EXPERIENCE EXCHANGE

Teaching comprehensive psychodynamic assessment to psychiatric mental health nurse practitioner students: A clinical review essay

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ABSTRACT

Contemporary Psychiatric Mental Health Nurse Practitioner (PMHNP) education provides strong preparation in pharmacology and diagnosis yet often affords insufficient depth in psychodynamic case formulation, developmental theory, and therapeutic relationship competencies. This clinical review essay describes a structured pedagogical approach developed to address this gap in advanced psychiatric nursing education. The approach was developed and refined over 27 years of PMHNP preceptorship at a large urban, safety-net academic medical center, encompassing supervision of approximately 800 students from more than ten universities across emergency, inpatient, outpatient, forensic, and community psychiatry settings. Core elements include biopsychosocial case formulation; developmental theory including Erikson, Piaget, Mahler, and Ainsworth; trauma-informed adverse childhood experiences assessment; psychodynamic insight; culturally humble therapeutic relationship skills; mechanism-based pharmacological reasoning; reflective documentation; and countertransference management delivered through individual and group clinical supervision. The educational benefits described reflect the author's informal, practice-based observations rather than systematically measured outcomes (see Limitations). Students who engaged with this approach appeared to show gains in clinical reasoning, individualized treatment planning, therapeutic alliance formation with complex patients, and documentation depth. The approach also addresses health equity by preparing practitioners to serve underserved and marginalized populations with cultural humility and relational depth. Deliberate integration of psychodynamic depth into PMHNP preceptorship may help produce practitioners capable of engaging patients as whole persons rather than diagnostic categories. Preceptors, educators, and program directors are encouraged to examine how these competencies are cultivated within supervised clinical training.

Key Words: Biopsychosocial formulation, Clinical preceptorship, Cultural humility, Psychodynamic assessment, PMHNP education

1. INTRODUCTION

Teaching psychiatric assessment to Psychiatric Mental Health Nurse Practitioner (PMHNP) students requires more than transmitting diagnostic criteria or medication algorithms. It demands immersion in the art and science of formulating comprehensive psychodynamic case conceptualizations that illuminate the patient's psychological journey from early life experiences through current presentation. This understanding lies at the heart of psychiatric nursing's disciplinary identity. Since Peplau[1] first articulated a framework for psychodynamic nursing rooted in the therapeutic relationship, the field has recognized that the nurse-patient encounter is not merely a vehicle for symptom assessment and pharmacological management, but a potentially transformative clinical

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experience in its own right.

Over more than two decades of precepting students in one of the most clinically complex and socioeconomically demanding practice environments in the country (the emergency, inpatient, outpatient, forensic, and community psychiatry settings of Jackson Health System in Miami, Florida), I have observed a persistent and troubling pattern. Many students arrive highly competent in the technical dimensions of their training; they can recite diagnostic criteria, discuss medication mechanisms, and navigate clinical algorithms with confidence. What many struggle with is the deeper work: holding the complexity of a patient's full biopsychosocial history, understanding the unconscious processes that shape the clinical encounter, and formulating a case not merely as a diagnostic category but as a human story unfolding across a lifetime.

This difficulty is not a reflection of individual student deficiency. It reflects, at least in part, how contemporary PMHNP education has been shaped. The American Nurses Credentialing Center (ANCC) PMHNP-BC certification examination allocates approximately 44% of its content to scientific foundations, diagnosis, and treatment domains in which pharmacology features prominently, while psychotherapy and related modalities constitute only 11%-15% of the examination blueprint.[2] Graduate program curricula, shaped by certification alignment and prescriptive authority requirements, tend to follow suit. Yet psychotherapy, including psychodynamic approaches, is a recognized standard of PMHNP practice, affirmed by national professional organizations and credentialing bodies alike.[3] The gap between what certification requires and what comprehensive psychiatric practice demands is one that clinical preceptorship is uniquely positioned to address.

This essay describes the pedagogical approach I have developed and refined over 27 years of PMHNP preceptorship, supervising approximately 800 students from more than ten universities across diverse psychiatric settings, building on earlier published reflections on PMHNP preceptorship.[4] It does not propose a new theoretical framework, nor does it claim that the clinical tools described here (biopsychosocial formulation, developmental theory, trauma-informed assessment, countertransference awareness) are unique inventions. These are time-honored dimensions of advanced psychiatric nursing practice. What this essay offers is one practitioner's account of how these dimensions can be deliberately, consistently, and effectively transmitted to students in the context of real clinical work, with real patients, in a setting that demands both clinical rigor and deep human attunement.

2. Contextualizing the Approach: The Clinical and Educational Setting

Any account of a teaching approach is only fully intelligible in the context of where and with whom it was developed. Jackson Health System, Miami's public, safety-net academic medical center, is one of the most clinically and socioeconomically complex psychiatric practice environments in the United States. Its patient population includes individuals with severe and persistent mental illness, co-occurring substance use disorders, histories of profound trauma, forensic involvement, housing instability, and limited prior engagement with mental health care. Many patients present across multiple clinical thresholds simultaneously: acute psychiatric crisis overlaid on chronic illness overlaid on unaddressed trauma overlaid on social disintegration. As Drew[5] noted, PMHNPs practice across the full spectrum of psychiatric services and are uniquely positioned to address this complexity, provided their training equips them to do so.

The students I precept, drawn from master's and doctoral PMHNP programs across Florida and beyond, arrive with varying degrees of preparedness for this depth of clinical engagement. Virtually all have received strong didactic training in psychopharmacology and DSM-based diagnosis. Fewer arrive with fluency in psychodynamic case formulation, a working grasp of developmental theory as a clinical tool, or comfort with examining their own countertransference in supervision. This observation aligns with broader concerns in the field: Gallop and O'Brien[6] identified that despite acknowledgment of the therapeutic relationship's importance; there has been limited attention in psychiatric nursing education to the psychodynamic knowledge that informs it. More recently, the APNA[3] has called explicitly for PMHNP programs to strengthen supervised training in psychotherapeutic approaches, acknowledging that the current clinical training environment does not consistently cultivate these competencies.

The approach described in this essay emerged organically from the demands of this setting and these students. It was not designed in advance as a curriculum and then implemented; it was built iteratively over years of clinical supervision, case conferences, documentation feedback, and direct observation of students in the room with patients. Over time, I observed informally, through direct clinical supervision rather than any systematic measurement; those students who engaged with this psychodynamic depth often appeared to become more individualized in their treatment planning, more reflective in their documentation, and more durable in their therapeutic alliances with difficult patients. These are

practice-based impressions rather than measured outcomes (see Limitations). How such development might be more reliably cultivated, and formally evaluated, is what this essay seeks to describe.

The populations served at Jackson Health System reflect broader patterns of mental health disparity that persist across the United States. Racial and ethnic minority communities, individuals experiencing poverty, those involved in the criminal justice system, and patients without stable housing face well-documented barriers to accessing comprehensive psychiatric care.[7] PMHNPs who are trained only to diagnose and prescribe are less equipped to address these complex, multilayered presentations. Preparing students to engage with the full biopsychosocial and psychodynamic dimensions of a patient's experience is, therefore, not merely a matter of clinical sophistication; it is a matter of equity.

3. The foundation: Biopsychosocial case formulation

I begin by teaching students a structured approach to case formulation that examines four key dimensions: predisposing factors (genetic vulnerability, adverse childhood experiences, developmental trauma); precipitating factors (recent stressors, acute losses, life transitions); perpetuating factors (ongoing substance use, maladaptive coping, unstable housing, toxic relationships); and protective factors (family support, treatment engagement, adaptive coping skills, employment). This framework, widely recognized as a core clinical competency across mental health professions,[8] provides students with a systematic method for organizing the complex data gathered during psychiatric evaluation. Sampogna et al.[9] describe case formulation as the bridge between symptoms and treatment, enabling clinicians to develop individualized hypotheses about the origins of a patient's difficulties rather than relying solely on categorical diagnosis.

For example, when teaching students to assess a 50-year-old female patient with comorbid and co-occurring psychiatric, medical, and substance use disorders who demonstrates treatment inconsistency, I guide them to consider how her adverse childhood experiences, namely teenage pregnancy, foster care placement, and kidnapping, may be understood as early adversities that could contribute to her chronic challenges across the lifespan. These early relational disruptions and unprocessed traumatic events may contribute to maladaptive coping mechanisms, impaired affect regulation, and difficulties establishing trust within therapeutic relationships. Students learn to consider how her inconsistent treatment engagement, delayed progress toward remission, and persistence of multiple syndromal presentations might be understood, in part, in light of these possible unresolved conflicts — a working clinical hypothesis to be explored collaboratively with the patient and weighed alongside medical, pharmacological, substance-related, and social contributors rather than treated as an established cause. This trauma-informed, psychodynamically oriented understanding meaningfully shapes how students approach treatment planning. Throughout, I frame psychodynamic formulation as one interpretive lens among several, offered as a hypothesis to be tested against the clinical course rather than as a definitive explanation of a patient's symptoms or behavior.

4. Integrating developmental theory

Students learn to apply developmental frameworks systematically across the lifespan. When assessing pediatric patients, I teach them to reference Erikson's psychosocial stages and Piaget's cognitive development theory to contextualize presenting problems. For an 8-year-old child with ADHD, students must understand that this developmental period encompasses Erikson's stage of Industry versus Inferiority and Piaget's Concrete Operational stage, where mastery of academic and social skills builds self-esteem and competence. Neurodevelopmental differences can impact brain maturation, executive functioning, and social learning, making children more susceptible to frustration, peer difficulties, and negative self-appraisal. The PMHNP's role extends beyond symptom management and medication response to proactively supporting developmental scaffolding through family engagement and school advocacy.

I also teach students to apply Margaret Mahler's theory of separation-individuation and Mary Ainsworth's attachment theory as essential lenses for understanding early relational development. Mahler's framework, particularly the phases of differentiation, practicing, rapprochement, and object constancy, helps students understand how disruptions in the earliest caregiving relationship can produce lasting difficulties with autonomy, identity, and interpersonal boundaries. When a patient struggles to tolerate being alone, oscillates between idealization and devaluation of caregivers, or demonstrates profound separation anxiety, students learn to consider whether these presentations may reflect unresolved separation-individuation themes, among other explanations. Ainsworth's delineation of secure, anxious-ambivalent, avoidant, and disorganized attachment patterns provides students with a clinically actionable framework for interpreting how patients relate to the PMHNP, engage with treatment, and form or dissolve therapeutic alliances. Together, these developmental frameworks equip students to see beyond the presenting diagnosis to the relational blueprint that often drives it.

Without sensitive intervention, children in this vulnerable period may develop maladaptive coping mechanisms such as avoidance, oppositionality, and low self-worth, all of which hinder growth and long-term adjustment. I push students to consider: How do parental involvement, family system dynamics, and consistent support at home and school influence this child's developmental trajectory? What role does social learning theory play in acquiring adaptive behaviors? Students learn to advocate for school accommodations that promote healthy brain development during formative years.

5. Teaching psychodynamic insight

Central to my teaching is helping students understand unconscious processes and defense mechanisms. When students present cases where patients minimize psychiatric symptoms or demonstrate inconsistent medication adherence, I guide them to recognize defense mechanisms, such as denial and projection, that protect self-esteem and reduce anxiety about having chronic mental illness. These defenses make it challenging to foster insight and engagement, especially with longstanding patterns of limited self-awareness. Students learn that building trust and slowly addressing defenses through strong therapeutic alliance and gentle psychoeducation is key; progress may be gradual given these ingrained barriers.

For instance, when teaching about a geriatric patient presenting with adjustment difficulties following retirement, I challenge students to apply Erikson's stage of Integrity versus Despair. The transition into this developmental stage can bring adjustment-related stress and anxiety, particularly when individuals are unprepared for emotional and identity shifts. I guide students to recognize how unresolved grief and unprocessed internalized emotional pain, particularly trauma-related anger, can complicate the ability to find meaning and acceptance in late adulthood. This internalized pain may manifest as guardedness and defensiveness, making it difficult to engage fully in treatment. Yet the patient's willingness to participate in supportive and motivational interviewing signals gradual movement toward healing and self-acceptance.

6. Assessment of adverse childhood experiences

I emphasize the critical importance of systematically assessing for Adverse Childhood Experiences (ACEs) and understanding their long-term sequelae. Research has consistently established ACEs as among the most important determinants of mental and physical health outcomes across the lifespan.[10] ACEs are associated with increased risk of anxiety, depression, PTSD, substance use disorders, and suicidality, with higher cumulative ACE scores corresponding to progressively greater risk across multiple life domains.[11, 12]

When students encounter an 18-year-old male patient struggling with identity formation and family-cultural conflicts, I teach them to consider how ACEs related to sexual identity, family rejection, and cultural stigma intersect with developmental challenges described by Erikson, specifically identity versus role confusion and intimacy versus isolation. At this critical juncture, patients may feel uncertain about societal role and personal identity while navigating family and cultural expectations. Students learn to think beyond presenting symptoms to consider the patient's entire ecological context and the cumulative burden of adversity across development. In cases where early childhood trauma combines with challenges related to sexual identity, high-risk behaviors, chronic illness, and substance abuse, all factors become interconnected, underscoring the importance of comprehensive trauma-informed care.

7. The therapeutic relationship as intervention

Students observe and learn to track the crucial interplay between provider-patient therapeutic relationship and treatment outcome. I teach them that the therapeutic alliance is not merely a pleasant backdrop to evidence-based interventions; it is itself a powerful mechanism of change. An extensive body of research confirms that the therapeutic alliance is a robust predictor of outcomes across diverse forms of psychotherapy and clinical care, even after controlling for prior symptom improvement and other factors.[13] When students encounter patients presenting with guardedness and trauma history, I emphasize utilizing motivational interviewing skills and building trusting therapeutic relationships, drawing on Peplau's[1] interpersonal relations theory and Carl Rogers' person-centered approach.

I also teach students that the therapeutic relationship begins before a single clinical word is spoken. The act of extending a warm handshake upon meeting a patient, a simple overlapping gesture of welcome, communicates safety, respect, and human connection in what is, for many patients, an environment of considerable apprehension. In the unfamiliar and often intimidating milieu of a psychiatric setting, these non-verbal gestures of warmth and authenticity can meaningfully lower a patient's defensive posture and open the door to genuine therapeutic engagement. Equally important is what I describe to students as the art of breaking the ice with cultural curiosity: taking a genuine, unhurried interest in a patient's ethnic or cultural background, perhaps by asking about the origin of a name, gently inquiring about an accent,

or acknowledging a cultural reference the patient introduces. This signals authenticity and communicates that the clinician sees the whole person, not merely the diagnosis.

This practice reflects the broader principle of cultural humility: an ongoing, reflective stance of openness and respect toward the patient's lived cultural experience, approached not as a checklist of demographic facts but as a dynamic, evolving dimension of the therapeutic relationship. Research demonstrates that cultural humility is positively associated with stronger therapeutic alliance and improved psychotherapy outcomes, particularly for patients from marginalized communities.[14, 15] Students learn that cultural humility is not a technique applied at intake; it is an orientation sustained throughout the entire course of care.[16]

For patients with histories of trauma, the PMHNP's role extends beyond diagnosis and medication management to include fostering a therapeutic alliance that provides corrective emotional experiences and supports development of secure attachment. By integrating trauma-informed, attachment-based interventions with evidence-based modalities like CBT, DBT, ACT, and motivational enhancement therapy, students learn to address both underlying relational wounds and present symptoms. This holistic, patient-centered approach targets not only symptom relief but promotes long-term resilience, emotional regulation, and healthier interpersonal functioning, which are core goals in advanced psychiatric nursing practice.[17]

8. Teaching diagnostic precision and differential diagnosis

I hold students to high standards of diagnostic precision. When students miss distinguishing between schizophrenia and schizoaffective disorder or fail to recognize that Disruptive Mood Dysregulation Disorder (DMDD) in childhood may herald bipolar disorder in adolescence, I provide direct feedback. I teach them that prior to DMDD's introduction in DSM-5, many youths with chronic irritability and mood dysregulation were misdiagnosed with pediatric bipolar disorder or other conditions, leading to missed treatment opportunities. Observing how a patient's illness trajectory evolves from DMDD to full manic episode, especially with strong family history of bipolar disorder, provides crucial clinical pearls for PMHNPs working with developing populations.

Students learn the importance of always considering differential diagnoses, particularly when working with complex presentations involving comorbid conditions. For instance, when assessing an adolescent with mood dysregulation, trauma history, and emerging psychotic-like symptoms, I teach them to consider differential diagnoses such as early-onset schizophrenia spectrum disorders, schizoaffective disorder, or complex PTSD with dissociative features. They learn that children and adolescents are in critical periods where healthy coping and defense mechanisms are being formed, and disruptions at this stage can have lasting effects across the lifespan.

9. Pharmacological reasoning and mechanism-based prescribing

While psychodynamic understanding provides depth, students must also demonstrate sophisticated pharmacological reasoning. When I observe a student prescribing lithium without explaining its specific indication for refractory suicidality rather than mood stabilization or failing to discuss why aripiprazole may help with hyperprolactinemia while paliperidone exacerbates it, I provide direct corrective feedback. Students learn to explain medication choices by mechanism of action, not merely by diagnostic category.

For example, when teaching about a patient prescribed dual mood stabilizers (Depakote and lithium), I challenge students to address the clinical rationale for using both medications concurrently and to document therapeutic levels for each drug, as this information is critical for safe and effective management. When students overlook such details, I remind them: "Attending to these important clinical details is essential for demonstrating your clinical competency." This integration of psychopharmacology with psychodynamic understanding creates clinicians who can think biologically while never losing sight of the person behind the diagnosis. Research supports the additive value of combined pharmacological and psychotherapeutic treatment for a range of psychiatric conditions over either approach alone.[18]

10. Documentation as clinical thinking made visible

I teach students that documentation is not bureaucratic busywork; it is clinical thinking made visible. Some students have relayed informal, often unsolicited feedback that employers valued their thorough documentation integrating psychodynamic and psychosocial perspectives with diagnostic precision and comprehensive treatment planning; such reports are anecdotal rather than systematically gathered. However, when students produce documentation lacking scholarly depth, I provide specific feedback. For instance, when a student writes generic reflections that could apply to any case rather than analyzing the unique aspects of a specific patient's presentation, I push them to develop deeper, independent psychodynamic analysis grounded in theoretical frameworks.

Students learn that expanded notes should be narratively written, person-centered, and analytically reflective, capturing comorbid and co-occurring biopsychosocial, psychodynamic, sociocultural, pharmacological, and developmental issues relevant to patient presentation. These notes should address diagnostic and treatment challenges, psychodynamic maturational processes, family system dynamics, environmental influences, ego development, coping mechanisms, and pharmacological mechanisms targeting specific symptoms. This level of documentation demonstrates not just what was observed, but how the clinician thinks about the case: the hallmark of advanced practice.[19]

11. Managing Countertransference and Self-Awareness

I create space for students to process their emotional reactions to challenging cases, both individually through one-on-one clinical supervision and collectively in case conference-style group settings where shared reflection normalizes the emotional complexity of psychiatric work. Countertransference, defined as the clinician's emotional response to a patient arising from the clinician's own internal world and relational history, is recognized as an inevitable and clinically significant dimension of therapeutic encounters.[20] The ability to recognize, understand, and manage countertransference is not a peripheral clinical skill; it is fundamental to safe, ethical, and effective advanced practice.[21]

When a student expressed feeling overwhelmed by a pediatric case involving extensive trauma and foster care instability, I validated these feelings while teaching about countertransference. I explained: "While we are clinicians, we are also human, and it's natural to experience strong emotions in response to situations we encounter. Being aware of these emotions is key; managing them therapeutically and professionally allows us to remain effective advocates for our patients while maintaining appropriate boundaries." Students learn to identify and monitor their own emotional responses, biases, and potential influences from their own family dynamics. I encourage regular self-reflective practices, perhaps journaling after sessions or discussing reactions in supervision. Students ask themselves: What am I feeling in response to this patient's situation? How might these feelings influence my clinical judgment or interactions? Am I able to maintain appropriate boundaries while still offering empathy and support?

12. NP Practice Implications

Preceptors and clinical supervisors are encouraged to create deliberate, structured opportunities for students to practice biopsychosocial case formulation beyond symptom-focused assessment. Even brief supervisory conversations that ask students to articulate the predisposing, precipitating, perpetuating, and protective dimensions of a case can meaningfully shift clinical reasoning over time. Psychodynamic depth is not a luxury reserved for long-term psychotherapy; understanding a patient's defensive structure, attachment history, and developmental injuries bears directly on medication adherence, treatment engagement, diagnostic accuracy, and therapeutic alliance in any clinical encounter, however brief.

Cultural humility is a clinical competency with measurable effects on therapeutic alliance and treatment outcomes, particularly with patients from marginalized and underserved communities.[15] NPs are encouraged to approach every clinical encounter with genuine interest in the patient's cultural identity and to model this orientation explicitly for students.

Countertransference awareness and regular self-reflective practice are essential to safe and effective advanced psychiatric nursing. NPs and preceptors should normalize discussion of emotional responses to clinical work, in both individual supervision and group or peer consultation, resisting a professional culture that treats such discussion as a sign of inadequacy rather than clinical maturity.

Finally, program directors and faculty are encouraged to examine how psychodynamic content, developmental theory, and therapeutic relationship competencies are weighted within PMHNP curricula relative to pharmacological and diagnostic content. The National Task Force on Quality Nurse Practitioner Education[22] and NONPF[23] competency frameworks emphasize comprehensive clinical preparation; integrating these dimensions into supervised clinical training, rather than didactic coursework alone, is most likely to produce durable effects on student development and patient care.

13. Limitations

This essay is a reflective, practice-based account, and its observations carry important limitations. The educational benefits described derive from the author's informal observations during 27 years of supervised clinical preceptorship, reviewing students' clinical dialogue with patients, their documentation, and their case presentations; rather than from systematic assessment. No validated rubric, standardized outcome measure, or comparison group was used, and the reported employer feedback reflects informal, largely unsolicited communication relayed by former students and, at times, collaborating clinicians, rather than data obtained through structured evaluation. These impressions are therefore subject to the author's own perspective and to potential unconscious bias, including the absence of systematically

identified disconfirming cases. They are best regarded not as demonstrated outcomes but as working hypotheses for future, more systematic evaluation; for example, through a structured reflective rubric or an objective structured clinical examination administered across a preceptor cohort.

14. Conclusion: A deliberate reemphasis

This pedagogical approach represents a deliberate reemphasis on dimensions of advanced psychiatric nursing practice that have room for deeper integration within PMHNP graduate education. Many students have reflected, informally, that this training strengthened their ability to navigate challenging cases; these accounts are encouraging but as noted, remain to be formally evaluated. By teaching comprehensive psychodynamic case formulation, systematic assessment of biopsychosocial factors, sophisticated pharmacological reasoning, and attention to the therapeutic relationship, I aim to prepare students not merely to diagnose and prescribe, but to understand the complex human beings who seek their help.

The journey from novice to clinical expert is neither linear nor easy. It requires students to tolerate uncertainty, sit with complexity, and develop both the technical skills and the human capacity to witness suffering without turning away. As I continue this work, now with up to 15 students simultaneously in clinical settings, I remain committed to the belief that excellent psychiatric care requires both the science of evidence-based intervention and the art of psychodynamic understanding, producing clinicians who can think deeply, intervene precisely, and relate authentically, qualities our field needs as mental health demands continue to grow.

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