ORIGINAL RESEARCH

Comments surrounding the doctor of nursing practice (DNP): Stress, ambiguity, and strain

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ABSTRACT

Background/Objective: The Doctor of Nursing Practice (DNP) degree is the recommended preparation for advanced nursing practice. However, lack of clarity surrounding the DNP degree has contributed to role ambiguity for the DNP prepared nurse. The present study sought to evaluate the written comments obtained from a quantitative analysis that utilized a framework adapted from works on role conflict and ambiguity, role stress and strain, and classical organization theory.
Methods: The sample consisted of 113 participant comments. The length of the comments ranged from 1 to 28 lines. Content analysis was performed and the areas of role stress, ambiguity, and strain were identified.
Results: Distinct areas for intervention to address DNP role stress and strain with the goal of preventing the harmful outcomes of role ambiguity were identified. For example, comments centered along the lines that the benefits of pursuing a DNP degree did not outweigh costs. There is contention among PhD, DNP, and MSN prepared nurses. The DNP causes role confusion among health care providers and the public and conflict exists about the DNP role and professionalism, faculty preparation, and leadership.
Conclusions: The authors provide several recommendations that can reduce role stress, strain, and ambiguity in order to meet the ultimate goal of achieving improved patient/population and policy outcomes. The nursing profession must not only articulate clear and distinct intended outcomes of the DNP degree, but then must also assure that the product of the DNP degree is consistent with those outcomes.

Key Words: Doctor of Nursing Practice (DNP), DNP Role, Stress

1. INTRODUCTION

There are now two distinct doctoral degrees in nursing: the PhD (doctor of philosophy) and the DNP (doctor of nursing practice). The two doctoral degrees are meant to complement each other, one for research (PhD) and one for practice (DNP), and to maintain a commitment to advance the nursing profession and pursue scholarly excellence within the discipline.[1] Nevertheless, there is a lack of clarity related to the objectives, competencies, and outcomes of the different doctoral degrees.[2] Since 1970, the PhD in nursing has been widely accepted as a research doctorate and understood as the highest degree and attainment of scholarship of the nursing profession.[3] The DNP degree is the recommended preparation for advanced nursing practice which includes both indirect and direct nursing care roles. Examples of indirect care areas are nursing administration and leadership, health policy, informatics, and population health. There are four direct care areas or roles, all considered advanced practice registered nurses (APRN): certified nurse-midwife (CNM), certified registered nurse anesthetist (CRNA), clinical nurse

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specialist (CNS), and nurse practitioner (NP).[1,4]

Support for the value of the DNP degree has resulted in rapid proliferation of DNP programs over a relatively short period of time.[4] However, issues regarding DNP program variability in terms of length, program focus, DNP project/scholarly project/capstone, rigor, and number of credits have been reported.[5,6] In the academic setting, recent DNP graduates have identified role strain and stress surrounding faculty expectations, preparation, and support.[2] Despite the exponential growth of DNP programs (20 in 2006 to 264 in 2014), the complete transition to the DNP degree for APRNs is still evolving, and the majority of programs continue to prepare APRNs at the master's level (masters of science in nursing [MSN]).[4,7,8]

With two terminal nursing degrees, multiple entries to APRN preparation, DNP program variability, and doctoral programs developing at an unprecedented rate, lack of role clarity and increased role ambiguity have surfaced. While it is understood that the DNP is an academic degree and not a role, DNP graduates will ultimately fulfill various roles within the nursing profession and society. Role ambiguity does not only potentially result in dissatisfaction and uncertainty for the DNP prepared nurse, but can also ripple outward to create confusion for the nursing profession and for other healthcare colleagues. Transitional stress and strain are natural and arguably expected with any change, particularly one as significant as a new doctoral degree in the profession. However, DNP role ambiguity, if left unattended and unaddressed, may result in adverse consequences and thus jeopardize the actualization of this practice doctorate in nursing.

1.1 Clarity or confusion

Multiple publications from nursing organizations have attempted to deliver a clear and consistent message regarding the intended goals and outcomes of the DNP.[1,4,9–12] Nurse leaders have articulated the potential and actual confusion related to understanding the DNP degree and differentiation from other advanced nursing degrees.[10,13,14] Yet, the operationalization of the DNP degree has been less than clear and consistent. Unease and uncertainty may occur with any new degree requirement, however, ongoing lack of role clarity may result in negative outcomes.

Collaboration between PhD and DNP prepared nurses has been proposed as a means to improving healthcare, developing a reciprocal relationship between practice driving research and research driving practice.[15–17] However, the lack of role clarity and the presence of role ambiguity between the PhD and DNP degrees are prevalent.[18–20] This lack of role clarity threatens the goal of PhD-DNP collaboration because interprofessional collaboration requires an understanding of the roles of other members of the health care team.[21]

Lack of role clarity may also be the impetus for people questioning the necessity and feasibility of the DNP degree. Chief nursing officers (CNOs) have been shown to agree that the DNP degree provides nurse executives with knowledge to impact business operations, nursing retention, patient care, implementation of nursing research, and health policy.[22] However, in the same study, CNOs disagreed with endorsing the DNP degree as the recommended advanced degree for nurse executives. Another survey of CNOs in the Midwest showed that less than half (41%) (n = 17) reported employing DNP prepared nurses. Furthermore, the CNOs who completed the survey lacked knowledge of actual DNP practice and its potential impact on outcomes.[23] Another group of community and public health nurse leaders felt that there were few advantages to the DNP degree in their setting and that awareness of the DNP among their practice colleagues was minimal. In addition, these nurse leaders were not sure how the DNP would have any additional value over a doctor of public health, which is a more recognized doctorate in the public health setting.[24]

The MSN-prepared APRN is well-supported as a quality and safe provider of direct patient care while the DNP degree has been perceived to be more a costly and burdensome preparation for APRNs.[25] In addition, it has been argued that the type of degree (DNP or MSN) does not impact the marketability of nurse practitioners.[26] Many master's prepared nurses may be wondering why they need a DNP degree when they have been successfully practicing with their current academic preparation. APRNs will be educated at both the MSN and DNP level in the foreseeable future, and thus, both types of APRNs will continue to practice side by side.[7] The recent RAND report, *The DNP by 2015*, revealed that the master's in nursing (MSN) remains the most common educational preparation for APRNs across programs. Furthermore, 65% of schools that do offer the BSN-to-DNP degree continue to confer an MSN along the way.[7] APRNs prepared at the master's level have a vast array of evidence to support their contributions, improved access to care, quality of care, and safe care in the healthcare environment.[27,28] Strain between MSN and DNP prepared APRNs has the potential to negatively impact the successful incorporation of the DNP degree into the APRN profession.

1.2 Conceptual framework

The framework guiding this research was adapted from the works of Rizzo et al. (1970) and Hardy et al. (1988).[29,30] Rizzo et al. focused on the principles of unity and chain of command to deter role conflict and ambiguity.[29] Hardy

et al. (1988) examined how rapid changes in organizations and accelerated technology contributed to role stress and strain which can prevent goal attainment for organizations and its members.[30] The AACN, as a leading nursing organization, has recommended the DNP be the terminal degree for all advanced nursing practice by 2015 to improve patient, population, and policy outcomes.[9]

A role is defined as a set of obligations, demands, and behaviors associated with a position.[29,31] When expectations and values about the role are not met, role stress ensues. Role stress is a sense of awareness that causes feelings of conflict, distress, and irritation when role obligations are vague and difficult to meet. Role stress is external to the individual; it is inherent to the organization and is most prevalent in the form of role ambiguity among nurses.[31] Operationally, role ambiguity is defined as an absence of clarity regarding one's responsibilities and expectations.[31] Role ambiguity may conceivably foster dissatisfaction and uncertainty,[29] and leads to role strain or feelings of tension, anxiety, or frustration surrounding the role.[31] Role strain is more personal than role stress and promotes ineffectiveness and impedes goal attainment. Role stress, ambiguity, and strain are reciprocal and interrelated.

2. METHODS

2.1 Aim

This study sought to evaluate the written comments obtained from the quantitative study: "Perceptions of the Role of the DNP Prepared Nurse: Clarity or Confusion"[19] which explored how nurses perceived the various roles of the DNP prepared nurse. Using the comments obtained at the end of the questionnaire, the current study aims to answer the question: Are areas of role stress, ambiguity, and strain present? The quantitative results, generated from a questionnaire, revealed that nurses valued the DNP degree and its contributions to advancing healthcare outcomes through nursing leadership, policy, evidence-based practice and interprofessional collaboration. However, areas of ambiguity were identified in the questionnaire items regarding nursing research, academia, academic leadership and scholarship. In addition, statistically significant differences were present in perceptions of DNP roles across participants' levels of education (PhD, DNP and MSN).[19]

2.2 Design

The full questionnaire development, reliability and validity information, as well as results can be found in the initial article.[19] A researcher–developed 20-item questionnaire was distributed on-site at two large Midwestern United States nursing conferences in the spring of 2013. In addition, there was an option to complete the same questionnaire online. The first conference site was a four day research conference that attracted a majority of PhD prepared, academic-research focused nurses. The second conference site was a three day pharmacology conference attended primarily by masters prepared advanced practice nurses. The goal of administering the questionnaire in these two settings was to obtain a convenience sample representative of nursing in the areas of scholarship, academia, and practice. All persons in attendance of the conferences who identified themselves as nurses with at minimum a Bachelor of Science in nursing degree were eligible to participate.

The questionnaire included a single line at the end with the header: Comments. The comment line was included to obtain complementary data and allow participants to expand their thoughts into words. Comment sections and open-ended questions are often included in questionnaires so that participants can briefly share experiences and personal information, comment on the survey itself, and qualify their responses.[32,33] The analysis of the comments aimed to further assess nurses' ideas about the DNP prepared nurse and to examine the comments for areas of role stress, strain, and ambiguity.

2.3 Sample

One hundred twenty-one of the 340 (35.5%) participants included written comments. Of these 121, eight participants only addressed the survey design without commenting on the DNP degree or role and were not used in analysis. Therefore, 113 participant comments were included in the final content analysis. The sample was predominately white females (93.8%) with a mean age of 51. The majority of participants were master's prepared (60%), 29% were PhD-prepared, 8% were DNP prepared, and 3% were BSN-prepared. A third of the sample (33%) identified themselves as faculty with an average of 12 years in the faculty role. The distribution of degree level across those who were in the faculty role were: 62% PhD, 8% DNP, and 30% MSN. Just over 70% of the sample listed clinical practice as their main practice setting with 70% of this group identifying themselves as APRNs. The distribution of degree level across those who were in the clinical practice role was: 16% PhD, 9% DNP, 71% MSN, and 4% BSN. Almost 5% of the sample identified their practice settings as both faculty and clinical. The nursing education mix of this qualitative sample closely resembled the education mix of the quantitative sample. Furthermore, this sample represented nurses who have DNP degrees and those nurses who reasonably should be expected to have knowledge of the DNP degree. The length of the comments ranged from 1 to 28 lines.

2.4 Analysis

A document of the 113 participant comments was read and memos were taken in the margins. To decrease bias, participant numbers were the only identifiers used to separate comments, i.e. the participants' nursing degrees and background were unknown during this analysis. The document was then uploaded to the online qualitative analysis software Dedoose and content analysis was used to identify reoccurring areas in the participants' comments. Content analysis is often used to identify trends or test existing theories and therefore was well-suited for working with this type of data.[34,35] Participant comments and portions of their comments were divided, sorted, and labeled using open coding techniques. If a participant commented, for instance, on the DNP degree as being confusing as well as costly, the comment was broken down into two parts and coded accordingly. At first, the codes were given broad titles and loose definitions and then narrowed as analysis continued. For example, the code name Confusion was used only until it became evident that participants were commenting more specifically about who might be confused by the DNP degree. This code name was then broken down into several different Confusion codes.

Initial code titles and the frequency of comments within those codes were identified by author 1. The code titles were discussed and verified by authors 2 and 3. Each code title and the excerpt within that title were then examined by all three team members for fit within the pieces of the Role Stress, Ambiguity, and Strain framework. The original figure from Udlis and Mancuso[19] was updated to incorporate the qualitative findings (see Figure 1). Code titles and excerpt counts within the areas of role stress, ambiguity, and strain were also identified within the participants' comments as seen in Table 1.

3. Results

Participants frequently chose to write about what they thought the differences in the DNP and PhD degrees and roles were. Twenty-four participants wrote in goal oriented or qualifying comments similar to "...The DNP should be the practice/research degree and the PhD should be the research/education degree," and "PhD – prepares a scientist and leader. DNP – prepares advanced practice leader that incorporates data into daily critical thinking and decision making." Areas of role stress, ambiguity, and strain were also identified within the participants' comments as seen in Table 1. The comments supported and expanded the original framework presented in Udlis and Mancuso.[19] Using the comments, we were able to identify that both role ambiguity and role strain have the potential to inhibit goal attainment (see Figure 1). Furthermore, the comments allowed us to identify more specific areas of stress, strain, and ambiguity and to move forward with a discussion regarding areas of intervention.

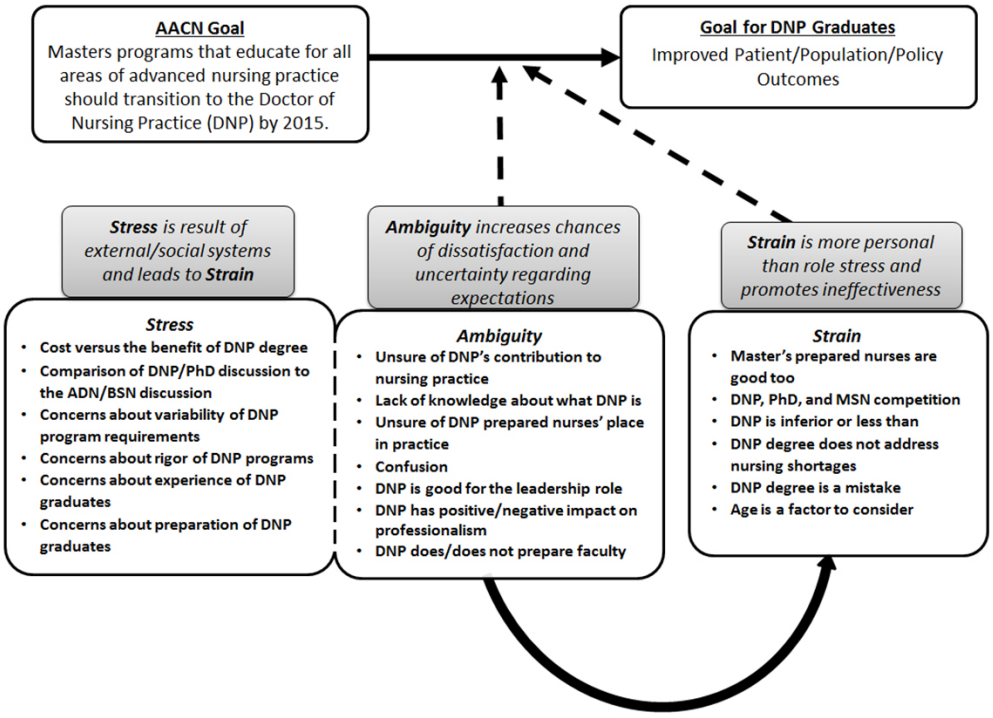

Figure 1. Role stress, ambiguity, and strain framework with qualitative findings

Table 1. Code titles and excerpt counts within the framework

Framework Area	Code Titles	Participants Excerpt Counts
Stress	Cost versus the benefit of DNP Degree	23
	Comparison of DNP/PhD discussion to the ADN/BSN discussion	11
	Concerns about variability of DNP program requirements	11
	Concerns about rigor of DNP programs	10
	Concerns about experience of DNP graduates	8
	Concerns about preparation of DNP graduates	4
Ambiguity	Unsure of DNP's contribution to nursing practice	19
	Lack of knowledge about what DNP is	18
	Unsure of DNP prepared nurses' place in practice	9
	Confusion (other healthcare providers)	9
	Confusion (nurses)	8
	Confusion (public)	7
	Confusion (not specified/general)	7
	DNP is good for the leadership role	6
	DNP has positive impact on professionalism*	5
	DNP has negative impact on professionalism*	4
	DNP does prepare faculty*	3
	DNP does not prepare faculty*	6
Strain	Master's prepared nurses are good too	16
	DNP, PhD, and MSN competition	10
	DNP is inferior or less than…	6
	DNP degree does not address nursing shortages	5
	DNP degree is a mistake	5
	Age is a factor to consider	4

*Indicates paired code titles that contribute to ambiguity

3.1 Role stress

Areas of role stress were identified in the participants' comments. Participants cited uncertainty that the benefits of pursuing a DNP degree outweighed the costs. They also frequently compared the DNP and PhD discussions to that of the ongoing Associate degree versus bachelor's degree in nursing discussions with comments such as, *"I believe that the nursing profession continue[s] to look at the wrong end of entry into practice."*

Another participant wrote:

> "There is still a lot of education to be done in and out of nursing as to what the DNP offers to practice. I do think eventually employers will prefer DNPs just as many are starting to prefer BSNs (RN) to other nursing degrees for entry level nursing."

Another form of role stress was found in participants questioning the rigor and large variability of DNP programs and concerns that the experience and preparation of DNP prepared nurses when they enter the workforce. One participant commented:

> "In my experience, the DNP program is less rigorous than the PhD or DNSc. The DNP is really a 'glorified' MSN. The emphasis is EBP, rather than research. I think it's a 'quick fix' and the easy way to be 'called' Dr. but the program lacks substance. DNPs make a mockery of 'PhDs/DNSc'."

Similarly, another participant wrote:

> "There may be potential for our DNP grads to be better prepared, but currently they are often primarily focused on becoming APRNs, not doctorally prepared clinicians. The programs are rushed, the students are often young and poorly prepared as leaders when they finish. We are trying to prepare too many students at the DNP level to be successful…"

3.2 Role ambiguity

Overwhelmingly, participants mentioned the DNP degree as causing confusion. Confusion for other nurses, other healthcare providers, and confusion to the general public were

mentioned 31 times in comments such as this participant who cites the various sources of confusion.

> "While I support the role of the DNP, I am becoming disheartened with the bigger picture of nursing. When will we be our own identity and stop trying to compete with other professions. We are confused with our own identity as nurses- I fear that we have so many roles/degrees that not only is it confusing for other healthcare professionals, it is for us as 'nurses'. We are slowly eliminating 'who we are' because there are too many nursing degrees. Lay people still have a hard time understanding RN and BSN now add more confusion with the DNP and PhD."

Likewise another participant wrote,

> "I feel the DNP has muddied the picture in the nursing profession. A PhD is already a terminal degree. A DNP is confusing to patients, other APN, nurses, and physician colleagues."

Participants also admitted to a lack of knowledge about the DNP degree. Comments such as:

> "More education is needed to educate practicing APRN's regarding the goal, purpose, benefits of the DNP role. How does the DNP change practice? What is the DNP role? What can a DNP do that a MSN prepared APRN can't do?"

and

"... I do not truly know the difference between PhD and DNP nurses" demonstrated that even nurses attending research and clinical conferences still did not fully understand the DNP degree and role.

Participants were also concerned about how the DNP degree contributes to nursing practice and patient outcomes and were unsure of the DNP prepared nurse's place in practice. *"... We still are not nurses or physicians. Lost in the middle yet..."*

Another participant wrote,

> "Employers (and potential DNP students) do not really know or understand the benefit of the degree and how it will impact their clinical practice, salaries, etc."

Ambiguity regarding the DNP degree and role was also evident in conflicting code categories. For example, participants commented that the DNP degree does not prepare nurses for leadership positions, faculty roles, nor adds to nursing professionalism, while other participants commented the exact opposite, praising the degree and its value. Comments such as "Having [two] separate terminal degrees is harming the profession" were at odds with comments such as *"I believe the 'Dr' title will add more in practice by bringing us up to other allied health professions... and allows us to develop different roles..."*

3.3 Role strain

Areas of role strain also were identified in the participants' comments. Comments within this portion of the framework were wrought with contention, including frequent comments about the MSN prepared nurse being good too or that adding the DNP was a mistake. One participant commented,

> "Pushing all of us who have master's to get a DNP is rather annoying and insulting... I don't get to do anything extra in regards to role, practice, prescribing."

Another wrote:

> "I cannot believe that having a DNP will improve the quality of patient care. I believe that all levels of nursing improve safe nursing care. NPs [nurse practitioners] have been master's prepared for years and have practiced keeping patients safe..."

Participants also commented that the DNP degree does nothing to address nursing shortages.

> "I don't feel the DNP role effectively responds to the health care needs and shortages for nursing need to develop more practitioners researchers and academics."

Other areas of role strain were evident in participants' comments about the DNP degree being inferior or that the three graduate nursing degrees, MSN, PhD, and DNP, were in some way competing with each other.

> "It is imperative that DNP programs do not seriously compromise the PhD programs..."

Another participant wrote:

> "The DNP and PhD are not equitable. If DNP graduate faculty are held to PhD standards, they will be set up for failure. Without data I do believe the DNP is the bridge between research and translation to practice. I do not think DNP graduates are prepared to conduct original research."

Other participants also cited age as a factor to consider when promoting the DNP degree, writing comments such as *"Okay to have a doctorate, but too late in my career to do this."*

4. DISCUSSION

The role stress, ambiguity, and strain framework pictured in Figure 1 demonstrates that role stress leads to role ambiguity and role ambiguity leads to role strain, indicating goal attainment is impeded by both role strain and ambiguity. The complex relationship among role stress, ambiguity, and strain is presented in various directions and connections in the role perception literature. However, it is clear that role ambiguity poses a particularly detrimental threat to the nursing professionn.[31] Because of this, our team chose to focus the discussion on the areas of role stress and strain, with the goal of preventing role ambiguity altogether.

This report of the qualitative findings complements and informs the framework and quantitative results presented in Udlis and Mancuso[19] and supports the recent findings of cost, program confusion, and lack of clarity in the faculty role reported by Dreifuerst and colleagues.[2] Participants valued the DNP prepared nurse to advance healthcare outcomes through nursing leadership, policy, evidence-based practice and interprofessional collaboration.[19] However, when given the opportunity to comment in their own words, many nurses frequently addressed areas of role stress, ambiguity, and strain. This shed light on areas of concern where further education or intervention are needed (see Table 1) providing the foundation for a discussion framed with solutions, rather than causing further turmoil and confusion among the nursing profession.

4.1 Role stress

Concerns regarding DNP degree academic preparation, program rigor and variability, the benefit of a DNP degree, and the entry into practice debate appeared to be a great source of role stress for the study participants. The AACN set certain DNP degree objectives meant to strengthen the nursing profession and address identified needs in the healthcare environment. These objectives address areas of concern such as nursing faculty and leader shortages and achieving parity with the education of other healthcare professionals. The AACN objectives also address areas for improvement of patient quality and safety through evidence-based practice and translation.[36] This vision has been valued and rapidly adopted by the nursing profession with a proliferation of DNP programs. However, a lack of a clear and/or unified understanding of the degree and the educational preparation for the degree has contributed to areas of role stress.

Various nursing organizations have published documents and white papers with the intention to bring unity and clarity to the DNP degree. The National Organization of Nurse Practitioner Faculties (NONPF) published their perspective of DNP nurse practitioner (NP) preparation and made clear that NP preparation needs to be seamless and consistent in terms of competencies, clinical hours, and the consistent naming of culminating project to "DNP Project" to facilitate the DNP as the entry level degree to the NP role.[11] AACN has addressed and clarified issues of curricular and practice expectations by convening a DNP Implementation Task Force. The Task Force published recommendations to describe and clarify the characteristics of DNP graduate scholarship, the DNP project, efficient use of resources, program length, curriculum considerations, practice experiences, and collaborative partnership guidelines.[4]

Schools of nursing should unite in assuring that DNP education takes a harmonious and consistent approach to educational preparation of a DNP prepared nurse.[1,4,36] This does not imply that all DNP programs should be the same in structure or focus (i.e. policy, population health, executive leadership, etc.). The operationalization of the DNP Essentials has varied across DNP programs. All DNP programs should encompass a core set of competencies, as outlined in the DNP Essentials, which prepare graduates to improve health outcomes whether it be in the areas of patient, population, and/or policy. Review and accreditation processes for programs offering a DNP degree must uphold these core standards, but also be flexible to allow programs to develop curricula that meet the needs of their communities of interest.

The benefits of obtaining a DNP degree need to be widely communicated to those who are entering graduate education, as well as to the profession as a whole, the public, and other healthcare professionals. Likewise, future research should investigate the contributions and value of the DNP degree.[7,12,25] Graduates from DNP programs should be prepared to fully articulate their distinct contributions to the nursing profession and encouraged to disseminate their accomplishments in various forms.

Efforts to unify nursing's voice regarding the DNP degree and DNP graduate will evolve over time. Discourse and opposition are both valuable tools that contribute to the process of growth and understanding of a new concept. This discourse and opposition has been well articulated in the area of the DNP graduate assuming roles in academia. Additional education and preparation for educator roles are recommended for the DNP graduate who wishes to assume faculty positions (this recommendation is also made for the PhD graduate).[1,2,4] Even though the intended outcome of the DNP degree has been consistently stated to develop prac-

tice experts and not experts in academia, academic roles for DNP prepared nurses can greatly enhance the educational setting with the knowledge and skills of practice experts and the contributions of practice scholarship. The academic preparation of the DNP nurse remains a practice focus, and not an academic focus. AACN has recently restated their original stance that the, "discipline of education is. . . .not an area of advanced nursing practice" and that the sole focus on preparation as nurse educators is incongruent with the intended outcomes of the DNP degree.[4] Yet, 50% of DNP students and 46% of DNP graduates reported their intention to become nurse educators when starting their doctoral program.[2] Moreover, discourse regarding an education-focused DNP curriculum continues anecdotally and in the literature. For example, Danzey et al.[37] and O'Lynn[38] have advocated for programs that prepare the DNP educator for roles as faculty as well as academic leadership and administration with the ability of the DNP educator to advance scholarship. This type of debate regarding roles and expectations has been instrumental in moving the nursing profession forward through the years. However, given the past and current recommendations and statements from AACN, it is prudent to consider the potential harms (role stress) of ongoing debate versus the potential benefits. These conversations may be more productive once the level of role stress has reduced.

4.2 Role strain

Role strain resonated in the areas of degree competition, competition between the DNP and the PhD, and competition between the DNP and the MSN. We believe these concerns regarding the "place" that the DNP takes within the nursing profession stem from the lack of understanding about the degree and the variability of the DNP preparation. According to the framework (see Figure 1), strategies to prevent role stress and ambiguity should prevent or reduce role strain.

While much has been written in the literature regarding DNP/PhD differentiation and similarities, the issues surrounding DNP/MSN role ambiguity need further examination, especially in the area of the advanced practice registered nurse (APRN). Currently, it may appear that a MSN prepared APRN functions in the clinical setting just as a DNP prepared APRN does, however; healthcare is rapidly changing. DNP preparation has a greater emphasis on leadership, policy, population health, and quality improvement that can provide the APRN with a greater depth of knowledge and preparation to lead change beyond direct patient care competencies. Courses in informatics, translational research, quality improvement methods, health policy, and leadership expand the breadth of education allowing DNP graduates to step beyond individual direct care roles and assume greater leadership, responsibility, and accountability for change to advance quality improvement, healthcare delivery, and clinical scholarship.[39] The roles for the DNP prepared nurse are currently evolving and we are seeing examples of DNP prepared nurses having greater influence in the changes taking place in the delivery of healthcare, translating evidence into practice, and upholding best practices in nursing care. However, MSN prepared APRNs have much to contribute to the improvements in patient care.

While there is a dearth of literature regarding DNP and MSN collaboration, several studies have addressed the benefits of DNP and PhD prepared nurses working together to improve health outcomes.[13,17,40,41] However, without a clear understanding of each other's contribution to the team, divergence will materialize, regardless of degree level. There should not be competition or a feeling of inferiority among the MSN, DNP, and PhD prepared nurse. "Intraprofessional" collaborative practice is the key to bringing harmony and reducing role strain in order to meet the goal of safe, high quality, accessible, and patient-centered care for improved patient and population outcomes. Such collaboration can be guided by the Core Competencies developed by the Interprofessional Education Collaborative (IPEC).[21] IPEC outlines four competencies that guide interprofessional collaborative practice: values and ethics for interprofessional practice, roles/responsibilities, interprofessional communication, and teams and teamwork. These competencies (see Table 2) can be used as strategies to reduce role strain among all levels of nursing and should be integrated into all nursing curricula, not only to emphasize the need for interprofessional collaboration, but to help reduce the role strain intraprofessionally.

Collaborative relationships among DNP and PhD nurses are appearing in the literature. However, there needs to be networking and collaboration among MSN and DNP prepared nurses, as each has much to offer in terms of leadership, translating research into practice, and contributing to scholarship. With the slow, but steady, transition from MSN to DNP programs for advanced nursing practice, many well-educated and highly skilled MSN prepared nurses will continue to enter the nursing workforce. Partnerships between all levels of nursing, including our BSN colleagues, must be valued and nurtured as all members of the nursing profession have distinct knowledge and skills to contribute to the team.

4.3 Limitations

There are limitations within this study. Although comments and open-ended questions do address salient concepts, there was no opportunity to follow up with the participants to further probe or ask for clarification. The comments are a snap shot of what the nurses felt was most important to share after

completing the survey. There is also the limitation that only those that felt most passionately about the DNP degree took the time to write in comments and therefore the findings are skewed in this way and exclude those who feel neutrality towards the DNP degree. Another limitation is the sample size, specifically the number of DNP comments (8%) included in the analysis. Less than half (33%) of the quantitative questionnaires had participant comments. Although the sample size breakdown is similar to the original quantitative breakdown, including more DNP comments about their role would have benefitted analysis. Lastly, sample bias may be an issue as the sample was obtained in the Midwest. Nurses from other parts of the country may have an entirely different view regarding the DNP degree and role.

Table 2. Using IPEC competencies to reduce role strain*

IPEC Competency	Specific Competencies to Reduce Role Strain
Values/Ethics for Interprofessional Practice	• Embrace individual differences • Respect the unique roles/responsibilities that characterize the nursing team
Roles/Responsibilities	• Communicate roles and responsibilities clearly • Recognize differences in skills and knowledge and use the combined knowledge to strengthen the team • Communicate effectively
Interprofessional Communication	• Avoid professional hierarchies • Encourage ideas and opinions from others
Teams and Teamwork	• Foster nursing collaboration • Develop consensus • Integrate each member's knowledge and experience • Share accountability • Engage the team to manage disagreements about roles, goals, and values

*(IPEC = Interprofessional Education Collaborative)[21]

5. Conclusion

The DNP degree is emerging quickly and as with any change comes uncertainty and confusion. This study identified several elements which are prevalent among nurses and identified in the literature that foster role stress and strain relating to the DNP prepared nurse. The identification of these key elements that contribute to role stress and role strain can assist academic institutions, healthcare and nursing organizations, and the profession as a whole to recognize the presence of stress and strain and to adopt tailored interventions and strategies to reduce them. These strategies may include a unified vision among the nursing profession regarding the DNP degree, a consistent core approach among schools of nursing in terms of program and curriculum, education of the profession, public, and other health professionals, and intraprofessional collaboration within the discipline, across all academic levels.

There is much to gain with the introduction of a practice doctorate in nursing. The DNP prepares nurses for leadership roles in a practice or systems focus making them ideal candidates to orchestrate change from the ground up in the health system, academic, and policy making arenas with the ultimate goal of improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care. From its inception, the DNP degree was designed to further meet the needs of the complex and rapidly changing healthcare environment. The profession has again evolved and with that evolution has come the expected stress, ambiguity, and strain that accompanies changes in organizations. The amount, duration, and severity of this stress, ambiguity, and strain will depend upon the nursing profession's ability to unite and work together to move our profession forward.

Conflicts of Interest Disclosure

The authors declare that there are no conflicts of interest.

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