new models of treatment will be made to the nursing staff and to other health care providers on the team for feedback. I provided a synthesis of the evidence gleaned from the literature and suggestions on how SCT could be incorporated into the current orientation process. I led the development guideline based on SCT and created a PowerPoint presentation on the use of the guideline for the nursing staff. The nurses' consensus proposal will be presented to interprofessional team members and to the Nursing Practice Council as part of the implementation process.

The next two stages of the model will not be a part of the project, but need to be understood in the context of changes in nursing practice. Integration is perhaps the most familiar stage in health care due to society's long-standing expectation that health care be based on the most current knowledge, thus it requires the implementation of innovations. This step involves changing both individual and organizational practices through formal and informal channels (Stevens, 2012). Major aspects addressed in this stage are factors that affect individual and organizational rates of adoption of innovations and factors that affect the integration of the change into sustainable systems.

The final stage in knowledge transformation is evaluation. In EBP, a broad array of endpoints and outcomes is evaluated. These include evaluation of the impact of EBP on patient health outcomes, provider and patient satisfaction, efficacy, efficiency, economic analysis, and health status impact. In conclusion, as new knowledge is transformed through the five stages, the outcome is the evidence-based quality improvement of health care. In this case, nurses in the PTSD unit will be involved in incorporating the new tailored package into the weekly orientation process. This new package will contain concepts be taught to veterans with the hope that those veterans will be able to successfully participate in the PTSD program.

Significance to Practice

Every system and organization encounters different challenges when implementing new practices at one time or another. McHugh and Barlow (2010) noted that many of the improvements that are initially successful fail to become part of the practices and procedures of the host organizations and communities. One organizational

force that may facilitate this evidence-based program in the PTSD unit is the VA recognizing the need to promote the use of best practices to achieve better outcomes in health care for veterans. This is in alignment with the VHA's vision (VA, 2013) to be the benchmark of demonstrating excellence and value in delivering patient-centered and evidence-based health services. To fulfill this vision, the VA has devoted significant capital and human resources to promoting research on EBPs, CPG implementation, and quality improvement programs. By nurses successfully developing, implementing, and evaluating the effect of the CPG, they will be fulfilling the VA's vision and Essential I of the AACN (2006), utilizing science-based knowledge as the basis for the highest level of nursing practices and upholding the highest ethical and legal standards.

Furthermore, many veteran organizations are very involved with the VA. In fact, a significant number of the hospital's volunteers are either retired veterans or their families want to give back to the veterans. Even though there is support from the VA, implementing this project is not without its barriers. Current trauma-based group therapy is administered by mental health practitioners (psychiatrists, psychologists) who report to a separate service line, but this proposed EBP will be administered by nurses. Another challenge might be the client's behavior, which is exhibited due to the disease process itself (PTSD), which Kettner, Moroney, and Martin (2008) called prerequisites to the existence of the problem.

Mental health is a state of the successful performance of mental function resulting in engaging in productive activities, fulfilling relationships with other people, and maintaining the ability to adapt to change and to cope with challenges (Department of

Health and Human Services [DHHS], 2010). Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to the community or society (DHHS, 2010). *Mental illness* is the term that refers collectively to all diagnosable mental disorders (DHHS, 2010), which is a growing area of research and practice. Early diagnosis and treatment is the key, but assessing and addressing mental health remains important to ensure that all Americans lead longer, healthier lives.

Maintaining positive mental health is essential for all individuals. According to the President's New Freedom Commission on Mental Health (2003), in their report *Achieving the Promise: Transforming Mental Health Care in America*,

We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community. (p. 11)

This report was the catalyst for the VA Action Agenda to transform mental health through implementing a national strategic plan for mental health. The plan was derived from the commission's report and approved by the Secretary of Veterans Affairs in the fall of 2004. The overall intent of the mental health strategic plan was to ensure all veterans have prompt access to state-of-the-art general and specialized mental health services, consistent with the vision of the President's New Freedom Commission on Mental Health (2003).

A major objective of the transformation of mental health care in VA hospitals is the transition to a patient-centered, psychosocial rehabilitation and recovery model with the goal of incorporating recovery into every level and type of mental health care. The most salient premise of this model is that individual veterans with mental disorders, including those with serious mental illnesses, can be active participants in their treatment and can improve and recover; that is, they can gain or regain the capacity to live a meaningful, self-determined life and thrive in their communities (VA, 2013). These guiding principles are consistent with VA initiatives to ensure care is personalized with patient involvement that is applicable to an inpatient mental health setting.

PTSD is a mental health illness that occurs in people who have visible encounters with traumatic events and have not been able to recover from those events (Chard, Gilman, Holleb, & Teeters, 2012). Thousands of veterans impacted with this disorder come through the VA seeking treatment. Even though the VA has made many strides in helping veterans cope with this disease, there is still much more to be done. One evidence-based mechanism of assisting the veterans may be the incorporation of SCT-based patient education provided by the nurses.

Evidence-Based Significance of the Project

SCT was developed by social scientists and has been successfully used in this field (Benight & Bandura, 2004). Within the PTSD unit, the expectation is for program participants to respect each other during treatment, which is not happening. Thus, there are daily behavioral outbursts in the unit, especially during group therapy sessions. If this expectation cannot be achieved, Bandura (1986a) stressed looking at the relationship

between expectation and self-efficacy. SCT suggests people need to engage in health-enhancing behaviors, not only to be confident in their ability to perform the behavior but to believe that the outcome of the behavior is beneficial.

Mental disorders are among the most common causes of disability, and the resulting disease burden of mental illness is seen by the DHHS (2010) as among the highest of all diseases. According to the National Institute of Mental Health (2015), in any given year, an estimated 13,000,000 American adults (approximately 1 in 17) have a seriously debilitating mental illness. Ferry et al. (2015) estimated the total direct and indirect cost of PTSD in Northern Ireland in 2008 to be £172,756,062. The World Health Organization (2013) identified PTSD as the leading cause of disability in the United States and Canada, accounting for 25% of all years of life lost to disability and premature mortality. Untreated PTSD could drive one to commit suicide (World Health Organization, 2013). The Centers for Disease Control and Prevention (2015) documented suicide was the 11th leading cause of death in the United States, accounting for the deaths of approximately 30,000 Americans each year.

According to the National Institute of Mental Health (2016), PTSD is an anxiety disorder some people get after seeing or living through a dangerous event. Feeling afraid is a natural response to danger that would trigger a fight-or-flight response (National Institute of Mental Health, 2015). This is a healthy reaction meant to protect a person from harm, but in PTSD, this reaction is damaged (National Institute of Mental Health, 2015). People who have PTSD may feel stressed or frightened, even when they are no longer in danger. In the *Diagnostic and Statistical Manual of Mental Disorders*

(American Psychiatric Association [APA], 2013), PTSD consists of re-experiencing, effortful avoidance, negative mood or cognitive symptoms, and hyper excitement (Vermetten, Baker, Jetly, & McFarlane, 2016).

Working collaboratively with mental health practitioners to enhance existing PTSD treatments is in alignment with the Institute of Medicine's (IOM, 2011) recommendation for nurses to act as full partners in redesigning efforts while working collaboratively with leaders from other health professions. IOM also charged nurses as full partners, taking responsibility for identifying problems and areas of system waste, for devising and implementing improvement plans, tracking improvement over time, and making necessary changes to realize set goals.

Implications for Social Change in Practice

Untreated PTSD could lead to social, political, technological, or financial consequences for taxpayers and the community. The long-term implications of untreated PTSD include quality of life issues, impaired psychosocial and occupational functioning, impaired overall well-being, and suicide (Schnurr, Lunney, Bovin, & Marx, 2009). It is necessary to develop strategies that will be effective and efficient in dealing with PTSD. In a prospective cohort study, 10,671 U.S. service members joined after September 11, 2001, to determine incidence rates and comorbidities of mental and behavioral disorders (Crum-Cianflone et al., 2016). As more than 40% reported combat-related PTSD, Crum-Cianflone et al. (2016) concluded that U.S. service members joining during recent conflicts experienced high rates of mental and behavioral disorders. The highest rates were among those deployed to combat. Because most cases were not represented in

medical codes, Crum-Cianflone et al. (2016) suggested that targeted interventions are needed to address the burden of mental disorders among service members and veterans.

Assumptions and Limitations

Some predictors of behavioral outburst, such as psychiatric history, are fixed and cannot be modified (Wild et al., 2016), which may limit the success of the guideline. Thus, it was also assumed that the nurses in the PTSD unit would contribute to this practice improvement project. This project is limited to one VA hospital in the northeastern United States.

Summary

Untreated PTSD can lead to social, political, technological, or financial consequences for taxpayers and the community. The long-term implications of untreated PTSD include quality of life issues, impaired psychosocial and occupational functioning, overall well-being, and suicide (Schnurr et al., 2009). The current TFGT is not as efficient as expected in keeping veterans in the program due to behavioral issue arising from group therapy. Hence, the purpose of this project is to create a CPG based on SCT with the nurses in the PTSD unit. The acquisition of knowledge in using the CPG should enable the nurses to incorporate it into their practice to improve the orientation process for veterans entering the PTSD unit. Evidence from the literature provides guidance for incorporating newer therapies into the current ones. This EBP protocol could improve the way that the VA provides culturally competent treatment plans for veterans. Successful implementation of this project may ultimately enable veteran participants to remain in the program, to successfully participate, and to live a productive life in the community. This

is in alignment with the AACN (2006) Essential VII and VIII: Apply sophisticated advanced nursing practice knowledge to support the design, implementation, and evaluation of comprehensive approaches that promote patient and population health outcomes.

Section 2 will elaborate more on the concepts, models, and theories behind this approach. The relevance to nursing practice and the role of the DNP student will be discussed in detail.

Section 2: Background and Context

Introduction

Even though mental health practitioners in the PTSD unit at the VA hospital are familiar with current evidence-based approaches and are skilled at adapting these approaches to the individual needs of veterans, behavioral outbursts continue to be an issue on this unit. Currently, 2 of 10 veterans admitted are expelled without completing the program, and 1 of 5 veterans who complete the program return within 6 months. These data indicate a change may be needed in the treatment processes or in practices. This project will result in the development of an evidence-based CPG based on SCT to improve the nursing orientation process and nursing care for veterans entering the PTSD unit. With the CPG and education about how it is used, the nurses can confidently translate the knowledge acquired during the project into improved nursing practices. Education is a fundamental factor for enhancing nursing care. Lahl et al. (2013) explained a relationship between education and positive patient outcomes.

The rationale for the SCT of change is, as defined by Benight and Bandura (2004), the belief in one's capability to exercise some measure of control over traumatic adversity. As the nurses in the PTSD unit become confident in providing the proposed evidence-based education to veteran participants, veterans may become more self-assured and confident in group therapy, remain in the program, and benefit from the group therapy sessions. This will result in a reduction in irregular discharges and readmissions, as well as save the VA millions of dollars.

Theories, Models, and Concepts

Theories

With SCT, Bandura (1997, 1986b) hypothesized person–behavior–environment interaction with others as a basis for reciprocal determinism. An individual’s self-efficacy expectations, Bandura (1997, 1986a) suggested, largely determine outcome expectations. Basically, the core of self-efficacy theory is the assumption that people can exercise influence over what they do. SCT is based on a dynamic and reciprocal model of interactions among behavior, personal factors, environmental influences, and self-efficacy and is considered the key construct in the theory (Bandura, 1986a). Self-efficacy concerns people’s confidence in their ability to perform a certain behavior. The primary sources of efficacy information include performance experience, verbal persuasion, vicarious experience, and physiologic and affective states (Bennight & Bandura, 2004).

Key construct of SCT is self-efficacy (i.e., people’s confidence in their ability to perform a certain behavior), meaning if individuals feel more confident that they can successfully engage in a certain behavior (e.g., overcome barriers), they are more likely to engage in that activity and in interventions. Improving self-efficacy should then increase behavioral compliance. In SCT, confidence is one’s ability to engage in a specific behavior, goal, and expectation. In doing so, positive outcomes become evident through healthy behavior. Glanz and Rimer (2005) explained that if individuals have a sense of self-efficacy, they could change behaviors, even when faced with obstacles.

With nurses understanding the CPG based on SCT, the expectation is for nurses to gain confidence and demonstrate the ability to make changes in the unit. SCT originated

from the fields of developmental, cognitive, and social psychology and has been successfully used in many fields, such as psychology, nursing, and social sciences.

Bandura (1995) suggested that for people to engage in health-enhancing behaviors, they need to not only be confident in their ability to perform the behavior but understand that the outcome of the behavior is beneficial.

SCT is based on a dynamic and reciprocal model of interactions among behavior, personal factors, environmental influences, and self-efficacy and is considered the key construct in the theory (Bandura, 1986a). Self-efficacy concerns people's confidence in their ability to perform a certain behavior; the primary sources of efficacy information include performance experience, verbal persuasion, vicarious experience, and physiologic and affective states (Bennight & Bandura, 2004). Individuals need that assurance in themselves to achieve their goals. Bandura (1997) defined self-efficacy as individuals' constructs of self-perceptions of capability that are instrumental to the goals they pursue and to the control they exercise over their environments, thoughts, emotions, and actions.

This project aims to build knowledge and confidence in the nurses in the PTSD unit through participation in the development of the guidelines so they can incorporate the construct of the SCT into the orientation process of program participants dealing with PTSD. This will be beneficial for patients because SCT is associated with the belief that trauma has brought about a negative and permanent change in the self and in the likelihood of achieving life goals (Dunmore, Clark, & Ehlers, 1997). SCT originated from the fields of developmental, cognitive, and social psychology and has been successfully used in many fields, such as psychology, nursing, and the social sciences.

Bandura (1986) suggested that for people to engage in health-enhancing behaviors, they need to not only be confident in their ability to perform the behavior but understand that the outcome of the behavior is beneficial.

Concepts

PTSD is among the most public and incapacitating psychiatric disorders among military personnel serving in combat. Thomas et al. (2010) indicated that an increasing body of literature has established the association of combat in Iraq and Afghanistan with postdeployment mental health problems, particularly PTSD and depression. Seal, Bertenthal, Miner, Sen, and Marmar (2007) agreed by indicating that several reports have revealed high rates of mental health disorders, including PTSD, depression, and alcohol use disorders among active duty military personnel and veterans of OIF and, to a lesser extent, OEF. This is in alignment with what the National Center for PTSD reported after 9/11 (as cited in VA, 2015): Recent military operations in Iraq and Afghanistan represent the most sustained ground combat operations involving American forces since the Vietnam era. As a result, the majority of military personnel experience high-intensity terrorist warfare and the chronic threat of roadside bombs and improvised explosive devices.

PTSD is associated with intrusive, trauma-related thoughts and avoidance behaviors that contribute to its severity and chronicity. The *DSM-5* would diagnose PTSD if there were an experience of intense fear, helplessness, or horror at the time of trauma (APA, 2013). Robert et al. (2011) examined thought control and avoidance coping strategies associated with both a probable diagnosis and the symptom severity of

combat-related PTSD in a sample of 167 treatment-seeking OEF and OIF veterans. Within 1 year of returning from deployment, veterans completed a survey containing measures of combat exposure, coping strategies, psychopathology, and postdeployment social support. Veterans with a positive screen for PTSD scored higher than veterans without a positive screen for PTSD on measures of worry, self-punishment, social control, behavioral distraction, and avoidance coping strategies. Worry and social avoidance coping were positively related to PTSD symptoms.

A structural equation model adopted by Foa et al. (2008) revealed that scores on a measure of postdeployment social support were negatively associated with scores on measures of maladaptive cognitive coping (i.e., worry, self-punishment) and avoidance coping (i.e., social and nonsocial avoidance coping) strategies, which were positively associated with combat-related PTSD symptoms. These results suggested that maladaptive thought control and avoidance coping may partially mediate the relationship between postdeployment social support and combat-related PTSD symptoms in treatment-seeking OEF and OIF veterans (Foa et al., 2008). Consistent with cognitive therapy models, these findings suggested that interventions that target maladaptive coping strategies, such as worry, self-punishment, and social avoidance, and that bolster social support, most notably understanding from others, may help reduce combat-related PTSD symptoms in this population.

One evidence-based treatment used commonly in the VA to manage PTSD is TFBGT. This treatment embeds exposure in a group context that includes psychoeducation, cognitive restructuring, relapse prevention, and coping skills training

(VA, 2013). This treatment was developed specifically for patients who might not otherwise tolerate or comply with individual exposure therapy. There is no evidence that these therapies allow participants to gain the self-confidence and self-control to participate in program.

Terms

Department of Veterans Affairs (VA): The VA's VHA, according to Maciejewski, Liu, and Sales (2005), provides a health care safety net to veterans.

Essentials for the doctor of nursing practice: The doctor of nursing practice essentials describe the core knowledge and competencies of the baccalaureate-prepared nurse. The essentials emphasize the importance of using science-based concepts to evaluate and enhance health care delivery and improve patient outcomes (AACN, 2006).

Mental disorders: According to the *DSM-5*, a mental disorders is a syndrome characterized by clinically significant disturbance in an individual's cognitive, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorder is associated with significant distress or disability in social, occupational, or other important activities. (APA 2013, p. 20)

Posttraumatic stress disorder (PTSD): The *DSM-IV-TR*'s definition of PTSD is an anxiety disorder that develops from traumatic events that can occur after childhood sexual abuse or a life-threatening trauma (Seides, 2010). SCT as recognized by Lee, Kim, and Lee (2015) is the most popular theory used in intervention for behavior changes. Lee

et al. further concluded that an education program should include multiple avenues, such as cognitive changes, skill improvements, and environmental changes.

Self-efficacy: This is the idea of being able to set a goal and having the confidence to complete the task that will lead to the accomplishment of the goal.

Trauma-focused behavior group therapy (TFBGT): Group sessions are facilitated by a multidisciplinary team consisting of psychologists, cognitive behavioral therapists, occupational therapists, and art therapists and focus on working on trauma memories connected to military service. According to Murphy et al. (2015), group sessions included psychoeducational groups (e.g., understanding PTSD, cognitive behavioral therapy education, and medication and exploring the links between PTSD and memory, sleep hygiene, and relaxation techniques) and symptom-management groups (e.g., managing anxiety, managing anger, and attending behavioral activation for depression and mindfulness groups).

Relevance to Nursing Practice

Search Strategy

The literature search was conducted on databases and search engines, including Cochrane, Ovid, CINANL, SAGE, PCYCHInfo, and Google Scholar. The keywords searched were *PTSD among veterans, social cognitive theory and self-efficacy, behavior management, self-efficacy tool, OEF/OIF veterans, ACE Star Model in nurse education, the Veteran Administration website, and the National Institute for Mental Health*. Current literature is limited to two to three related systematic reviews. To include both more general and more specific literature, the review was expanded to include articles

published within 10 years, and 30 to 35 additional articles were available. Twenty of those articles were relevant to the EBP and are included in the review. Sources or reviews include the Archives of Internal Medicine, *Journal of Behavior Research and Therapy*, *VHA Handbook*, *Iraq War Clinical Guide*, IOM, *Journal of Psychiatry Research & Neuroimaging*, Web-based Injury Statistics Query and Reporting System, Annual Review of Public Health, Nurse Practitioner Healthcare Foundation, *Journal of Addiction Medicine*, U.S. Government Fact Sheets, *Science Direct*, and *American Journal of Nursing*. This search encompassed a comprehensive review of the literature to address the practice focus question and will be exhausted after the problem has been addressed.

The search was conducted using search words including *cognitive therapy*, *stress disorders*, *post-traumatic*, *therapy veterans*, *psychotherapy*, and *group*. The Method Cochrane Database of Systematic Reviews resulted in limited evidence-based research on SCT for veterans. The search was conducted on multiple databases and resulted in for specific papers. One paper was excluded, as it was specific to schizophrenia. One article was a duplicate.

General Literature

PTSD. PTSD is associated with abnormal changes in self-identity including poor perceived self-efficacy. Adam et al. (2016) examined whether enhancing perceptions of self-efficacy in combat veterans with and without symptoms of PTSD would promote cognitive strategies associated with positive mental health outcomes. Prior to completing a future thinking and social problem-solving task, 62 OEF and OIF veterans with and without PTSD symptoms were randomly divided into two groups. The first group was a

high self-efficacy (HSE) induction, in which the participants were asked to recall three autobiographical memories demonstrating self-efficacy. The second group was a control, in which participants were asked recall any three autobiographical events. An interaction between HSE and PTSD revealed that individuals with PTSD symptoms in the HSE group generated future events with more self-efficacious statements than those with PTSD in the control group. Those without PTSD did not differ in terms of self-efficacy content across the conditions. In addition to such findings, individuals in the HSE condition exhibited better social problem-solving skills than those in the control condition. Increasing perceptions of self-efficacy may promote future thinking and problem-solving in ways that are relevant to overcoming trauma and adversity (Adam et al., 2016).

In another study, Sloan et al. (2015) looked at an efficacious group treatment approach to PTSD treatment. In a sample consisting of 196 veterans diagnosed with PTSD, veterans were randomly assigned to either a group cognitive-behavioral treatment ($n = 98$) or a group present centered treatment ($n = 98$). Two therapists administered both treatments over the course of 14 sessions. Assessments took place at baseline, mid-treatment, and posttreatment as well as during 3-month, 6-month, and 12-month follow-up visits. There was no significant difference in PTSD symptoms between the two groups with $p < 0.05$. Even though Sloan et al. recognized the significant advances in individual approaches for PTSD treatment, they concluded that the knowledge regarding group approaches is insufficient due to the complexity of conducting randomized controlled trials (RCTs) in group treatment contexts. This limited experimental knowledge is

unfortunate given the frequency with which PTSD group treatment is used in clinical settings including the VA.

Brown et al. (2016), in completing a future thinking and social problem-solving task, randomly placed 62 OEF and OIF veterans with and without PTSD symptoms into either a HSE induction or a control condition. Veterans in the HSE group were asked to recall three autobiographical memories that demonstrated self-efficacy, whereas those in the control group could recall any three autobiographical events. An interaction between HSE and PTSD revealed that individuals with PTSD symptoms in the HSE group generated future events with more self-efficacious statements than those with PTSD in the control condition, whereas those without PTSD did not differ in their recollections of self-efficacy across the conditions. In addition, individuals in the HSE condition exhibited better social problem-solving than those in the control condition. The study's conclusion suggested that increasing perceptions of self-efficacy may promote future thinking and problem-solving in ways that are relevant to overcoming trauma and adversity.

Makhashvili et al. (2014) conducted a cross-sectional household survey among adult IDPs who served in conflicts from the 1990s and 2008 as well as returnees. PTSD, depression, anxiety, and disability were measured using cut scores on the Trauma Screening Questionnaire, Patient Health Questionnaire 9, Generalized Anxiety Disorder 7, and the WHO Disability Assessment Schedule 2.0. Among the 3,025 respondents, the probable prevalence of PTSD, depression, anxiety, and comorbidity (> 1 condition) was 23.3%, 14.0%, 10.4%, and 12.4%, respectively. Pearson correlation coefficients ($p <$

.001) were .40 (PTSD with depression), .38 (PTSD with anxiety), and .52 (depression with anxiety).

SCT effectiveness has also been used to manage behaviors in other areas.

Compared to standard care or no intervention, SCT interventions are effective in reducing HIV and STI incidences among female sex workers (FSWs). One study conducted 13 trials with 8,698 participants in RCTs and quasi-RCTs to examine and compare different behavioral interventions' effects on HIV transmission risks. The primary outcomes (HIV and STI prevalence and incidences) were reported in seven trials. Of these, incidences of HIV were only reported in three trials. After a 6-month follow-up assessment, there was no evidence suggesting that social cognitive behavioral interventions were effective in reducing HIV incidences ($RR = 0.12$, 95% CI [0.01, 2.22]). However, HIV incidences were reduced at the 3-month follow-up assessment regarding the promotion of female and male condom use ($RR = 0.07$, 95% CI [0.00, 1.38]). Social cognitive interventions and the promotion of female and male condom use significantly reduced STI incidences ($RR = 0.57$, 95% [CI 0.34, 0.96]) and ($RR = 0.63$, 95% CI [0.45, 0.88]), respectively. Secondary outcomes were identified in 13 trials. Meta-analyses showed evidence that interventions promoting the use of female and male condoms reduce noncondom use ($RR = 0.83$, 95% CI [0.65, 1.05]) compared to the promotion of male condoms alone. Further, social cognitive interventions reduced drug use among sex workers ($RR = 0.65$, 95% CI [0.36, 1.16]) compared to standard care. Given the benefits of SCT and the promotion of condom use in reducing HIV/STIs and the public health need to control transmission amongst FSWs, there is a clear finding that supports SCT-based behavioral interventions.

SCT. SCT has been used to manage behaviors in various settings. In developing an educational nutritional program, Hall, Chai, Koszewski, and Albrecht (2015) assessed knowledge, behavior, and self-efficacy for healthy eating among the fifth-grade students. A positively correlated relationship between self-efficacy and behavior was identified ($r = 0.40, P = 0.0001$). The premise of this evidence-based intervention is to provide education based on SCT to supplement the current evidence-based TFBGT intervention used in the PTSD unit. By doing this, the participants in the PTSD group therapy may have better control over their behavioral outbursts. Belsher et al. (2012) theorize that the adjustment period following trauma depends, in part, on interpersonal processing and the support of others, which is the foundation of group therapy. Identified behavioral outbursts are triggered by some of the veterans' activities during group therapy. Benight and Bandura (2004) discovered that an individual's ability to participate effectively in group therapy and achieve positive psychological outcomes is dependent upon the individual's "coping self-efficacy," which is defined as an individual's perceived ability to manage psychological and environmental demands associated with traumatic events. In support of TFBGT, the goal is to employ SCTs of change, which Bandura (2004) referred to as operant training where the positives outweigh the negative consequences. This theory suggests that nurses will help the participants achieve coping self-efficacy; this process has emerged as a proven focal mediator for posttraumatic recovery (Benight & Bandura, 2004).

A study examining pediatric nurses' perceptions about patient-family education in hospital settings used a 20-item questionnaire to explore how factors including SCT

affected the teaching behaviors of 54 pediatric nurses in an acute care hospital (Lahl et al., 2013). The study's results suggest that pediatric nurses who frequently used SCT constructs were confident in educating patients and families about common disorders (asthma, pneumonia, and bronchiolitis).

Specific Literature

PTSD in veterans. Multiple studies have reported the prevalence of PTSD in OEF and OIF veterans; however, according to Dursa, Reinhard, Barth, and Schneiderman (2014), these studies are limited to populations who use the VA for health care, individuals in specialty clinic populations, or deployed veterans.

A study conducted by Dursa et al. (2014) reported the weighted prevalence estimates of positive PTSD screenings among OEF and OIF and non-deployed veterans, demographic subgroups, and VA health care system users and nonusers. The study analyzed data from the National Health Study for a New Generation of American Veterans, a large population-based cohort of OEF and OIF and OEF and OIF-era veterans. The overall weighted prevalence of a positive PTSD screening in the study population was 13.5%–15.8% among OEF and OIF veterans and 10.9% in non-deployed veterans. Among OEF and OIF veterans, there was an increased risk of a positive PTSD screening among VA health care users ($OR = 2.71$), African Americans ($OR = 1.61$), those who served in the army ($OR = 2.67$), and those on active duty ($OR = 1.69$). The same trend with decreased magnitude was observed in non-deployed veterans. PTSD is a significant public health problem in OEF and OIF-era veterans and should not be considered an outcome solely related to deployment.

SCT in veterans. In one study, Haynes et al. (2016) used cognitive behavioral social rhythm therapy on 24 veterans with PTSD over a 12-week period to improve sleep and mood by reducing chaotic or isolated lifestyles. Veterans improved on all measures including (a) PTSD symptoms, MDD symptoms, and sleep quality and (b) 46%–58% of the sample received clinically significant benefits targeting their MDD and PTSD symptoms, respectively. The data from this initial pilot study demonstrates that cognitive behavioral social rhythm therapy may be an effective group treatment option for veterans presenting all three of these symptoms.

Evidence to Address the Gap-in-Practice

The current evidence-based treatment method is TFBGT. The current treatment method does not address behavioral crises occurring among participants during group activities. Therefore, the purpose of this DNP project is to develop an evidence-based CPG based on SCT to improve clinical nursing practices. The goal of incorporating SCT as part of the education provided by nurses is to address the 20% return rate and improve veteran completion of the 6-week program and its outcomes. The project will support a nursing revision of the existing veteran orientation package, which includes the provision of PTSD education. There is limited evidence in the literature regarding SCT's effect on veterans with PTSD, but SCT has been used successfully in other settings. An examination of pediatric nurses' perceptions about patient and family education in hospital settings used a 20-item questionnaire that explored how factors including SCT affected the teaching behaviors of 54 pediatric nurses in an acute care hospital setting (Lahl et al., 2013). Results from this study suggest that pediatric nurses who frequently

use SCT constructs are confident in educating patients and their families on common disorders (asthma, pneumonia, and bronchiolitis). Wilroy et al. (2017) developed and tested a SCT-based instrument aimed at predicting physical activity among people with SCI. Results indicated that the physical activity variable was significantly and positively correlated with all five-factor SCT models: self-regulatory efficacy ($r = 0.575$), task self-efficacy ($r = 0.491$), self-regulation ($r = 0.432$), social support ($r = 0.284$), and outcome expectations ($r = 0.247$). Internal consistency for the constructs ranged from 0.82 to 0.96. Construct reliability values for the self-regulation (0.95), self-regulatory efficacy (0.96), task self-efficacy (0.94), social support (0.84), and outcome expectations (0.92) each exceeded the 0.70 a priori criteria.

Local Background and Context

Evidence to Justify the Problem

The VA hospital offers a PTSD program that includes therapy, education, support, and housing for 6 or 12 weeks. Eighty percent of the veterans who complete the program do not return; however, 20% return to the program within 6 months after program completion (VA, 2010). The current evidence-based method used for treatment is TFBGT. The current treatment method does not address the participants' behavioral crises that occur during group activities. If this expectation cannot be achieved, Bandura (1986a) suggested looking at the relationship between expectation and self-efficacy. SCT prompts individuals to engage in health-enhancing behaviors not only to strengthen their confidence in their performance ability but also to encourage the belief that the outcome of their behavior is beneficial (Bandura, 1986b). As the nurses interacting with PTSD

individuals become confident in incorporating the proposed evidence-based CPG into the orientation process for veteran participants, veterans may become more self-assured and confident in group therapy, and thus remain in the program and benefit from the group therapy sessions.

Institutional Context

With the recent wars involving American troops, PTSD is a serious concern for the Veteran's administration (VA). Giardino (2009) states that PTSD manifests after physical and emotional trauma. Foa et al. (2008) agreed by identifying PTSD as one of the most public and debilitating psychiatric disorders among soldiers in combat who receive their medical care from the VA, so it is a necessity for the interdisciplinary team to work together to ensure the current program does not fail.

VA recognizes the need to promote better practices to achieve better outcomes in veteran health care. This is aligned with the VHA's vision (VA, 2010) to be a benchmark of excellence and value in delivering patient-centered and evidence-based health services. To fulfill this vision, the VA has devoted significant capital and human resources to promote research on EBPs, CPG implementation, and quality improvement programs.

State and Federal Context

Giardino (2009) identified over 1.5 million Americans who participated in combat operations in Iraq and Afghanistan over the past 7 years (Giardino, 2009). Between 2009 and 2010's fiscal years, nearly 613,000 veterans accessed VHA services. These veterans were relatively young (31.9 years \pm 9.6), and 29.3% of those veterans were diagnosed with PTSD (Cifu et al., 2013). The National Center for PTSD (2010) confirmed that 65%

of military personnel who reported having PTSD were exposed to high-intensity terrorist warfare and chronic threats of roadside bombs and improvised explosive devices. Crum-Cianflone et al. (2016) concluded that those in combat had the highest incidence rates of PTSD (25 cases/1,000 people per year).

Nationally, the VA provides 6-week inpatient PTSD treatment to about a half a million OIF, OEF, and OND. The selected VA for this project is located in the Eastern United States. The facility has a 25-bed inpatient residential PTSD treatment program with an occupancy rate greater than 90%. Participants ages 19 to 69 come for either a 6-week or 12-week PTSD and addiction therapy program. The multi-disciplinary staff includes psychiatrists, nurse practitioners, registered nurses, social workers, psychologists, recreational therapists, addiction therapists, chaplains, and dieticians. The major presenting diagnoses are PTSD and drug and alcohol addiction. Major medical diagnoses include chronic pain, traumatic brain injury, hypertension, diabetes, and dental caries. Therapeutic activities include a range of addiction programs, recreational and sleep therapy, as well as therapeutic family meeting groups.

Role of the DNP Student

The professional role of the DNP student is to facilitate dissemination through scholarship, evidence-based knowledge to improve healthcare outcomes for the veterans in the PTSD unit, (Essential III) AACN (2006). The DNP student's role is to empower the nurses in the VA hospital's PTSD unit by incorporating an evidence-based project into the orientation package for veteran participants. Behavioral outbursts are a daily occurrence in this unit, and as a result, 20% of the admitted veterans are expelled without completing the

6-week program. In addition, 20% of the veterans who complete the program return within 6 months asking for more mental health assistance. When seeking project volunteers, candidates were made aware of the researcher's role as a DNP student.

Spending the first quarter of NURS 8400 clinical hours in the PTSD unit served as a motivation to establish why there are so many behavioral outbursts in the unit despite the millions of dollars the VA invests in mental health research. By probing, it was made clear that nurses assigned to this unit could be part of the solution by employing the DNP essential IV of the AACN (2006). They will need to have effective collaboration skills in both interdisciplinary and intra-professional teams to improve patient and population health outcomes.

Since the project leader is also a VA employee, has spent over 500 clinical hours in the PTSD unit, and has become familiar with some of the nurses, an independent volunteer was employed to ensure that there was no bias in the selection of participants. Program managers picked volunteer names from a general pool of participants, and the selectee will be notified via email. Another bias could include the staff feeling coerced into participating. It was the role of the project leader to reinforce the nature of voluntary participation.

Summary

The premise of this evidence-based intervention seeks to develop a new set of practice guidelines for nurses assigned to the PTSD unit. Through this intervention, they will develop the confidence to transfer their gained knowledge to program participants during the current orientation process. By doing so, participants in PTSD group therapy

may have better control over their behavioral outbursts. Belsher et al. (2012) theorize that the adjustment period following trauma depends, in part, on interpersonal processing with the support of others, which is the foundation of group therapy. Identified behavioral outbursts are triggered by some veterans' activities during group therapy. Benight and Bandura (2004) discovered that to participate effectively in group therapy and obtain positive psychological outcomes, an individual has to possess coping self-efficacy, which is defined as an individual's perceived ability to manage psychological and environmental demands associated with traumatic events. In supporting TFBGT, the goal is to employ the SCT of change, which Bandura (2004) referred to as operant training where the positives outweigh the negative consequences. With this theory, nurses will help the participants develop their coping self-efficacy. This process emerged as a proven focal mediator for posttraumatic recovery (Benight & Bandura, 2004).

Section 3 will describe the guideline development process and assess the nurses' knowledge and confidence after participating in the process.

Section 3: Collection and Analysis of Evidence

Introduction

As PTSD is one of the most visible and debilitating psychiatric disorders among veterans seeking medical care, the VA is extremely concerned about clinicians' ability to provide appropriate support and care for these veterans (Foa et al., 2008). However, current treatment approaches (e.g., TFBGT) have not been successful in managing the behavioral outbursts among PTSD group therapy participants at this specific VA facility. Sloan et al. (2015) acknowledged the inefficiencies of PTSD-specific research and the multiple group approaches to therapy due to the complexity of conducting RCTs in group treatment contexts. This limited experimental knowledge is problematic given the frequency with which group treatment for PTSD is used in clinical settings like the VA. Nurses can address this practice gap, hence the purpose of this EBP, which was to create an evidence-based CPG based on SCT and develop an educational program where nurses can improve their clinical practices. This new CPG can reduce the number of veterans who are unable to complete the program due to behavioral outbursts.

Practice-Focused Question

The VA hospital utilizes TFBGT, an evidence-based method that includes therapy, education, support, and housing for 6 or 12 weeks as treatment. Eighty percent of the veterans complete the program (VA, 2010), and 20% are expelled from the program due to a behavioral outburst. In addition, 20% of the 80%—or 16 out of 100 veterans—who complete the program return within 6 months (VA, 2010). The major identifiable gap in TFBGT is that it does not address behavioral outbursts during group

activities. Therefore, the purpose of the project is to create a CPG for the nurses to address the identified gap in the practice. Upon admission to the PTSD program, the nurses conduct a veteran orientation. The orientation packet includes the unit's rules and regulations. The implementation phase for the CPG will be completed after this project. The project includes developing the guidelines using the Delphi technique to gather expert feedback to help construct the CPG. The consensus CPG, in the form of a proposal, was then presented to an interprofessional team. Because this is a new process for nursing at this VA facility, an additional question was asked regarding the impact an evidence-based CPG (based on SCT) would have on the nurses' knowledge and confidence in incorporating CPG into the orientation process.

Project Purpose and Method Alignment

The purpose of this project is to create an evidence-based CPG based on SCT for nurses to use during the orientation process for veterans entering a PTSD unit at a VA hospital. The CPG was created using a review of the contemporary evidence-based literature, a review of the current protocol, and four group meetings to develop the guideline. The project included the creation of a PowerPoint instructional on how to use the CPG. A pre- and postsurvey design was implemented using a 15-item validated survey instrument to assess the nurses' knowledge and confidence in using the CPG.

Sources of Evidence

Evidence from the literature review indicated that SCT can increase an individual's self-confidence and self-efficacy. The underlying concept of SCT is reciprocal determinism, which asserts that a behavior arises from people's continuous,

bidirectional interactions and environments; resulting behavior, in turn, affects people and their environments (Bandura, 1986). According to SCT, an individual's confidence comes from the ability to engage in specific behaviors, goals, and expectations, and the behavior will have positive outcomes; these are the main contributors to health behavior. Program participants need to have confidence in themselves. Glanz and Rimer (2005) explained that if individuals have a sense of self-efficacy, they can change their behaviors even when faced with obstacles. Thus, this EBP was designed to incorporate SCT into a CPG that the nurses could use in their program orientation.

A group meeting with 10 volunteer nurses from the PTSD unit was held, and participants used the Delphi technique to reach a consensus. Consensus, per Avella (2016), does not mean 100% agreement, as it might be extremely difficult to get groups representing different constituencies with varying viewpoints and priorities to reach unanimity. Vernon (2009) stated that the Delphi consensus typically ranges from 55% to 100% agreement, and 70% is considered the standard. Because reaching a consensus among the nurses was essential in incorporating the SCT-based orientation, a volunteer opportunity was made available to all shifts.

The revised EBP orientation program may equip participants with self-regulatory skills to manage their mental health habits. Self-management therapy attempts to change specific behavioral components of depression by teaching simple cognitive-behavioral principles for self-monitoring, self-evaluation, self-reinforcement promoting self-esteem, and self-efficacy. Dunn et al. (2007) published extensive evidence on the efficacy of self-management therapy in various outpatient populations. This consumer-directed care is

very similar in its philosophy and intended outcome to that of patient-centered medical care as outlined by the IOM (2001a).

Project Design

The project followed the AGREE II framework—the rigorous internationally recognized “gold standard” for developing and assessing CPG quality (Brouwers et al., 2010). The CPG development framework requires a systematic method that incorporates inclusion and exclusion criteria to search the literature and grade the strength of evidence (Moran, Burson, & Conrad 2017). The AGREE II is a valid and a reliable assessment guide with 23 key criteria organized within six domains (Appendix B). The six domains include Domain 1: scope and purpose; Domain 2: stakeholder involvement; Domain 3: rigor of development; Domain 4: clarity of presentation; Domain 5: applicability; and Domain 6: editorial independence. A valid and reliable CPG will receive a high AGREE score based on the 23 criteria. This means there is a clear link between the evidence evaluated by qualified clinicians and the CPG elements.

As the AGREE II requires expert assessment and consensus regarding the quality of the evidence and its incorporation into a meaningful guideline, this project used a Consensus Decision Making (Process) Model (Hartnett, 2010) with Delphi technique (Avella, 2016). The summary of the literature and suggestions for new models of treatment were presented to the nursing staff, as well as other health care providers on the team, for feedback. The group utilized this information in its discussions guideline drafts. The developed protocol and guidelines were presented to the group for feedback, review, and a final drafting. The nurses’ consensus proposal was presented to interprofessional

team members and the Nursing Practice Council. The Delphi technique involves group discussions in which participants share expert clinical opinions and perspectives about the elements in a quality improvement project (Avella, 2016). The goal is to arrive at a collective conclusion regarding the strategies that will guide the project (Hartnett, 2010). Keeney, Hasson, and McKenna (2006) identified the Delphi technique as an essential method in achieving a consensus on subjects where none previously existed. The nurses were informed that this was their practice change initiative to improve their participation. Encouraging the team of nurses to recognize this as their quality improvement project may empower them to execute the project and practice change.

Hutchings, Raine, Sanderson, and Black (2005) described this process of reaching a consensus as a nominal group technique, which involves a “nominal” sample of about 10 people who meet to discuss areas of disagreement. As an alternative to this technique, Hutchings et al. identified the mail-only Delphi survey, in which participants complete two or more rounds of questionnaires. This approach is a hybrid method that was developed by the RAND Corporation under a U.S. government contract in the 1950s as a method to forecast likely outcomes from using nuclear weapons in war. To promote sustainability, consideration will be given to the volunteers’ ideas, and the DNP student will facilitate the EBP implementation.

Once the CPG was finalized, an educational presentation was developed for nurses to learn about the guidelines. This education was intended to increase the nurses’ understanding and confidence in using the CPG.

Analysis and Synthesis

Data Systems and Procedures

The CPG was assessed with the AGREE II framework—the rigorous, internationally recognized gold standard for the development and assessment of CPG quality. The nurses’ knowledge regarding the CPG was assessed using the General Perceived Self-Efficacy Scale, a self-reported 15-item, 5-point Likert scale (Schwarzer & Jerusalem, 1995). The scale has been translated into more than 30 languages and has been used in more than 26 countries. The scale’s reliability and validity is well established with Cronbach alphas reported between .75 and .91 (Schwarzer & Scholz, 2000). The scale’s criterion-related validity has also been confirmed through extensive research, which indicates that low scores on the General Perceived Self-Efficacy Scale correlate with depression, helplessness, and anxiety; high scores correlate with motivation, optimism, successful coping strategies, superior achievements, and social integration (Schwarzer & Scholz, 2000).

Domain 1: Scope and purpose. The guideline’s overall objective is to support the nurses’ revisions to the existing veteran orientation package, which will include provisional education for veterans in the PTSD unit. By incorporating the principles postulated by SCT in a CPG and educating the nurses on its use, they will acquire self-efficacy and self-confidence in incorporating the same principles into the orientation process. STAR was utilized for this project. STAR is a framework for the systematic integration of evidence into practice (Stevens, 2013). STAR has five major stages: knowledge discovery, evidence summary, translation into practice recommendations,

integration into practice, and evaluation. STAR is one of the most commonly used frameworks used to influence nursing practices (Stevens, 2012).

The practice seeks to examine the impact an evidence-based CPG (based on SCT) will have on nurses' confidence levels. To answer this question, the pre- and postsurvey design was implemented as a submeasure to gauge this process's impact on improved nursing knowledge and their comfort level in moving forward with new guidelines. A validated survey instrument—The Generalized Self-Efficacy Scale (GSE)—was provided to the participants before and after the implementation of a PowerPoint presentation. The instrument was modified with permission from Schwarzer and Jerusalem (1995). The GSE has been used successfully in 23 nations in assessing general perceived self-efficacy with the goal of predicting individuals' tendencies to cope with daily hassles and adapt after experiencing stressful life events. The GSE has both reliability and validity, with Cronbach's alphas ranged from .76 to .90, and criterion-related validity documented in numerous correlation studies where positive coefficients were found in measuring favorable emotions, optimism, and work satisfaction. The premise of this evidence-based intervention is that by participating in the process of guideline development, the nurses will develop enough confidence to transfer their gained knowledge into the current program orientation they hold for participants. Participants in PTSD group therapy may have better control over their behavioral outbursts. Belsher et al. (2012) theorized that the adjustment period following trauma depends, in part, on interpersonal processing with the support of others, which is the foundation of group therapy.

Domain 2: Stakeholder involvement. The guideline development group included nurses from the PTSD unit. As the AGREE II requires expert assessment and consensus regarding the quality of the evidence and its incorporation into a meaningful guideline, this project uses a Consensus Decision Making (Process) Model (Hartnett, 2010) with Delphi technique (Avella, 2016). The Delphi technique involves group discussions in which participants share expert clinical opinions and perspectives about the elements in a quality improvement project (Avella, 2016). The goal is to arrive at a collective conclusion regarding the strategies that will guide the project (Hartnett, 2010). Keeney et al. (2006) identified the Delphi technique as an essential method in achieving a consensus on subjects where none previously existed. The nurses were informed that this was their practice change initiative to improve their participation. Encouraging the team of nurses to recognize this as their quality improvement project may empower them to execute the project and practice change.

The chief of quality management, the Nurse Practice Council at the VA hospital, the nursing administration staff, and mental health practitioners reviewed the final draft of the guideline and made some suggestion that were taken into consideration. The end users agreed to update the guideline with the other nursing SOP every 3 years per policy.

Domain 3: Rigor of development. The literature search was conducted on databases and search engines including Cochrane, Ovid, CINANL, SAGE, PCYCHInfo, and Google Scholar. The keywords searched were *PTSD among veterans, social cognitive theory and self-efficacy, behavior management, self-efficacy tool, OEF/OIF veterans, ACE Star Model in nurse education, Veteran Administration website, and the*

National Institute for Mental Health. The current literature was limited to two to three related systematic reviews. To include more general and specific literature, the review was expanded to include articles published over the last 10 years, and 30 to 35 additional articles were made available. Twenty of those articles are relevant to the EBP and are included in the review. Sources or reviews include the Archives of Internal Medicine, *Journal of Behavior Research and Therapy*, *VHA Handbook*, *Iraq War Clinical Guide*, IOM, *Journal of Psychiatry Research & Neuroimaging*, Web-based injury Statistics Query and Reporting System, The Annual Review of Public Health, Nurse Practitioner Healthcare Foundation, *Journal of Addiction Medicine*, U.S. Government Fact Sheets, Science Direct, and the *American Journal of Nursing*. This search encompassed a comprehensive review of the literature to address the practice-focused question and will be exhausted after the problem has been addressed.

The search conducted using keywords including *cognitive therapy*, *stress disorders*, *post-traumatic*, *therapy veterans*, *psychotherapy*, and *group* in the Method Cochrane Database of Systematic Reviews resulted in limited evidence-based research on SCT in the veterans category. A search conducted in multiple databases resulted in four specific papers. One paper was excluded, as it was specific to schizophrenia. One article was a duplicate.

Domain 4: Clarity of presentation. One evidence-based treatment used commonly in the VA to manage PTSD is TFBGT. This treatment embeds exposure in a group context and includes psychoeducation, cognitive restructuring, relapse prevention, and coping skills training (VA, 2013). This treatment was developed specifically for

patients who might not otherwise tolerate or comply with individual exposure therapy. There is no evidence that these therapies allow participants to gain the self-confidence and self-control necessary for program participation.

The STAR model, a framework for the systematic integration of evidence into practice, will guide this project (Stevens, 2012). STAR is composed of five major stages: knowledge discovery, evidence summary, translation into practice recommendations, integration into practice, and evaluation. STAR is one of the most commonly used frameworks to influence nursing practices (Stevens, 2012).

The transformation of evidence into practice requires two stages: the recommendations for the translation of evidence into practice and the integration into practice (Stevens, 2012). The aim of the translation is to provide a useful and relevant package of summarized evidence to clinicians in a form that suits time, cost, and care standard. The providers, in turn, integrate the evidence into their daily practices. Recommendations are generically termed CPGs and may be represented or embedded in care standards, clinical pathways, protocols, and algorithms. CPGs are tools that support informed clinical decisions for clinicians, organizations, and clients (Jaeschke et al., 2008). The strongest CPGs are developed systematically using a clear, reproducible process. Stevens (2012) further stresses that summarized research evidence is interpreted and combined with other sources of knowledge (such as clinical expertise and theoretical guides) and then contextualized to the specific client population and setting. Evidence-based CPGs explicitly articulate the link between the clinical recommendation and the strength of supporting evidence and the strength of the recommendation.

The first step is a knowledge-generating stage where new knowledge is discovered through the traditional research methodologies and scientific inquiry. This stage of development constructs the corpus of research about clinical actions. The literature review will focus on the impact SCTs have in managing behavior in PTSD patients. Stevens (2013) suggested that the next step is to synthesize the body of research knowledge into a single, meaningful statement of the state of the science. To date, the most advanced EBP methods are those used to develop evidence summaries (e.g., evidence synthesis, systematic reviews, and systematic review methods), which Stevens noted is outlined in the Cochrane Handbook from randomized control clinical trials. This stage is also considered a knowledge-generating stage, which occurs simultaneously with the summarization. Evidence summaries produce new knowledge by combining findings from all studies while identifying biases and limiting chance effects in the conclusions. The systematic methodology also increases the results' reliability and reproducibility.

The summary of the literature and the suggestions for new treatment models were presented to nursing staff, as well as other health care providers on the team, for feedback. The first draft of protocols was created based on SCT. The development protocol and guidelines were presented to the group for feedback, review, and a final drafting. The nurses' consensus proposal will then be presented to inter-professional team members and to the Nursing Practice Council.

The next two stages of the model will not be part of the study, but they need to be understood in the context of changes in nursing practices. Integration is perhaps the most familiar stage in health care, because society expects health care to be based on the most

current knowledge, thus requiring innovation implementation. This step involves changing both individual and organizational practices through formal and informal channels (Stevens, 2012). Major aspects addressed in this stage are factors that affect individual and organizational adoption rates of innovation and factors that affect integration of the changes into sustainable systems.

The final stage in knowledge transformation is evaluation. In EBP, a broad array of endpoints and outcomes are evaluated. These include: evaluation of the EPB's impact on patient health outcomes, provider and patient satisfaction, efficacy, efficiency, economic analysis, and health status impact. In conclusion, as new knowledge is transformed through the five stages, the outcome is the evidence-based quality improvement of health care. In this case, nurses assigned to the PTSD unit will be involved in incorporating the new tailored package into weekly orientation processes. This new package will contain concepts nurses will teach to the veterans in hopes that the veterans will be able to successfully participate in the PTSD program.

Domain 5: Applicability. Throughout the development of this proposal, the nurses who will be the main end users, and the unit manager, asked questions and were very involved in the development. In addition, they saw the veterans' plight within their units. Staffing is one anticipated barrier in applying this EBP to the weekly orientation process. According to the manager, the PTSD unit is down three nurses. Pre-implementation data and the post 12-month implementation of the CPG can be presented to the VA for justification of an additional RN FTE. This evaluation is beyond the scope of this project.

Domain 6: Editorial independence. There is no financial influence on the guideline's content. To promote sustainability, consideration will be given to the volunteers' ideas, and the DNP student will facilitate the EBP implementation.

Data Integrity

All minutes of the meetings and subsequent drafts will be shared with team members for accuracy and validation.

Summary

Seal et al. (2007) identified PTSD as one of the most public and debilitating psychiatric disorders among military personnel serving in combat. Foa et al. (2008) concluded that PTSD is a serious concern for veterans, as well as for the nation. There are several treatment approaches currently in use to manage this mental health disease, one of which is the current evidence-based TFBGT. The problem identified in this current TFBGT is that veteran participants become agitated and exhibit behavioral outbursts during the program, which results in their dismissal prior to the full 6 weeks. Further, veterans return within 6 months after their discharge from program. A CPG based on SCT was developed following the AGREE II format and includes an education program that can be used to extend this new process to all staff in the PTSD unit. A sub-measure was used to gauge this process's impact on the nurses' knowledge and confidence.

Section 4 details the process and the formative evaluation of nursing knowledge and confidence, as well as recommendations for future practice.

Section 4: Findings and Recommendations

Introduction

Despite the familiarity and skills of mental health practitioners in adapting the current evidence-based approaches to the needs of the veterans in a PTSD unit in an eastern United States VA hospital, behavioral outbursts continue to be an issue. The purpose of this evidence-based project is to create a CPG based on SCT. This will address the gap in effective practice by introducing a CPG based on SCT of self-efficacy. The expectation is that the nurses who develop the CPG will have increased knowledge and confidence in incorporating it into the orientation process they conduct with veterans. The development of the CPG followed the AGREE II guideline, which is valid, reliable, and consists of 23 key criteria organized within six domains (Brouwers et al, 2010)

Process

After obtaining IRB approval (approval # 06-28-17-0521281) and consent from VA management, then I posted flyers at the nurses' station and break room outlining the purpose of the project and seeking nurse volunteers to participate in the project. A total of 10 nurses volunteered, six from the day shift, three from the evening shift, and three from the night shift. The nurses were informed that this was a practice change initiative to improve their participation. Having a team of nurses see this as their quality improvement project may have empowered them to execute the project and practice change.

There were five face-to-face meetings. A pretest was given to the nurses during the first meeting to test their knowledge of the role of SCT in behavior management. The first meeting involved a review of evidence. The second meeting involved examining the

ways in which the orientation package could be adapted. The next two meetings were spent developing the new protocol. The final meeting was spent reaching a consensus on the use of the protocol.

In the first meeting, I provided an overview of the CPG development process and a synopsis of the relevant evidence-based literature. A total of six articles were reviewed—two each from evidence levels 1, 2, and 3—using AGREE II for practice guideline development and a template obtained from the guideline development clearing house. The group reviewed the evidence of how SCT had shown some notable success in other programs. In one of the articles, researchers showed a positive correlation between HSE and PTSD among veterans, revealing that individuals with symptoms of PTSD in the HSE condition generated future events with more self-efficacious statements than those with PTSD in the control condition (Brown et al., 2016). In another article, a meta-analysis was conducted to evaluate behavioral changes regarding condoms among sex workers, and RCTs and quasi-RCTs were conducted to examine the effects of different behavioral interventions on HIV transmission risks (Wilroy et al., 2017). These trials entailed comparing different behavioral interventions with instances of no interventions. There was a reduction in HIV incidences at 3-month follow-up assessments after promotions of female and male condoms to $RR = 0.07$ and 95% CI [0.00, 1.38]. Social cognitive interventions and female and male condom usage promotions significantly reduced STI incidences to $RR = 0.57$ and 95% CI [0.34, 0.96] and $RR = 0.63$, 95% CI [0.45, 0.88], respectively. Also, in developing and testing an SCT-based instrument to predict physical activity among people with SCI, results indicated physical activity

outcome variables significantly and positively correlated with all five factors of the SCT model; self-regulatory efficacy ($r = 0.575$), task self-efficacy ($r = 0.491$), self-regulation ($r = 0.432$), social support ($r = 0.284$), and outcome expectations ($r = 0.247$).

Table 1

Review of Evidence

Article	Evidence Level	Summary
Wariki, W. M. (2012). Behavioral interventions to reduce the transmission of HIV infection among sex workers and their clients in low- and middle-income countries. <i>Cochrane Database of Systematic Reviews</i> , 2012(2), CD005272.	1	Evidence suggests that compared with standard care or no intervention, SCB are effective in reducing HIV and the incidence of STIs amongst female sex workers (FSWs) here is benefits of social cognitive theory and the promotion of condom use in reducing HIV/STI and the public health need to control transmission amongst FSWs
Benight, C. C., & Bandura, A. (2004). Social cognitive theory of posttraumatic recovery: The role of perceived self-efficacy. <i>Behaviour Research and Therapy</i> , 42(10), 1129-1148.	2	Perceived coping self-efficacy emerges as a focal mediator of posttraumatic recovery
Lahl, M., Modic, M. B., & Siedlecki, S. (2013). Perceived knowledge and self-confidence of pediatric nurses as patient educators. <i>Clinical Nurse Specialist</i> , 27(4), 188-193.	2	Findings from this study can be used to develop teaching resources for nurses and to plan educational programs specific to less common pediatric problems.

(table continues)

Article	Evidence Level	Summary
Brown, A. D., Kouri, N. A., Rahman, N., Joscelyn, A., Braynt, R. A., & Marmar, C. R. (2016). Enhancing self-efficacy improves episodic future thinking and social decision making in combat veterans with posttraumatic stress disorder. <i>Psychiatry Research</i> , 242, 19–25.	2	Individuals with symptoms of PTSD in the HSE condition generated future events with more self-efficacious statements than those with PTSD in the control condition. Also individuals in the HSE condition exhibited better social problem solving than those in the control condition

The next two meetings were spent developing the guidelines, and the fourth meeting was spent reaching a consensus to proceed with the proposal. The day shift nurses and I developed protocols based on SCT. The developed protocol and guidelines were then presented to the other nurses for review and feedback before making a final draft. Eight out of the 10 participants reached a consensus to proceed with the CPG. The other two nurses remained neutral throughout the discussion. These two nurses' major concerns were staffing and implementing the guidelines. This response is not unusual. Avella (2016) identified that it could be extremely difficult to get groups of individuals representing different constituencies with varying viewpoints and priorities to reach unanimity. Vernon (2009) agreed, stating that Delphi consensus typically ranged from 55% agreement to 100%, with 70% considered the standard.

The nurses' consensus proposal was then presented to interprofessional team members and to the Nursing Practice Council. The Delphi technique involves group discussions in which participants share expert clinical opinions and perspectives about elements of quality improvement projects (Avella, 2016). The goal is to arrive at a

collective conclusion about the strategies to guide the project (Hartnett, 2010). Because the role of SCT in nursing practice was a new concept to this unit, opportunities were given to all the nurses to express their thoughts and ideas.

Since this VA facility had not used this process to develop guidelines in the past, an addition was made to show administration that this process surveyed whether it actually improved the knowledge and confidence level of the participants. A pre- and postsurvey design was implemented using a 15-item validated survey instrument. The GSE instrument was used with permission from Dr. Raff Swartzart. All participants ($N = 10$) completed the survey.

Table 2

Comparison of Pretest and Posttest Survey Percentage of Nurses' Knowledge and Confidence Levels

Question	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. I have a good understanding of PTSD and the role of self-efficacy in behavior management	20	10	40	20	10
2. I can always manage to help others solve difficult social problems if I try hard enough	0	10	10	40	40
3. If someone opposes me, I can find the means and ways to accomplish what needs to be done	20	10	20	30	20
4. I can change behaviors even when faced with obstacles	0	10	10	40	30
5. I believe I can help change this things I believe in	10	20	30	30	10
6. It is easy for me to stick to my aims and accomplish my goals	0	10	30	30	30
7. I am confident that I could deal efficiently with unexpected events	0	0	40	30	30
	0	0	20	40	40
	10	10	30	30	20
	0	10	20	30	40

(table continues)

Question	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8. Thanks to my resourcefulness, I know how to handle unforeseen situations	10	10	10	40	30
9. I can solve most problems if I invest the necessary effort	0	0	40	30	30
10. I am able to set a goal and I have the confidence to complete the tasks that will lead to the accomplishment of the goal	0	0	40	40	20
11. I can remain calm when facing difficulties because I can rely on my coping abilities	10	10	20	30	30
12. When I am confronted with a problem, I can usually find several solutions	0	10	30	50	10
13. If I am in trouble, I can usually think of a solution	0	0	30	40	30
14. I can usually handle whatever comes my way	10	10	30	30	20
15. I am confident enough to incorporate the CPG into the orientation process	10	10	20	40	20

Note. The pretest % for Questions 1–15 at on top, and the posttest responses are under.

For the first question, participants answered whether they had a good understanding of PTSD and of self-efficacy's role in behavior management. The purpose of this question and Question 15 were to evaluate the possibility of the nurses incorporating SCT into the veterans' PTSD orientation process. The pretest results indicated that, of the 10 participants, two strongly disagreed, one disagreed, four were neutral, two agreed, and one agreed. After the process of creating the CPG, the posttest results indicated none of the participants strongly disagreed with the question, one disagreed, one was neutral, four agreed, and four strongly agreed. Questions 2 through 14 assessed the nurses' self-efficacy and confidence in managing behavioral outbursts of the PTSD unit. Glanz and Rimer (2005) explained that if an individual had a sense of self-efficacy, they could change behaviors, even when faced with obstacles.

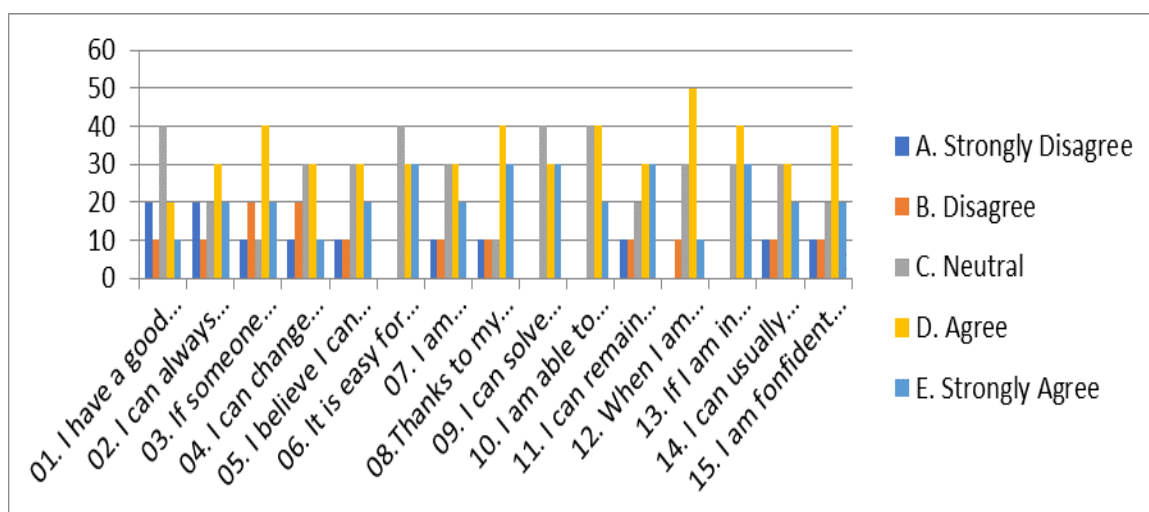


Figure 1. Pretest responses.

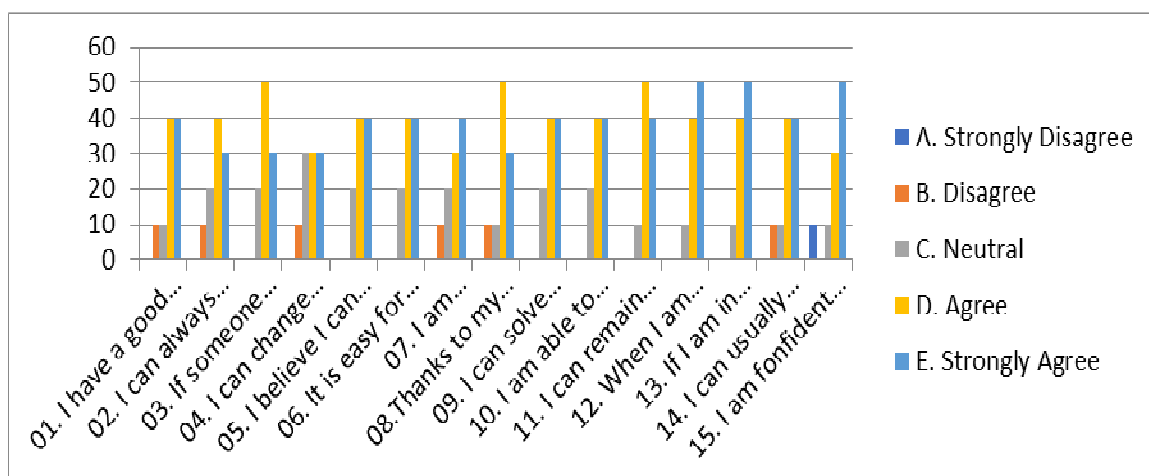


Figure 2. Posttest responses.

After the instruction on the use of the CPGs, the nurses reported confidence in incorporating the CPGs into the orientation process. Using Kendall's tau coefficient, a nonparametric analysis used to measure the ordinal association between two measured quantities showed a positive correlation, .575 with $p < 0.001$, indicating a statistically significant difference between the pre- and postsurvey results of the participants' understanding of the role self-efficacy played in managing behavior on the PTSD unit. More than half of the participants who strongly disagreed, disagreed, or were neutral either agreed or strongly agreed after the process. These nurses could also articulate the theory and how they believed using the CPGs could help veterans stay in the program and remain in the community.

A one-tailed paired sample t test was used to test the mean differences of a single sample of the population using two scale measures and a fairly normal distribution of different scores. The results are shown in Table 3.

Table 3

Paired Samples Test of the Pretest and Posttest

		Paired Differences					t	df	Sig.
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				(2-tailed)
					Lower	Upper			
Pair 1	Preunderstand	-	1.075	.340	-2.169	-.631	-	9	.003
	PTSD - Postunderstand PTSD	1.400					4.118		
Pair 2	Premanage for help -	-	1.398	.442	-2.200	-.200	-	9	.024
	Postmanage for help	1.200					2.714		
Pair 3	Prebelieve change -	-.700	1.160	.367	-1.529	.129	-	9	.089
	Postbelieve change						1.909		
Pair 4	preoppose m... -	-.700	.675	.213	-1.183	-.217	-	9	.010
	- postoppose m...						3.280		
Pair 5	pretrouble... -	-.400	.516	.163	-.769	-.031	-	9	.037
	posttrouble...						2.449		
Pair 6	prehelp c... -	-.100	.316	.100	-.326	.126	-	9	.343
	posthelp c...						1.000		
Pair 7	prestick t... -	-.600	.699	.221	-1.100	-.100	-	9	.024
	poststick t...						2.714		
Pair 8	preconfident... -	-.300	.483	.153	-.646	.046	-	9	.081
	postconfident...						1.964		

(table continues)

		Paired Differences				t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower Upper			
Pair 9	preresource... - postresource...	-.300	.483	.153	-.646 .046	- 1.964	9	.081
Pair 10	presolve m... - postsolve m...	-.400	.516	.163	-.769 -.031	- 2.449	9	.037
Pair 11	preable t... - postable t...	-.700	.949	.300	-1.379 -.021	- 2.333	9	.045
Pair 12	precalm w... - postcalm w...	-.800	.632	.200	-1.252 -.348	- 4.000	9	.003
Pair 13	precomfront... - postcomfront...	-.400	.516	.163	-.769 -.031	- 2.449	9	.037
Pair 14	preincoporat... - postincoporat...	-.900	1.197	.379	-1.756 -.044	- 2.377	9	.041
Pair 15	preusually... - postusually...	-.700	.675	.213	-1.183 -.217	- 3.280	9	.010

For Item 1, $t(9) = -4.188, p < 0.05$, means there was a significant difference between the pretest and posttest mean for Question 1. For Item 2, $t(9) = -2.714, p < 0.05$, there was a significant difference in the nurses' pre- and posttest responses. For Item 3, $t(9) = -1.909, p > 0.05$.

For items 3, 6, 8, and 9, even though there were differences between the means of the nurses' pretest and posttest responses, the differences were not significant. For items, 1, 2, 4, 5, 7, 10, 11, 12, 13, 14, and 15, there were significant differences in the mean scores of the pretest and posttest.

Recommendations

Based on the findings from this DNP project, the key recommendation for the nursing administration at this VA hospital is to implement the guidelines with further evaluation of the results with patients. Registered nurses who participated in the guideline development on this unit will be champions of reorganizing the orientation process and in including SCT into the process. Utilizing the proposed evidence-based orientation package, the nurses will help participants develop confidence in themselves, and by developing self-efficacy for coping, they may be able to successfully participate in the program. This approach has emerged as a focal mediator of posttraumatic recovery (Bandura, 2004).

Belsher et al. (2012) theorized that adjustment following trauma depended, in part, on interpersonal processing with supportive others, the foundation of group therapy. They identified behavioral outbursts as a clinical practice issue that may result in removal from therapeutic groups. Bandura (1986) identified that individuals needed coping self-efficacy, or the perceived ability to manage psychological and environmental demands associated with traumatic events for effective participation in group therapy and positive psychological outcomes.

Strengths and Limitations of the Project

A major strength of the project was that the development of the CPGs were based on current evidence and national guidelines on SCT-based behavior management among people with PTSD. With the opportunity to read about and discuss its use, participants were equipped with vital skills, knowledge, and confidence to transfer knowledge to

veterans they meet daily. Zaccagnini and White (2011) indicated that advanced nursing practice required effective use of current and complete evidence to guide clinical decision-making. Even though there were significant differences in the nurses' pretest and posttest responses, signifying a higher probability of incorporating evidence into nursing practice, actual implementation was beyond the scope of this project. As a result, the DNP student could not collect data on the final outcome. The use of one site and the small sample for the pre- and posttest data also limited the generalizability of the findings (Kuhberger, Fritz & Scherndl, 2014).

Recommendation for Future Projects

The next steps would be implementation of the CPG with frequent peer coaching as this change is introduced and evaluation over a 9- to 12-month timeframe. The recommendation for future projects should focus on barriers to effective behavioral management during group activities occurring among people with PTSD. Within the PTSD unit, the expectation is for program participants is to respect each other during treatment. If this expectation cannot be achieved, according to Bandura (1986), looking at relationship between expectation and self-efficacy is the key. SCT suggests that for people to engage in health-enhancing behaviors, they not only need to be confident in their ability to perform the behavior but also need to believe that the outcome of the behavior is beneficial (Benight, & Bandura, 2004).

Future researchers should replicate this project and make more detailed studies with larger sample sizes to facilitate a clearer and more comprehensive understanding of the effect of SCT in managing behavior with PTSD. In addition, future projects should

involve other health care professionals who care for patients with PTSD. Educational programs should be extended to other health care staff, including psychiatrist, dieticians, social workers, psychologists, and recreational therapists at the VA. Working collaboratively with other mental health practitioners to enhance existing PTSD treatments is in alignment with the IOM (2011) recommendation for nurses to act as full partners in redesigning efforts working collaboratively with leaders from other health professions. The IOM also charges nurses to work as full partners taking responsibility for identifying problems and areas of system waste, to devise and implement improvement plans, tracking improvement over time, and making necessary changes to realize set goals.

In evaluating the long-term effectiveness of this EBP, the five-dimensional reach, effectiveness, adoption, implementation, and maintenance RE-AIM model (Planas, 2008) should be used. Clinical effectiveness will be measured as the number veterans who successfully complete the program without returning within 6 months of completion. Economic measures may include how much money the agency saved by not dismissing patients out of the program resulting in readmission for more serious mental health issues. On an individual level, veterans can feel some self-confidence and be able to participate in group therapy and thus learn additional coping skills and behaviors. All these measures will indicate improved quality and the impact of the EBP.

Section 5: Dissemination Plan

The plan for dissemination is to present posters of the results of the process at the quality assurance poster presentation, which occurs annually at the VA. In addition, I will apply to have this paper and poster presented at nursing conferences. The nursing education PowerPoint will also be posted on the PULSE website for the VA's nurse leader groups. Finally, the evidence-based CPGs will be developed into a manuscript to be submitted for publication in professional journals.

Analysis of Self

The past 3 years have been a period of significant growth for me as a DNP student. I have grown spiritually, academically, and professionally. Spending many clinical hours on the PTSD unit and attending groups, recreational activities, team meetings, screening meetings, and staff meetings have given me opportunities and experiences with real people with real mental health needs and an understanding of how they cope, either effectively or not from my own perception.

Through the development of these CPGs, I have gained more knowledge, skill, and ability to effect change in the clinical area. As a director of a clinical service in my area, I have been able to make quality assurance changes based on evidence in the literature. One of those changes was the implementation of a fall-prevention program. This intervention affected nurse-sensitive indicator in my clinical area. This aligned with the AACN (2006) Essentials VII and VIII of applying sophisticated advanced nursing practice knowledge to support the design, the implementation, and the evaluation of comprehensive approaches that promote patient populations' health outcomes. AACN

(2006) referred to this utilizing of science-based knowledge as the basis for the highest level of nursing practice that upholds the highest ethical and legal standards; it also suggested disseminating scholarship and evidence-based knowledge to improve healthcare outcomes.

As project manager, developing evidence-based CPGs that nurses in the PTSD used in their clinical areas by establishing their confidence in incorporating theory into practice also helped me become confident as a practitioner and a leader. For instance, attending to spirituality in recovery and grounding techniques for coping in flashback groups was an attempt to associate self-confidence with having a degree of spirituality and control over one's emotions. Currier, Holland, and Drescher (2015) described spirituality as a many-sided concept that might affect veterans' recovery from PTSD in adaptive and maladaptive ways. I plan to incorporate spirituality into PTSD recovery in my clinical area.

Summary

The purpose of this project was to develop a new CPG with the nurses on the PTSD unit of a VA hospital. The creation of the CPG should increase the knowledge and the skill of the nurses on this unit, thereby increasing their confidence in incorporating evidence into nursing practices. The findings of this project demonstrated that nurses could make a change on the PTSD unit through implementation of the CPG based on SCT. With the nurses demonstrating increase confidence in implementing evidence into practice, veteran participants may be able to gain self-efficacy, to actively participate in the 6-week TFBGT, to remain in the program for the full 6 weeks, and to stay out of the

program. This, in turn, may save the VA's financial resources to utilize in improving patient outcomes. Nurses play an important role in health care through patient education; therefore, if the CPG proves successful, I recommend its adoption by all mental health units of VA hospitals across the United States, as effectively treating PTSD could lead to healthier lives for patients and families.

References

- American Association of Colleges of Nursing. (2006). *Essentials of doctoral education for advanced nursing practice*. Washington, DC: Author. Retrieved from <http://www.aacn.nche.edu/DNP/pdf/Essentials.pdf>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.
- Avella, J. R. (2016). Delphi panels: Research design, procedures, advantages, and challenges. *International Journal of Doctoral Studies*, *11*, 305-321. <https://doi.org/10.28945/3561>
- Bandura, A. (1986a). The explanatory and predictive scope of self-efficacy theory. *Journal of Social and Clinical Psychology*, *4*(3), 359-373. <https://doi.org/10.1521/jscp.1986.4.3.359>
- Bandura, A. (1986b). *Social foundations of thought and action*. Englewood Cliffs, NJ: Prentice Hall.
- Bandura, A. (1995). *Self-efficacy in changing societies*. New York, NY: Cambridge University Press.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York, NY: W. H. Freeman.
- Benight, C. C., & Bandura, A. (2004). Social cognitive theory of posttraumatic recovery: The role of perceived self-efficacy. *Behaviour Research and Therapy*, *42*(10), 1129–1148. <https://doi.org/10.1016/j.brat.2003.08.008>
- Belsher, B. E., Ruzek, J. I., Bongar, B., & Cordova, M. J. (2012). Social constraints,

posttraumatic cognitions, and posttraumatic stress disorder in treatment-seeking trauma survivors: Evidence for a social-cognitive processing model.

Psychological Trauma: Theory, Research, Practice, and Policy, 4(4), 386-391.

<http://doi.org/10.1037/a0024362>

Bisson, J. I., Roberts, N. P., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *Cochrane Database of Systematic Reviews*, 2013(12), CD003388.

<https://doi.org/10.1002/14651858.CD003388.pub4>

Brouwers, M., Kho, M. E., Browman, G. P., Burgers, J. S., Cluzeau, F., Feder, G., & Zitzelsberger, L. (2010). AGREE II: Advancing guideline development, reporting and evaluation in healthcare. *Canadian Medical Association Journal*, 182(18),

E839-E842. <https://doi.org/10.1503/cmaj.090449>

Brown, A. D., Kouri, N. A., Rahman, N., Joscelyn, A., Braynt, R. A., & Marmar, C. R.

(2016). Enhancing self-efficacy improves episodic future thinking and social decision making in combat veterans with posttraumatic stress disorder. *Psychiatry Research*, 242, 19-25. <https://doi.org/10.1016/j.psychres.2016.05.026>

Centers for Disease Control and Prevention. (2016, May). *Web-based injury statistics query and reporting system (WISQARS)*. Retrieved from

<http://www.cdc.gov/ncipc/wisqars>

Chard, K. M., Gilman, R., Holleb, L., & Teeters, A. (2012). Understanding and managing behaviors of children diagnosed with post traumatic stress disorder (PTSD). In J. B. Kolbert & L. M. Crothers (Eds.), *Understanding and managing behaviors of*

children with psychological disorders: A reference for classroom teachers (pp. 269–284). London, England: Bloomsbury Publishing.

- Cifu, D. X., Taylor, B., C., Carne, W. F., Bidelspac, D., Sayer, N. A., Scholten, J., . . . Campbell, E. H. (2013). Traumatic brain injury, posttraumatic stress disorder, and pain diagnoses in OIF/OEF/OND veterans. *Journal of Rehabilitation Research and Development*, *50*(9), 1169-1176. <https://doi.org/10.1682/JRRD.2013.01.0006>.
- Crum-Cianflone, N. F., Powell, T. M., LeardMann C. A., Russell, D. W., & Boyko, E. J. (2016). Mental health and comorbidities in U.S. military members. *Military Medicine*, *181*(6), 537-545. <https://doi.org/10.7205/MILMED-D-15-00187>
- Currier, J. M., Holland, J. M., & Drescher, K. D. (2015). Spirituality factors in the prediction of outcomes of PTSD treatment for U.S. military veterans. *Journal of Traumatic Stress*, *28*(1), 57-64. <https://doi.org/10.1002/jts.21978>
- Department of Health and Human Services. (2010). *Healthy people 2020*. Retrieved from http://www.healthypeople.gov/2020/TopicsObjectives2020/pdfs/HP2020_brochure.pdf
- Department of Veterans Affairs. (2010). *Analysis of VA health care utilization among Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans*. Washington, DC: Author. Retrieved from https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2937
- Department of Veterans Affairs. (2013). *VHA Handbook 1160.06*. Washington, DC: Author. Retrieved from https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2937

- Dunmore, D. M., Clark, M. D., & Ehlers, A. (1997). Cognitive factors in persistent versus recovered post-traumatic stress disorder after physical or sexual assault: A pilot study. *Behavioural and Cognitive Psychotherapy*, *25*(2), 147–159.
<https://doi.org/10.1017/S135246580001835X>
- Dunn, N. J., Rehm, L. P., Schillaci, J., Soucek, J., Mehta, P., Ashton, C. M., . . . Hamilton, J. D. (2007). A randomized trial of self-management and psychoeducational group therapies for comorbid chronic posttraumatic stress disorder and depressive disorder. *Journal of Traumatic Stress*, *20*(3), 221-237.
<https://doi.org/10.1002/jts.20214>
- Dursa, E. K., Reinhard, M. J., Barth, S. K., & Schneiderman, A. I. (2014). Prevalence of a positive screen for PTSD among OEF/OIF and OEF/OIF-era veterans in a large population-based cohort. *Journal of Traumatic Stress*, *27*(5), 542-549.
<https://doi.org/10.1002/jts.21956>
- Ferry, F. R., Brady, S. E., Bunting, B. P., Murphy, S. D., Bolton, D., & O’Neill, S. M. (2015). The economic burden of PTSD in Northern Ireland. *Journal of Traumatic Stress*, *28*(3), 191–197. <https://doi.org/10.1002/jts.22008>
- Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. A. (Eds.). (2008). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York, NY: Guilford Press.
- Giardino, A. E. (2009). Combat veterans, mental health issues, and the death penalty: Addressing the impact of post-traumatic stress disorder and traumatic brain injury. *Fordham Law Review*, *77*(6), 2955–2995. Retrieved from

<http://ir.lawnet.fordham.edu/flr/vol77/iss6/3>

- Glanz, K., Lewis, F. M., & Rimer, B. K. (Eds.). (2005). *Health behavior and health education: Theory, research and practice* (2nd ed.). San Francisco, CA: Jossey-Bass.
- Greenwald, R., & Shapiro, F. (2010a). What is EMDR?: Commentary by Greenwald and invited response by Shapiro. *Journal of EMDR Practice and Research*, 4(4), 170-179. <https://doi.org/10.1891/1933-3196.4.4.170>
- Greenwald, R., & Shapiro, F. (2010b). What is EMDR?: Concluding commentary by Greenwald and response by Shapiro. *Journal of EMDR Practice and Research*, 5(1), 25-28. <https://doi.org/10.1891/1933-3196.5.1.25>
- Hall, E., Chai, W., Koszewski, W., & Albrecht, J. (2015). Development and validation of a social cognitive theory-based survey for elementary nutrition education program. *International Journal of Behavioral Nutrition and Physical Activity*, 12(47), 1-12. <https://doi.org/10.1186/s12966-015-0206-4>
- Hartnett, T. (2010). *Consensus-oriented decision-making: The CODM model for facilitating groups to widespread agreement*. British Columbia, Canada: New Society Publishers.
- Haynes, P. L., Kelly, M., Warner, L., Quan, S. F., Krakow, B., & Bootzin, R. R. (2016). Cognitive behavioral social rhythm group therapy for veterans with posttraumatic stress disorder, depression, and sleep disturbance: Results from an open trial. *Journal of Affective Disorders*, 192, 234-243. <https://doi.org/10.1016/j.jad.2015.12.012>

- Hutchings, A., Raine, R., Sanderson, C., & Black, N. (2005). An experimental study of determinants of the extent of disagreement within clinical guideline development groups. *BMJ Quality & Safety, 14*(4), 240–245.
<https://doi.org/10.1136/qshc.2004.013227>
- Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. Washington, DC: National Academies. <https://doi.org/10.17226/12956>
- Jaeschke, R., Guyatt, G. H., Dellinger, P., Schunemann, H., Levy, M. M., Kunz, R., . . . Bion, J. (2008). Use of GRADE grid to reach decisions on clinical practice guidelines when consensus is elusive. *BMJ, 337*, a744.
<https://doi.org/10.1136/bmj.a744>
- Jerusalem, M., & Schwarzer, R. (1992). Self-efficacy as a resource factor in stress appraisal processes. In R. Schwarzer (Ed.), *Self-efficacy: Thought control of action* (pp. 195-213). Washington, DC: Hemisphere.
- Keeney, S., Hasson, F., & McKenna, H. (2006). Consulting the oracle: Ten lessons from using the Delphi technique in nursing research. *Journal of Advanced Nursing, 53*(2), 205-212. <https://doi.org/10.1111/j.1365-2648.2006.03716.x>
- Kettner, P. M., Moroney, R. M., & Martin, L. L. (2008). *Designing and managing programs: An effectiveness-based approach* (3rd ed.). Thousand Oaks, CA: Sage.
- Lahl, M., Modic, M. B., & Siedlecki, S. (2013). Perceived knowledge and self-confidence of pediatric nurses as patient educators. *Clinical Nurse Specialist, 27*(4), 188–193. <https://doi.org/10.1097/NUR.0b013e3182955703>
- Maciejewski, M. L., Liu, C., & Sales, A. E. (2005). Changes in characteristics of veterans

- using the VHA health care system between 1996 and 1999. *Health Research Policy and Systems*, 3(1), 5. <https://doi.org/10.1186/1478-4505-3-5>
- Makhashvili, N., Chikovani, I., Mckee, M., Bisson, J., Patel, V., & Roberts, B. (2014). Mental disorders and their association with disability among internally displaced persons and returnees in Georgia. *Journal of Traumatic Stress*, 27(5), 509-518. <https://doi.org/10.1002/jts.21949>
- McHugh, R. K., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments: A review of current efforts. *American Psychologist*, 65(2), 73-84. <https://doi.org/10.1037/a0018121>
- Moran, K., Burson, R., & Conrad, D. (2017). *The doctor of nursing practice scholarly project: A framework for success*. Burlington, MA: Jones & Bartlett Learning.
- Murphy, D., Hodgman, G., Carson, C., Spencer-Harper, L., Hinton, M., Wessely, S., & Busuttill, W. (2015). Mental health and functional impairment outcomes following a 6-week intensive treatment programme for UK military veterans with post-traumatic stress disorder (PTSD): A naturalistic study to explore dropout and health outcomes at follow-up. *BMJ Open*, 5(3), <https://doi.org/10.1136/bmjopen-2014-007051>
- National Center for PTSD (2010). Reports summarize mental health research from National Center for PTSD, Department of Veterans Affairs. *Mental Health Weekly Digest*.
- National Institute of Mental Health. (2015). *Strategic plan for research* (NIH publication number 15-6368). Bethesda, MD: Author. Retrieved from

https://www.nimh.nih.gov/about/strategic-planning-reports/nimh_strategicplanforresearch_508compliant_corrected_final_149979.pdf

National Institute of Mental Health. (2016, February). *Post-traumatic stress disorder*.

Retrieved from http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml#part_145370

President's New Freedom Commission on Mental Health. (2003, July). *Achieving the promise: Transforming mental health care in America* (Final Report, 115).

Rockville, MD: Substance Abuse and Mental Health Services Administration.

Retrieved from <https://store.samhsa.gov/shin/content/SMA03-3831/SMA03-3831.pdf>

Planas, L. G. (2008). Intervention design, implementation, and evaluation. *American Journal of Health-System Pharmacy*, 65(19), 1854-1863.

<https://doi.org/10.2146/ajhp070366>

Schnurr, P. P., Lunney, C. A., Bovin, M. J., & Marx, B. P. (2009). Posttraumatic stress disorder and quality of life: Extension of findings to veterans of the wars in Iraq and Afghanistan. *Clinical Psychology Review*, 29(8), 727-735.

<https://doi.org/10.1016/j.cpr.2009.08.006>

Schwarzer, R., & Jerusalem, M. (1995). Generalized self-efficacy scale. In J. Weinman, S. Wright, & M. Johnston (Eds.). *Measures in health psychology: A user's portfolio*. (pp. 35–37). Windsor, UK: NFER-Nelson.

Schwarzer, R., & Scholz, U. (2000, August). Cross-cultural assessment of coping resources: The general perceived self-efficacy scale. Paper presented at the Asian

Congress of Health Psychology: Health Psychology and Culture, Tokyo, Japan.

Retrieved from http://web.fuberlin.de/gesund/publicat/world_data.htm

- Seal, K. H., Bertenthal, D., Miner, C. R., Sen, S., & Marmar, C. (2007). Bringing the war back home: Mental health disorders among 103 788 US Veterans returning from Iraq and Afghanistan seen at Department of Veterans Affairs facilities. *Archives of Internal Medicine*, *167*(5), 476-482. <https://doi.org/10.1001/archinte.167.5.476>
- Seides, R. (2010). Should the current *DSM-IV-TR* definition for PTSD be expanded to include serial and multiple microtraumas as aetiologies? *Journal of Psychiatric and Mental Health Nursing*, *17*(8), 725–731. <https://doi.org/10.1111/j.1365-2850.2010.01591.x>
- Sloan, D. M, Unger, W., & Beck, J. G. (2015). Cognitive-behavioral group treatment for veterans diagnosed with PTSD: Design of a hybrid efficacy-effectiveness clinical trial. *Contemporary Clinical Trials*, *47*, 123-130. <https://doi.org/10.1016/j.cct.2015.12.016>
- Stevens, K. R. (2012). *Star model of EBP: Knowledge transformation*. San Antonio, TX: The University of Texas Health Science Center. Retrieved from <http://nursing.uthscsa.edu/onrs/starmodel/star-model.asp>
- Stevens, K. R. (2013). The impact of evidence-based practice in nursing and the next big ideas. *Online Journal of Issues in Nursing*, *18*(4), 4. <https://doi.org/10.3912/OJIN.Vol18No02Man04>
- Thomas, J. L., Wilk, J. E., Riviere, L. A., McGurk, D., Castro, C. A., & Hoge, C. W. (2010) Prevalence of mental health problems and functional impairment among

active component and National Guard soldiers 3 and 12 months following combat in Iraq. *Archives of General Psychiatry*, 67(6), 614–623.

<https://doi.org/10.1001/archgenpsychiatry.2010.54>

Wariki, W. M. V., Ota, E., Mori, R., Koyanagi, A., Hori, N., & Shibuya, K. (2012).

Behavioral interventions to reduce the transmission of HIV infection among sex workers and their clients in low- and middle-income countries. *Cochrane Database of Systematic Reviews*, 2012(2), CD005272.

<https://doi.org/10.1002/14651858.CD005272.pub3>

Wild, J., Smith, K. V., Thompson, E., Béar, F., Lommen, M. J., & Ehlers, A. (2016). A prospective study of pre-trauma risk factors for post-traumatic stress disorder and depression. *Psychological Medicine*, 46(12), 2571–2582.

<https://doi.org/10.1017/S0033291716000532>

Wilroy, J., Turner, L., Birch, D., Leaver-Dunn, D., Hibberd, E., & Leeper, J. (2017).

Development and evaluation of a social cognitive theory-based instrument to assess correlations for physical activity among people with spinal cord injury. *Disability and Health Journal*. Advance online publication.

<https://doi.org/10.1016/j.dhjo.2017.03.010>

World Health Organization. (2013). *The world health report 2004: Changing history*.

Geneva, Switzerland: Author. Retrieved from

http://www.who.int/whr/2004/en/report04_en.pdf?ua=1

Vermetten, E., Baker, D. G., Jetly, R., & McFarlane, A. C. (2016). Concerns over divergent approaches in the diagnostics of posttraumatic stress disorder.

Psychiatric Annals, 46(9), 498-509. [https://doi.org/10.3928/00485713-20160728-](https://doi.org/10.3928/00485713-20160728-02)

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Zaccagnini, M. E., & White, K.W. (2011). *The doctor of nursing practice essentials: A new model for advanced practice nursing*. Sudbury, MA: Jones & Barlett.

Appendix A: Literature Review Summary

Table 4

Literature Review Summary

Full Reference	Theoretical Framework	Research Method	Analysis & Result	Conclusion	Evidence Grading
Wariki, W. M. V., Ota, E., Mori, R., Koyanagi, A., Hori, N., & Shibuya, K. (2012). Behavioral interventions to reduce the transmission of HIV infection among sex workers and their clients in low- and middle-income countries. <i>Cochrane Database of Systematic Reviews</i> , 2012(2), CD005272. https://doi.org/10.1002/14651858.CD005272.pub3	None identified	Systematic review and meta-analysis of RCT	Evidence suggests that, compared with standard care or no intervention, SCBs are effective in reducing HIV and the incidence of STIs among female sex workers (FSWs)	There are benefits of social cognitive theory and the promotion of condom use in reducing HIV/STI, and the public health needs to control transmission among FSWs	1

(table continues)

Full Reference	Theoretical Framework	Research Method	Analysis & Result	Conclusion	Evidence Grading
Benight, C. C., & Bandura, A. (2004). Social cognitive theory of posttraumatic recovery: The role of perceived self-efficacy. <i>Behaviour Research and Therapy</i> , 42(10), 1129–1148. Retrieved from doi:10.1016/j.brat.2003.08.008	Diathesis-stress model; Proactive agentic model	Multivariate analyses		Perceived coping self-efficacy emerges as a focal mediator of posttraumatic recovery	2
Wilroy, J., Turner, L., Birch, D., Leaver-Dunn, D., Hibberd, E., & Leeper, J. (2017). Development and evaluation of a social cognitive theory-based instrument to assess correlations for physical activity among people with spinal cord injury. <i>Disability and Health Journal</i> . Article in press. Retrieved from doi:10.1016/j.dhjo.2017.03.010	Nonidentified	An expert panel review	Physical activity outcome variable was significantly and positively correlated with self-regulatory efficacy ($r = 0.575$), task self-efficacy ($r = 0.491$), self-regulation ($r = 0.432$)	The data provided support the convergent validity of the five-factor SCT model.	3

(table continues)

Full Reference	Theoretical Framework	Research Method	Analysis & Result	Conclusion	Evidence Grading
Stevens, K., (2013). The impact of evidence-based practice in nursing and the next big ideas. <i>Online Journal of Issues in Nursing, 18(4), 4</i> . Retrieved from doi: 10.3912/OJIN.Vol18No02Man04					
Schwarzer, R., & Jerusalem, M. (1995). Generalized self-efficacy scale. In J. Weinman, S. Wright, & M. Johnston (Eds.), <i>Measures in health psychology: A user's portfolio. Causal and control beliefs</i> (pp. 35–37). Windsor, UK: NFER-NELSON.					
Brown, A. D., Kouri, N. A., Rahman, N., Joscelyn, A., Braynt, R. A., & Marmar, C. R. (2016). Enhancing self-efficacy improves episodic future thinking and social decision making in combat veterans with posttraumatic stress disorder. <i>Psychiatry Research, 242</i> , 19–25. Retrieved from doi:10.1016/j.psychres.2016.05.026					3

(table continues)

Full Reference	Theoretical Framework	Research Method	Analysis & Result	Conclusion	Evidence Grading
<p>Lahl, M., Modic, M. B., & Siedlecki, S. (2013). Perceived knowledge and self-confidence of pediatric nurses as patient educators. <i>Clinical Nurse Specialist</i>, 27(4), 188–193. Retrieved from doi:10.1097/NUR.0b013e3182955703</p>				<p>Findings from this study can be used to develop teaching resources for nurses and to plan educational programs specific to less common pediatric problems.</p>	3
<p>Schwarzer, R., & Scholz, U. (2000, August 28–29). <i>Cross-cultural resources: The general perceived self-efficacy scale</i>. Paper presented at the Asian Congress of Health Psychology 2000: Health Psychology and Culture, Tokyo. Retrieved November 16, 2005, from http://web.fuberlin.de/gesund/publicat/world_data.htm.doi:10.1001/archpsyc.60.5.481</p>					

Table 5

Revision History

Revision History			
Revision #	Date of Release	Owner	Summary of Changes
7/15/17	8/5/17	Mary Badru	

Overview**Abstract**

Despite the familiarity and skills of mental health practitioners in adapting the current evidence-based approaches to the needs of the veterans in a PTSD unit in an Eastern U.S. VA hospital, behavioral outbursts continue to be an issue. This result in 2 out of 10 veterans admitted is expelled without completing the 6-week program. One out of 5 veterans who complete the program return to the program within 6 months. The purpose of the EBP is to create a clinical practice guideline based on SCT. Two out of 10 veterans admitted are expelled without completing the 6-week program. One out of 5 veterans who complete the program return to the program within 6 months, and there is a need for an improved approach for veterans with PTSD. Because SCT has been successfully used to manage behavior in other programs, the question is whether it will help manage behavioral outburst during group activities on the PTSD unit.

Methods

[AGREE II with consensus to implement. Four meetings with review of evidence, 15 Likert questions given to the nurses before and after the CPG development to compare the nurses' knowledge and comfort level with implementing the CPG.

Results and Discussion

A one-tailed paired samples *t* test is used to test the mean differences of a single sample of population using two scale measures and having a normal distribution of different scores. The results for items 1–15 (Item 1, $t(9) = -4.188, p < 0.05$) demonstrate that there is a significant difference between the pre- and posttest mean for question 1 and 15, which means knowledge was improved about the role SCT plays in behavior management, and the consensus to implement it was reached.

Institutional Affiliation of Adaptation Panel

Walden University

The AGREE II is both valid and reliable and consists of 23 key criteria organized within 6 domains (<http://www.agreetrust.org>). The 6 domains and 23 items by domain include:

Domain 1: Scope and Purpose

The overall objective of the guideline is to support a nursing revision of the existing veteran orientation package, which includes provision of education for veterans on the PTSD unit. By incorporating the principles postulated by SCT in a CPG and providing the nurses instruction on its use, they will acquire self-efficacy, self-confidence, and knowledge in incorporating the same principles into the orientation

process. STAR was utilized for this project. The STAR model is a framework for the systematic integration of evidence into practice (Stevens, 2004). The STAR model is composed of five major stages: knowledge discovery, evidence summary, translation into practice recommendations, integration into practice, and evaluation. The STAR model is one of the most commonly used frameworks that have influenced the nursing practice (Stevens, 2012).

The health question covered by the guideline is what impact the development of an evidence-based CPG will have, based on SCT, on the orientation process for veterans entering the PTSD unit at a VA hospital. The premise of this evidence-based intervention is to develop a CPG based on the SCT with the nurses on the PTSD unit. The expected outcome is that the nurses will develop confidence in transferring the knowledge gained into supplementing the current orientation process they lead for the program participants; by doing so, participants in the PTSD group therapy may have better control over behavioral outbursts. Belsher et al. (2012) theorized that adjustment following trauma depends, in part, on interpersonal processing with supportive others, which is the foundation of group therapy.

Domain 2: Stakeholder Involvement

The guideline development group includes individuals from all the relevant professional groups on the PTSD unit: registered nurses, licensed practical nurses, psychologists, and social workers. As the AGREE II requires expert assessment and consensus about the quality of the evidence and the incorporation of the evidence into a meaningful guideline, this project uses a Consensus Decision Making (Process) Model

(Hartnett, 2010) with the Delphi technique (Avella, 2016). The Delphi technique involves group discussions where participants share expert clinical opinions and perspectives about elements of a quality improvement project (Avella, 2016). The goal is to arrive at a collective conclusion about the strategies to guide the project (Hartnett, 2010). Keeney et al. (2006) identified the Delphi technique as an essential method in achieving consensus on subjects where none previously existed. The nurses will be informed that this is their practice change initiative to improve their participation. Having the team of nurses see this as their quality improvement project may empower them to execute the project and practice change.

Consensus, according to Avella (2016), does not mean 100% agreement, as it might be extremely difficult to get groups of individuals representing different constituencies with varying viewpoints and priorities to reach unanimity. Vernon (2009) stated that Delphi consensus typically ranges from 55 to 100% agreement, with 70% considered the standard. Because reaching consensus among the nurses will be essential in incorporating the SCT-based orientation into their practice, volunteer opportunities will be requested from all shifts. Hutchings et al. (2005) described this consensus-reaching technique as a nominal group technique involving a “nominal” sample of about 10 people and that includes a meeting to discuss areas of disagreement. As an alternative to this technique, Hutchings et al. (2005) identified the mail-only Delphi survey in which participants complete two or more rounds of questionnaires. This approach is a hybrid method developed by the RAND Corporation under the U.S. government contract in the 1950s as a method to forecast likely outcomes from nuclear weapon use in war. To

promote sustainability, consideration will be given to the volunteers' ideas, and the DNP student will act like a facilitator in implementing the EBP.

As PTSD is one of the most visible and debilitating psychiatric disorders among combat-seeking medical care, the VA is extremely concerned about clinicians' ability to provide the appropriate support and care for these veterans (Foa et al., 2008). However, current treatment approaches (e.g., the TFBGT), have not been successful in managing behavioral outbursts among PTSD group participants. Sloan et al. (2015) acknowledged that research specific to PTSD and multiple group approaches to therapy is lagging due to the complexity of conducting randomized controlled trials in the group treatment context. This limited experimental knowledge is problematic given the frequency with which group treatment for PTSD is used in clinical settings like the VA. Nurses can address this practice gap, hence the purpose of the EBP, which is to create an evidence-based CPG, based on SCT, with an educational program for nurses to improve clinical practice. This new CPG can reduce the number of veterans who are unable to complete the program due to behavioral outbursts. The nurses who provide clinical orientation once a week to the unit will be using the CPG with veterans' program participants.

Domain 3: Rigor of Development

SCT has been successfully used in many settings to change behavior. In a systematic review comparing the effects on the HIV transmission risk of different behavioral interventions with no intervention, RCTs and quasi-RCTs were examined. A total of 13 trials with 8,698 participants were included. Primary outcomes (HIV and STI prevalence and incidence) were reported in seven trials. Of these, HIV incidence was

reported in only three trials. After a 6-month follow-up assessment, there was no evidence that social cognitive behavioral intervention was effective in reducing HIV incidence (RR 0.12, 95% CI 0.01 to 2.22). However, there was a reduction in HIV incidence at 3-month follow-up assessment of the promotion of female and male condom use (RR 0.07, 95% CI 0.00 to 1.38). Social cognitive interventions and the promotion of female and male condom use significantly reduced STIs incidence (RR 0.57, 95% CI 0.34 to 0.96) and (RR 0.63, 95% CI 0.45 to 0.88), respectively. Secondary outcomes were identified in 13 trials. Meta-analyses showed evidence that the interventions to promote the use of female and male condoms reduced noncondom use (RR 0.83, 95% CI 0.65 to 1.05) compared to the promotion of male condoms alone and that social cognitive interventions reduced drug use among sex workers (RR 0.65, 95% CI 0.36 to 1.16) compared to standard care. The available evidence nevertheless suggests that, compared with standard care or no intervention, behavioral interventions are effective in reducing HIV and the incidence of STIs among FSWs. Given the benefits of SCT and the promotion of condom use in reducing HIV/STI and the public health need to control transmission among FSWs, there is a clear finding in favor of behavioral interventions based on SCT. SCT has been used in managing behavior in several settings. In developing an educational nutritional program, Hall et al. (2015) assessed knowledge, behavior, and self-efficacy for healthy eating among fifth-grade students. A positively correlated relationship between self-efficacy and behaviors was identified ($r = 0.40, p = 0.0001$).

In another study, an examination of pediatric nurses' perceptions about patient/family education in the hospital setting used a 20-item questionnaire that explored how factors including SCT affected the teaching behaviors of 54 pediatric nurses in an acute care hospital setting (Lahl et al., 2013). Results from this study suggest that pediatric nurses with higher use of SCT constructs were confident providing education about common disorders (asthma, pneumonia, and bronchiolitis). Wilroy et al. (2017), in developing and testing a SCT-based instrument, aimed to predict physical activity among people with SCI. The result indicated that the physical activity outcome variable was significantly and positively correlated with all the five-factor SCT models: self-regulatory efficacy ($r = 0.575$), task self-efficacy ($r = 0.491$), self-regulation ($r = 0.432$), social support ($r = 0.284$), and outcome expectations ($r = 0.247$). Internal consistency for the constructs ranged from 0.82 to 0.96. Construct reliability values for the self-regulation (0.95), self-regulatory efficacy (0.96), task self-efficacy (0.94), social support (0.84), and outcome expectations (0.92) each exceeded the 0.70 a priori criteria.

The literature search was conducted on databases and search engines including Cochrane, Ovid, CINANL, SAGE, PCYCHInfo, and Google Scholar. The keywords searched were PTSD among veterans, SCT and self-efficacy, behavior management, self-efficacy tool, OEF/OIF veterans, ACE Star model in nurse education, Veteran Administration website, and the National Institute for Mental Health. The current literature is limited to two to three related systematic reviews. To include more general and specific literature, the review was expanded to include articles within 10 years, and 30–35 additional articles were available. Twenty of those articles are relevant to the EBP

and are included in the review. Sources or reviews include the Archives of Internal Medicine, Journal of Behavior Research and Therapy, VHA Handbook, Iraq War Clinical Guide, Institute of Medicine, Journal of Psychiatry Research & Neuroimaging, Web-based injury Statistics Query and Reporting System, Institute of Medicine, The Annual Review of Public Health, Nurse Practitioner Healthcare Foundation, Journal of Addiction Medicine, US Government Fact Sheets, Science Direct, and the American Journal of Nursing. This search encompassed a comprehensive review of the literature to address the practice focus question and will be exhausted after the problem has been addressed.

Because some predictors of behavioral outburst such as psychiatric history are fixed and cannot be modified (Wild et al., 2016), the assumption is that others such as cognitive styles and behavioral traits are modifiable by training to reduce the risk of being expelled from the program. It is also assumed that the nurses on the PTSD unit will contribute to this practice improvement project. This study will be limited to one VA hospital in the Northeast United States.

The long-term implications of untreated PTSD include quality of life issues, impaired psychosocial and occupational functioning, overall well-being, and suicide (Schnurr et al., 2009). The highest rates were among combat deplorers. Because most cases were not represented in medical codes, Crum-Cianflone (2016) suggested that targeted interventions are needed to address the burden of mental disorders among service members and veterans.

It is necessary to develop strategies that will be effective and efficient in dealing with PTSD. SCT considers the key construct of self-efficacy (i.e., a person's confidence

in his or her ability to perform a certain behavior), which means that if an individual feels more confident, he or she can successfully engage in a certain behavior (e.g., overcome barriers), and he or she is more likely to engage in that activity and interventions.

Improving self-efficacy will increase behavioral compliance. Glanz and Rimer (2005) explained that if individuals have a sense of self-efficacy, they can change their behaviors, even when faced with obstacles.

Domain 4: Clarity of Presentation

One evidence-based treatment used commonly in the VA to manage PTSD is the TFBGT. This treatment embeds exposure in a group context that includes psychoeducation, cognitive restructuring, relapse prevention, and coping skills training (Department of Veterans Affairs, 2013). This was specifically developed for patients who might not otherwise tolerate or comply with individual exposure therapy. There is no evidence that these therapies allow participants to gain the self-confidence and self-control to be able to participate in the program.

The STAR model is a framework for the systematic integration of evidence into practice and will guide this project (Stevens, 2004). The STAR model is composed of five major stages: knowledge discovery, evidence summary, translation into practice recommendations, integration into practice, and evaluation. The STAR model is one of the most commonly used frameworks that have influenced nursing practice (Stevens, 2012).

The transformation of evidence summaries into practice requires two stages: the translation of evidence into practice recommendations and the integration into practice

(Stevens, 2012). The aim of translation is to provide a useful and relevant package of summarized evidence to clinicians in a form that suits the time, cost, and care standard. The providers in turn integrate the evidence into their daily practice. Recommendations are generically termed CPGs and may be represented or embedded in care standards, clinical pathways, protocols, and algorithms. CPGs are tools to support informed clinical decisions for the clinician, organization, and client (Jaeschke et al., 2008). The strongest CPGs are developed systematically using a clear process that is reproducible. Stevens (2004) further stressed that summarized research evidence is interpreted and combined with other sources of knowledge (such as clinical expertise and theoretical guides) and then contextualized to the specific client population and setting. Evidence-based CPGs explicitly articulate the link between the clinical recommendation and the strength of supporting evidence and/or the strength of recommendation.

The first step is a knowledge-generating stage where new knowledge is discovered through the traditional research methodologies and scientific inquiry. This stage of development constructs the corpus of research about clinical actions. The literature review will focus on the impact SCT has in managing behavior in PTSD patients. Stevens (2013) suggested that the next step is to synthesize the body of research knowledge into a single, meaningful statement of the state of the science. The most advanced EBP methods to date are those used to develop evidence summaries (i.e., evidence synthesis, and systematic reviews). For example, the systematic review methods that Stevens (2013) conveyed are outlined in the Cochrane Handbook from randomized control clinical trials. This stage is also considered a knowledge-generating stage, which

occurs simultaneously with the summarization. Evidence summaries produce new knowledge by combining findings from all studies while also identifying bias and limiting chance effects in the conclusions. The systematic methodology also increases the reliability and reproducibility of results.

The summary of the literature and suggestions for new models of treatment will be provided to the nursing staff and other health care providers on the team for feedback. The author will develop protocols based on SCT and create a PowerPoint on the use of the protocol to educate the nursing staff. The developed protocol and guideline will be presented to the group for feedback, review, and final draft. The nurses' consensus proposal will then be presented to interprofessional team members and to the Nursing Practice Council.

The next two stages of the model will not be part of the study but must be understood in the context of change in the nursing practice. Integration is perhaps the most familiar stage in health care because of society's long-standing expectation that health care is based on the most current knowledge, thus requiring implementation of innovations. This step involves changing both individual and organizational practices through formal and informal channels (Stevens, 2004). The major aspects addressed in this stage are factors that affect the individual and organizational rate of adoption of innovation and factors that affect integration of the change into sustainable systems.

The final stage in knowledge transformation is evaluation. In EBP, a broad array of endpoints and outcomes are evaluated. These include evaluation of the impact of EBP on patient health outcomes, provider and patient satisfaction, efficacy, efficiency,

economic analysis, and health status impact. In conclusion, as new knowledge is transformed through the five stages, the outcome is evidence-based, quality improvement of health care. In this case, nurses on the PTSD unit will be involved in incorporating the newly tailored package into the weekly orientation process. This new package will contain concepts to be taught to the veterans, with the hope that veterans will be able to successfully participate in the PTSD program.

Domain 5: Applicability

Description. This domain pertains to the likely barriers and facilitators to implementation, strategies to improve uptake, and cost implications of applying the guideline.

Items. The guideline describes the facilitators and barriers to its application; the guideline provides advice and/or tools on how the recommendations can be put into practice; the potential resource implications of applying the recommendations have been considered; and the guideline presents monitoring and/or auditing criteria.

Domain 6: Editorial Independence

Description. This domain is concerned with the formation of recommendations not being unduly biased with competing interests.

Items. 22) The views of the funding body have not influenced the content of the guideline; and 23) the competing interests of guideline development group members have been recorded and addressed.

Consensus, according to Avella (2016), does not mean 100% agreement, as it might be extremely difficult to get groups of individuals representing different constituencies with varying viewpoints and priorities to reach unanimity. Vernon (2009) stated that the Delphi consensus typically ranges from 55 to 100% agreement, with 70% considered the standard. Because reaching consensus among the nurses will be essential in incorporating SCT-based orientation into their practice, volunteer opportunities will be requested from all shifts. Hutchings et al. (2005) described this consensus-reaching technique as a nominal group technique involving a nominal sample of about 10 people and that includes a meeting to discuss areas of disagreement. As an alternative to this technique, Hutchings et al. (2005) identified the mail-only Delphi survey in which participants completed two or more rounds of questionnaires. This approach is a hybrid method developed by the RAND Corporation under the U.S. government contract in the 1950s as a method to forecast likely outcomes from nuclear weapons usage in war. To promote sustainability, consideration will be given to the volunteers' ideas, and the DNP student will act like a facilitator in implementing the EBP.

Recommendations: Advice for Veterans Admitted Into the 6-Week Posttraumatic Stress Disorder Program

- To be successful, one needs the ability to manage psychological and environmental demands (Bandura, 1986).
- If someone opposes you, you can exercise some self-control knowing there are consequences for all actions (Bandura, 1986).

- People can successfully engage in certain barrier-overcoming behavior (Glanz & Rimer, 2005).
- Stick to your aims and accomplish your goals (Bandura, 1986).
- Be confident when dealing efficiently with untoward behavior (Bandura, 1977, 1986).
- Identify resources available to you in handling unforeseen situations (Belsher et al., 2012).
- Remain calm when facing difficulties because you can rely on your coping abilities.
- When confronted with a problem, the IDT is here to help you explore several solutions (Belsher et al., 2012).
- When in trouble, you can usually think of a solution instead of reacting negatively (Glanz & Rimer, 2005).
- How do you cope with whatever comes your way (Bandura, 2004)?
- Having self-efficacy in dealing with negativity makes one successfully engage in a certain behavior (Hall et al., 2015).
- With self-efficacy, people can exercise influence over what they do.
- Are you able to set a goal and have the confidence to complete the tasks that will lead to the accomplishment of Bandura's (2004) goal?

Health Risks and Benefits

There is no risk associated with the recommendations, but benefits include the ability to participate successfully in the 6-week program and to not return within 6 months.

Supporting Evidence and Information

SCT hypothesizes that the person–behavior environment interaction with others is a basis for reciprocal determinism (Bandura, 1977, 1986). Bandura (1977, 1986, 1997) suggested that an individual’s self-efficacy expectations largely determine the outcome expectations. Basically, the core of self-efficacy theory is the assumption that people can exercise influence over what they do. SCT is based on a dynamic and reciprocal model of interactions among behavior, personal factors, and environmental influences, and self-efficacy is considered the key construct in the theory (Bandura, 1986). Self-efficacy concerns a person’s confidence in his or her ability to perform a certain behavior. The primary sources of efficacy information include performance experience, verbal persuasion, vicarious experience, and physiologic and affective states (Bennight & Bandura, 2004).

SCT considers the key construct self-efficacy (i.e., a person’s confidence in his or her ability to perform a certain behavior), which means that if an individual feels more confident that he or she can successfully engage in a certain behavior (e.g., overcome barriers), he or she is more likely to engage in that activity and interventions. Improving self-efficacy should then increase behavioral compliance. SCT described confidence as one’s ability to engage in specific behaviors, goals, and expectations. In doing so,

positive outcomes become evident through healthy behavior. Glanz and Rimer (2005) explained that if individuals have a sense of self-efficacy, they can their change behaviors, even when faced with obstacles.

External Review Panel

The nurse council included clinical nurse leaders, ADPAC, nurse managers, and nurse educators who reviewed the guideline.

Discussion of Feedback

As the AGREE II requires expert assessment and consensus about the quality of the evidence and the incorporation of the evidence into a meaningful guideline, this project uses a Consensus Decision Making (Process) Model (Hartnett, 2010) with the Delphi technique (Avella, 2016). The summary of the literature and suggestions for new models of treatment were provided to the nursing staff and other health care providers on the team for feedback. The nurses with the author developed protocols. The developed protocol and guideline were presented to the evening and night shift group for feedback, review, and final draft. The nurses' consensus proposal was then presented to interprofessional team members and to the Nursing Practice Council. The Delphi technique involves group discussions where participants share expert clinical opinions and perspectives about elements of a quality improvement project (Avella, 2016). The goal is to arrive at a collective conclusion about the strategies to guide the project (Hartnett, 2010). Keeney et al. (2006) identified the Delphi technique as an essential method in achieving consensus on subjects where none previously existed. The nurses will be informed that this is their practice change initiative to improve their participation.

Having the team of nurses see that this is their quality improvement project may empower them to execute the project and practice change. Eight of 10 nurses reached a consensus to proceed with the protocols.

Plan for Scheduled Review and Update

The chief of quality management, the Nursing Practice Council at the VA, the nursing administration staff, and mental health practitioners reviewed the guideline and made some suggestions that were taken into consideration. The end users agreed to update the guideline with the other nursing SOP every 3 years per policy.

Table 6

Algorithm or Summary Document

Self-efficacy: Made up of confidence and temptation

Confidence	Confidence that one can engage in the healthy behavior across different challenging situations
Temptation	Temptation to engage in the unhealthy behavior across different challenging situations

Social Cognitive Theory

Construct	Definition
Environment	Factors physically external to the person
Situation	Person's perception of the environment
Behavioral capability	Knowledge and skill to perform a behavior
Expectations	Anticipatory outcomes of a behavior
Expectancies	The values that the person places on a given outcome, incentives
Self-control	Personal regulation of goal-directed behavior or performance
Observational learning	Behavioral acquisition that occurs by watching the actions and outcomes of others' behavior
Reinforcements	Responses to a person's behavior that increase or decrease the likelihood of recurrence
Self-efficacy	The person's confidence in performing a particular behavior
Emotional coping responses	Strategies or tactics that are used by a person to deal with emotional stimuli
Reciprocal determinism	The dynamic interaction of the person, the behavior, and the environment in which the behavior is performed

Note: Table adapted from: Glanz et al., Table 4.1, p. 62 (*Transtheoretical Model*

Constructs) and Table 8.2, p. 157 (*Major Concepts in Social Cognitive Theory and*

Implications for Intervention).

Facilitators and Barriers

Sloan et al. (2015) acknowledged that research specific to PTSD and multiple group approaches to therapy is lagging due to the complexity of conducting randomized controlled trials in the group treatment context. Because some predictors of behavioral outburst such as psychiatric history are fixed and cannot be modified (Wild et al., 2016), the assumption is that others, such as cognitive styles and behavioral traits, are modifiable by training to reduce the risk of being expelled from the program. The current trauma-based group therapy is administered by mental health practitioners (psychiatrists and psychologists) who report to a separate service line, but this proposed EBP will be administered by nurses. Another challenge might be the client's behavior exhibited due to the disease process itself (PTSD), which Kettner et al. (2008) called a prerequisite to the existence of the problem.

The current trauma-based group therapy is administered by mental health practitioners (psychiatrists and psychologists) who report to a separate service line, but this proposed EBP will be administered by nurses. Another challenge might be the client's behavior exhibited due to the disease process itself (PTSD), which Kettner et al. (2008) called a prerequisite to the existence of the problem.

Monitoring Guideline Adherence

Evaluation will be conducted by the nurse manager over a 9–12-month timeframe with weekly peer coaching as the guideline is introduced.

Table 7

Glossary of Unfamiliar Terms

Term	Definition
Self-efficacy: Made up of confidence and temptation	
Confidence	Confidence that one can engage in the healthy behavior across different challenging situations
Temptation	Temptation to engage in the unhealthy behavior across different challenging situations
<i>Social Cognitive Theory</i>	
Construct	Definition
Environment	Factors physically external to the person
Situation	Person's perception of the environment
Behavioral capability	Knowledge and skill to perform a behavior
Expectations	Anticipatory outcomes of a behavior
Expectancies	The values that the person places on a given outcome, incentives
Self-control	Personal regulation of goal-directed behavior or performance
Observational learning	Behavioral acquisition that occurs by watching the actions and outcomes of others' behavior
Reinforcements	Responses to a person's behavior that increase or decrease the likelihood of recurrence
Self-efficacy	The person's confidence in performing a particular behavior
Emotional coping responses	Strategies or tactics that are used by a person to deal with emotional stimuli
Reciprocal determinism	The dynamic interaction of the person, the behavior, and the environment in which the behavior is performed

Appendix B: AGREE II Domains and Criteria

Table 8

One-Sample Kolmogorov-Smirnov Test

		Postpercent
N		75
Normal Parameters ^{a,b}	Mean	19.600
	Std. Deviation	17.9669
	Absolute	.210
Most Extreme Differences	Positive	.210
	Negative	-.179
Kolmogorov-Smirnov Z		1.820
Asymp. Sig. (2-tailed)		.003

a. Test distribution is Normal.

b. Calculated from data.

Table 9

One-Sample Kolmogorov-Smirnov Test

		Prepercent
N		75
Normal Parameters ^{a,b}	Mean	19.867
	Std. Deviation	12.7865
	Absolute	.193
Most Extreme Differences	Positive	.193
	Negative	-.159
Kolmogorov-Smirnov Z		1.673
Asymp. Sig. (2-tailed)		.007

a. Test distribution is Normal.

b. Calculated from data.

Table 10

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Prepercent	13.456	74	.000	19.8667	16.925	22.809
Postpercent	9.447	74	.000	19.6000	15.466	23.734

The AGREE II is both valid and reliable and consists of 23 key criteria organized within 6 domains (<http://www.agreetrust.org>). The 6 domains and 23 items by domain include:

Domain 1: Scope and Purpose

Description. The scope and purpose domain is concerned with the overall aim of the guideline, the specific health questions, and the target population.

Items. 1) The overall objective(s) of the guideline is (are) specifically described; 2) the health question(s) covered by the guideline is (are) specifically described; and 3) the population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.

Domain 2: Stakeholder Involvement

Description. This domain focuses on the extent to which the overall aim of the guideline was developed by the appropriate stakeholders and represents the views of its intended users.

Items. 4) The guideline development group includes individuals from all the relevant professional groups; 5) the views and preferences of the target population

(patients, public, etc.) have been sought; and 6) the target users of the guideline are clearly defined.

Domain 3: Rigor of Development

Description. This domain relates to the process used to gather and synthesize the evidence, the methods to formulate and update recommendations.

Items. 7) Systematic methods were used to search for evidence; 8) the criteria for selecting the evidence are clearly described; 9) the strengths and limitations of the body of evidence are clearly described; 10) the methods for formulating the recommendations are clearly described; 11) the health benefits, side effects, and risks have been considered in formulating the recommendations; 12) there is an explicit link between the recommendations and the supporting evidence; 13) the guideline has been externally reviewed by experts prior to its publication; and 14) a procedure for updating the guideline is provided.

Domain 4: Clarity of Presentation

Description. This domain deals with the language, structure, and format of the guideline.

Items. 15) The recommendations are specific and unambiguous; 16) the different options for management of the condition or health issue are clearly presented; and 17) key recommendations are easily identifiable.

Domain 5: Applicability

Description. This domain pertains to the likely barriers and facilitators to implementation, strategies to improve uptake, and cost implications of applying the guideline.

Items. 18) The guideline describes the facilitators and barriers to its application; 19) the guideline provides advice and/or tools on how the recommendations can be put into practice; 20) the potential resource implications of applying the recommendations have been considered; and 21) the guideline presents monitoring and/or auditing criteria.

Domain 6: Editorial Independence

Description. This domain is concerned with the formation of recommendations not being unduly biased with competing interests.

Items. 22) The views of the funding body have not influenced the content of the guideline; and 23) the competing interests of guideline development group members have been recorded and addressed.

Table 11

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Preunderstand PTSD	2.90	10	1.287	.407
	Postunderstand PTSD	4.30	10	.675	.213
Pair 2	Premanage for help	2.70	10	1.567	.496
	Postmanage for help	3.90	10	.994	.314
Pair 3	Prebelieve change	3.40	10	1.350	.427
	Postbelieve change	4.10	10	.738	.233
Pair 4	preoppose m...	3.10	10	1.197	.379
	postoppose m...	3.80	10	1.033	.327
Pair 5	pretrouble...	4.00	10	.816	.258
	posttrouble...	4.40	10	.699	.221
Pair 6	prehelp c...	3.90	10	.876	.277
	posthelp c...	4.00	10	.816	.258
Pair 7	prestick t...	3.40	10	1.265	.400
	poststick t...	4.00	10	1.054	.333
Pair 8	preconfident...	3.70	10	1.337	.423
	postconfident...	4.00	10	.943	.298
Pair 9	preresource...	3.90	10	.876	.277
	postresource...	4.20	10	.789	.249
Pair 10	presolve m...	3.80	10	.789	.249
	postsolve m...	4.20	10	.789	.249
Pair 11	preable t...	3.60	10	1.350	.427
	postable t...	4.30	10	.675	.213
Pair 12	precalm w...	3.60	10	.843	.267
	postcalm w...	4.40	10	.699	.221
Pair 13	preconfront...	4.00	10	.816	.258
	postconfront...	4.40	10	.699	.221
Pair 14	preincorporat...	3.50	10	1.269	.401
	postincorporat...	4.40	10	.699	.221
Pair 15	preusually...	3.40	10	1.265	.400
	postusually...	4.10	10	.994	.314

Table 12

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	preunderstand PTSD & postunderstand PTSD	10	.550	.099
Pair 2	premanage for help & postmanage for help	10	.478	.163
Pair 3	prebelieve change & postbelieve change	10	.513	.129
Pair 4	preoppose m... & postoppose m...	10	.827	.003
Pair 5	pretrouble... & posttrouble...	10	.778	.008
Pair 6	prehelp c... & posthelp c...	10	.933	.000
Pair 7	prestick t... & poststick t...	10	.833	.003
Pair 8	preconfident... & postconfident...	10	.969	.000
Pair 9	preresource... & postresource...	10	.837	.003
Pair 10	presolve m... & postsolve m...	10	.786	.007
Pair 11	preable t... & postable t...	10	.756	.011
Pair 12	precalm w... & postcalm w...	10	.678	.031
Pair 13	precomfront... & postcomfront...	10	.778	.008
Pair 14	preincorporat... & postincorporat...	10	.376	.285
Pair 15	preusually... & postusuallt...	10	.848	.002

Table 13

Paired Samples Test

		Paired Differences					T	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	preunderstand PTSD– postunderstand PTSD	-1.400	1.075	.340	-2.169	-.631	-4.118	9	.003
Pair 2	premanage for help–postmanage for help	-1.200	1.398	.442	-2.200	-.200	-2.714	9	.024
Pair 3	prebelieve change–postbelieve change	-.700	1.160	.367	-1.529	.129	-1.909	9	.089
Pair 4	preoppose m... – postoppose m...	-.700	.675	.213	-1.183	-.217	-3.280	9	.010
Pair 5	pretrouble...– posttrouble...	-.400	.516	.163	-.769	-.031	-2.449	9	.037
Pair 6	prehelp c...– posthelp c...	-.100	.316	.100	-.326	.126	-1.000	9	.343
Pair 7	prestick t...– poststick t...	-.600	.699	.221	-1.100	-.100	-2.714	9	.024
Pair 8	preconfident... – postconfident...	-.300	.483	.153	-.646	.046	-1.964	9	.081
Pair 9	preresource...– postresource...	-.300	.483	.153	-.646	.046	-1.964	9	.081
Pair 10	presolve m...– postsolve m...	-.400	.516	.163	-.769	-.031	-2.449	9	.037
Pair 11	preable t...– postable t...	-.700	.949	.300	-1.379	-.021	-2.333	9	.045
Pair 12	precalm w...– postcalm w...	-.800	.632	.200	-1.252	-.348	-4.000	9	.003

(table continues)

		Paired Differences					T	df	Sig.
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				(2-tailed)
					Lower	Upper			
Pair 13	preconfront... –	- .400	.516	.163	-.769	-.031	-	9	.037
	postconfront...						2.449		
Pair 14	preincorporation...	-.900	1.197	.379	-1.756	-.044	-	9	.041
	–						2.377		
Pair 15	postincorporation...								
	preusually... –	-.700	.675	.213	-1.183	-.217	-	9	.010
	postusually...						3.280		