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Nurse Practitioners' Attitudes Toward Nonpharmacological Interventions for Individuals Diagnosed with Clinical Depression

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This is to certify that the doctoral study by

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Walden University
2015

Abstract

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MSN, Lehman College, 2006

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Project Submitted in Partial Fulfillment

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Doctor of Nursing Practice

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Abstract

Depression negatively impacts the American economy, and there is a shortage of physicians to provide treatment. Nurse practitioners are viable alternatives to provide high-quality treatment of depression. The project's purpose was to describe nurse practitioners' attitudes toward nonpharmacological interventions to treat clinical depression. Attitude theory provided the theoretical framework. The American Psychiatric Association's guidelines for treating major depression provided the conceptual framework. The project used a quantitative nonexperimental descriptive survey research design. A purposeful sample of 63 nurse practitioners was obtained from members of the American Association of Nurse Practitioners. Data were collected through an online survey that included questions about participant demographics, attitudes about depression treatment modalities, and experience with individual and group psychotherapy in the treatment of depression. Frequencies and percentages were calculated for demographic information and information related to the use of individual and group therapy. Means and standard deviations were calculated for each of the Likert scale items. The findings showed that participants had more knowledge about medications used to treat depression and individual therapy than they did about group therapy. Findings showed that the participants believed that medication combined with individual therapy was the most effective treatment for individuals diagnosed with depression. Barriers to using group therapy were identified. These findings provided information to nurse practitioners about preferred treatment modalities for depression and the barriers to using group therapy to treat depression.

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Dedication

I am dedicating this project to my father and mother who have long passed on to the spirit world. My father; John Aidoo (alias Papa), a sweet, humble, God-fearing and loving father, who together with my mother, made it possible for my existence in the world. May his soul rest in everlasting peace. My mother; Lucy Essel (alias Mame), a strict disciplinarian was a kind and God-fearing individual, always making sure that all her children were fed. She called me often and said "Kojo," my native name, “always work hard, for had work does not kill, rather it makes you a better person.” May her soul rest in the bosom of the Almighty father in eternity. Amen.

Acknowledgments

Late one evening after I completed the proposal for this project, I received the devastating news that my older brother—the very reason for my education and prosperity—went home to join our parents in heaven. In silent reverie, I still lie awake in my room and return to that solemn night before my journey to America 28 years ago. My brother burned his last instruction in my memory forever. He said, "Kojo, do not come back to Ghana without attaining your doctorate degree."

His name is Joseph Afreh. And I thank him for giving the intellectual spirit to me so freely. His eccentricities rival any self-made man; everything he did—from his deep love of Jim Reeves records to his self-prescribed ritual of alcohol, women, and cigarettes—imprinted the idea upon me that if I fought for intellectual riches, I too will never be poor: neither in spirit, nor in other matters. Certainly, this project would remain a dream unrealized without him.

I thank my dear wife Freda Ocran, the woman who continues to see potential in me as a man, a father, a provider, and a nurse. Our journey together, through marriage, through college, and through parenthood has yielded an invaluable support. Freda's expertise as a psychiatric nurse has been the perfect sounding board for my thoughts on depression and her unwavering godliness continues to shelter me from the inevitable yet necessary storms of life. I will always love her: eternally, deeply, madly.

This project—inspired by my brother's spirit, shouldered by my wife's love—could not reach its conclusion without the tireless efforts and insights of my son, Nana Kwame. Nana possesses superior intellect and his ingenuity has been my saving grace on

countless occasions. He is my compass, my editor, my motivator. Time immemorial, Nana encouraged me to push past the walls of setbacks in the writing process; he found words that poignantly delivered my message. And when he was diagnosed as manic-depressive shortly after this work began, his personal struggle became the genuine counterpoint to my academic struggle. As he coped, recovered, and evolved, I too crawled, walked, and ran with the idea of transforming the way we deal with depression as a society. My hope is that his help and his example never cease to inspire change in our perception and treatment of depression in health care.

It would be remiss of me not to thank my second son, Papa Kwame Ocran, who, I am sure, will be extremely happy to know that I have finally obtained my Doctorate of Nursing Practice. And I thank my daughter, Maame Tiwaa Ocran, for being the jewel of my eye and my source of happiness during this endeavor.

There are a number of wonderful individuals who have been vital to this journey. A special thanks to: Dr. Allison Terry, my chairperson, who provided excellent guidance and support; Dr. Sherry Holly, committee member, who supported my project; and Dr. Nancy Moss, director of the DNP program, who also provided support and guidance; Dr. Shirley Walker (for her evenhanded approach to academic writing and her hopeful disposition), my classmates and my mentors at Walden University; you have made this final step in my educational journey easier.

I must thank my brother, Mr. James Atuah; my nephew Mr. Emmanuel Ofori-Yeboah; my dearest loving friend Flore Jean Claude, my sisters and brothers; my colleagues from my early days at Bronx Lebanon Hospital; my team at Harlem Hospital,;

colleagues from Bellevue and Montifiore Hospitals in New York City; and particularly Dr. Witter, Dr. Joseph, Miss Revulos, Adjoa Donkoh, Mr. Jones Abankwah. Miss Pauline Anderson, Emily Benjamin. Mr. Gannet, Peter Osei, Alma Wislon, Moose Huggette, Mr. Kofi Dankwa, Freda's mother Oye Agatha Mensah, my oldest friend—who lives in my hometown in Ghana—Mr. Kwaku Moosi.

Lastly, I thank God, my church community at Word Enlightenment Church in the Bronx and its general overseer, Dr. George Baah.

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Section 1: Nature of the Project

Introduction

Clinical depression, also referred to as major depressive disorder, is a severe mental illness whose presentation includes dysfunctional emotions, maladaptive behaviors, and poor cognition (Gelenberg et al., 2010). Individuals diagnosed with clinical depression commonly complain of fatigue, sleep disturbances such as insomnia, feelings of worthlessness or inappropriate guilt, loss of concentration or decisiveness, or recurring thoughts of death or suicide (National Institute of Mental Health, 2011). Clinical depression, a mood disorder, has been the third most common cause for hospitalization of 18 to 44 year olds; as of 2013, approximately 6.7% (14.8 million) American adults were diagnosed with clinical depression (Duckworth, 2013), which resulted in a significant economic impact.

The literature showed that workers diagnosed with depression, even subclinical levels of depression, caused significant losses in productivity that had a negative economic impact (McTernan, Dollard, & LaMontagne, 2013). The findings were consistent with Beck's et al. (2011) large quantitative study that found an inverse relationship between depression symptoms and work productivity in that higher depression symptoms resulted in lower work productivity. Researchers (Beck et al., 2011; Witters, Liu, & Agrawal, 2013) recommended that employers consider providing treatment for all workers diagnosed with depression as a cost-effective way to lessen the negative economic impact of depression.

The purpose of providing treatment for individuals diagnosed with depression is to help the individual function as before developing symptoms of depression. The American Psychiatric Association provided guidelines for treating depression (Gelenberg et al., 2010). Treatment modalities identified included "pharmacotherapy, depression-focused psychotherapy, the combination of medications and psychotherapy, or somatic therapies such as electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), or light therapy" (Gelenberg et al., 2010, p. 17). ECT, electrical stimulation to specific parts of the brain, and TMS, magnetic stimulation specific parts of the brain, were recommended for individuals with a severe major depressive disorder who have not responded to pharmacotherapy and/or psychotherapy. Light therapy was recommended for seasonal affective disorder, which is a mild form of depression. The guidelines (as cited in Gelenberg et al., 2010) recommended pharmacotherapy for the initial treatment of a severe major depressive disorder but indicated that depression-focused psychotherapy might be the only treatment needed for milder types of depression.

Several types of psychotherapy were determined by the American Psychiatric Association (as cited in Gelenberg et al., 2010) to be effective in treating individuals diagnosed with depression. The psychotherapies included "cognitive-behavioral therapy (CBT), interpersonal psychotherapy, psychodynamic therapy, and problem-solving therapy" (Gelenberg et al., 2010, pp. 17-18). An in-depth discussion of psychotherapy and the identified approaches is provided in Section 2. Each of the psychotherapy approaches can be provided in individual or group sessions by health care providers including psychiatrists, psychologists, social workers, and nurse practitioners.

Nurse practitioners can be a valuable resource in providing high-quality (Groh, 2013) and cost-effective (Bauer, 2010; Stanik-Hurt et al., 2013) primary care services, which included treating individuals diagnosed with depression. Nurse practitioners' training allows them to perform routine medical examinations, make diagnoses, order laboratory tests and procedures, prescribe medications and treatments, and provide psychotherapy interventions to patients (Mannheim, 2012). However, it is not known how nurse practitioners view their role in treating depression or their perceptions about using nonpharmacological interventions to treat depression.

Problem Statement

The problem addressed by this project was the lack of information about nurse practitioners' attitudes toward nonpharmacological interventions, including individual and group therapy, in the treatment of clinical depression. Only one current study (Bredow, 2014) was identified that explored nurse practitioners' attitudes toward treating depression. Bredow (2014) focused on identifying barriers to treating depression perceived by a small sample of nine nurse practitioners. In one study, Groes (2013) focused on patients' perceptions of treatment received by nurse practitioners. The researcher found that, in the rural setting, the patients reported that nurse practitioners treated depression more frequently with nonpharmacological treatments than medication, which might suggest that nurse practitioners' had positive attitudes towards nonpharmacological treatment. Both Bredow and Groes recommended future research to explore nurse practitioners' attitudes about treating depression.

Purpose Statement and Project Objectives

The purpose of the project was to describe nurse practitioners' attitudes toward nonpharmacological interventions in the treatment of clinical depression. The first objective of the project was to gather information from nurse practitioners about their knowledge about and use of nonpharmacological interventions including individual and group therapy as well as pharmacotherapy treatments for depression in inpatient and outpatient settings. The second objective of the project was to describe the extent to which the participants have been involved in treating individuals diagnosed with clinical depression. The third objective was to identify implications for nurse practitioner practice and training based on the results. The fourth objective was to make recommendations for further research related to nurse practitioners and the treatment of individuals diagnosed with depression. The fifth objective was to add to the nurse practitioner literature.

Relevance to Practice

Health care in the United States has undergone changes that necessitate expanding nurse practitioners' role in providing medical services (Fund & Swanson-Hill, 2014). Fund and Swanson-Hill (2014) and Groh (2013) found that, in many instances, nurses were viable alternatives to medical doctors, especially in rural areas. The researchers reported that nurse practitioners could provide high-quality, cost-effective treatment for individuals diagnosed with depression. However, the literature review did not provide information about nurse practitioners' attitudes toward treating depression. Thus, this project was relevant to nurse practitioners' training and work as the project obtained

information to describe nurse practitioners' attitudes toward treating depression and focused on nonpharmacological treatment modalities.

Project Question

The following question guided this quantitative nonexperimental descriptive survey design project: What attitudes do nurse practitioners have about nonpharmacological interventions for the treatment of individuals diagnosed with clinical depression?

Significance of the Project

Two factors in American health care contributed to the significance of this DNP project. First, a shortage of physicians in America (Center for Workforce Studies, 2012) required that additional health care providers be identified to meet the country's medical needs. Second, the negative economic impact caused by individuals diagnosed with depression required that high-quality, cost-effective treatment be identified to treat the individuals. Nurse practitioners have been shown to be a viable alternative to physicians (Fund & Swanson-Hill, 2014). Bauer (2010) found that nurse practitioners were more cost-effective than physicians.

This project's findings provided information about nurse practitioners attitudes toward treating depression and which nonpharmacological treatment modalities were preferred. The information may provide guidance to nurse practitioner programs about additional training that may be needed to assure that nurse practitioners are confident in diagnosing and treating individuals presenting with depression symptoms. Further, the information may provide guidance to practicing nurse practitioners about professional

development that might be needed to increase their skills in identifying and treating depression. Lastly, the project added to the nurse practitioner literature.

Definition of Terms

The following definitions apply to this project.

Attitudes: Two definitions of attitudes were pertinent to this project. First, Hogg and Vaughan (2005) defined attitudes as "a relatively enduring organization of beliefs, feelings, and behavioral tendencies toward socially significant objects, groups, events or symbols" (p. 150). Second, Eagly and Chaiken (1993) stated that "an attitude is a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor" (p. 1).

Clinical depression: Clinical depression, also known as major depressive disorder, is a severe mental illness that presents with dysfunctional emotions, maladaptive behaviors, and poor cognition (National Institution of Mental Health, 2011). The terms are used interchangeably within this project.

Nurse practitioner: The National Institutes of Health (as cited in Mannheim, 2012) definition was used for this project: "A nurse with a graduate degree in advanced practice nursing" (para. 1).

Psychotherapy: Herkov (2014) defined psychotherapy as "a process whereby psychological problems are treated through communication and relationship factors between an **i**ndividual and a therapist" (para. 1) that could be provided in individual or group sessions. Gelenberg et al. (2010) and Herkov identified several types of

psychotherapy that could be used to treat depression. However, this project used *psychotherapy* generically.

Assumptions, Limitations, and Delimitations

The following assumptions, limitations, and delimitations were identified for this project.

Assumptions

Three assumptions were identified for this project. First, it was assumed that the participants would provide honest responses to the self-administered survey. Second, it was assumed that the nurse practitioners responding to the survey had experience in treating individuals diagnosed with clinical depression. The last assumption was that a sufficient number of nurse practitioners would respond to the invitation to participate.

Limitations

Two limitations were identified for this study. The first limitation of the study related to the sample size, which would depend on how many nurse practitioners invited to participate actually took the online survey. The population for this quantitative descriptive project was obtained from a list of 1,500 members' names and addresses rented from the American Association of Nurse Practitioners (AANP, 2013-2014). The second limitation related to the development of the survey, I developed as the researcher, as no existing survey about nurse practitioners attitudes toward non-pharmacological treatment of depression could be found. To compensate for this limitation, the survey was vetted by a panel of nurse practitioner experts.

Delimitations

Delimitations for this project included the population and the instrument. The population for this study was limited to nurse practitioners who were members of the AANP. The population was selected in hopes of obtaining a diverse sample rather than being limited to a specific state or region. The focus of the project was limited to attitudes toward and experience with treating individuals with depression. The survey's main focus was on nurse practitioners' attitudes toward nonpharmacological treatment modalities, specifically individual and group psychotherapy.

Summary

This section provided an introduction to and an overview of the quantitative nonexperimental descriptive project. The problem, the purpose, and the project objectives were identified. The project's relevance to practice was discussed as was the question to be answered. The significance of the project was explained. Definition of terms, assumptions, limitations, and delimitations were also provided in the section. Section 2 provides a review of specific and general literature related to the project. Further, Section 2 provides information about the theoretical framework that supports the project and the contextual framework that organizes the project. Section 3 provides details about the methodology for the study.

Section 2: Background and Context

Introduction

This project aimed to describe nurse practitioners attitudes toward nonpharmacological interventions to treat individuals diagnosed with clinical depression. A quantitative nonexperimental descriptive survey research design was used to obtain information from nurse practitioners about their knowledge and use of nonpharmacological interventions including individual and group therapy as well as pharmacotherapy treatments for depression in inpatient and outpatient settings. The project further described the extent to which the participants have been involved in treating individuals diagnosed with clinical depression.

This section presents a review of the literature related to the project. The literature search for relevant research included queries from the following databases: CNAHIL, MEDLINE, Cochrane Database of Systematic Reviews, Google, and ProQuest. The literature review focused on material published from 2010 to 2015. Search terms used in the literature search included the following: *nurse practitioners, depression, treatment for depression, economic costs of depression, group therapy, individual therapy,* and *attitudes*. Literature identified through the literature search is presented in the next sections, which include specific literature related to nurse practitioners identifying and treating depression; general literature related to nurse practitioners; depression and the treatment of depression; and the contextual and theoretical frameworks that organize and provide the foundation for this research project.

Specific Literature

In this section, I discuss literature specific to nurse practitioners who treat persons diagnosed with depression symptoms including major depressive disorders in primary care or hospital settings. The review was limited because only three current studies were identified that specifically examined how nurse practitioners diagnosed and treated individuals presenting with symptoms of depression. Two of the studies (Anthony et al., 2010; Bredow, 2014) employed a mixed methods design that included survey data and interviews. The other study (Groh, 2013) employed a descriptive survey quantitative research design. Although authors of all the studies reported similar results and, in general, explored the same topic, there were differences in sample composition and size and localities. For example, the sample in Anthony's et al. (2010) mixed methods research included 15 general internists, 10 nurse practitioners, and 15 family practice physicians who practiced as primary care clinicians in Ohio. The research question asked about what conditions the participants perceived to influence their decision to refer patients for treatment of depression. Data were obtained from two quantitative surveys from the 40 participants identified and face-to-face interviews with six participants—two from each of the groups. Data analysis identified three conditions related to referring patients: (a) patient's financial and insurance resources, (c) primary care provider's comfort in prescribing medication and counseling patients diagnosed with depression, and (c) primary care provider's knowledge of and professional relationship a mental health professional or facility in the area.

The second mixed methods study's sample included 113 nurse practitioners in Texas (Bredow, 2014). Bredow (2014) identified and evaluated nurse practitioners' perceptions of barriers to treating patients diagnosed with depression in a primary care setting. Quantitative and qualitative data were collected through a demographic survey, which included open-ended questions about treating depression and a Likert scale questionnaire regarding attitudes about and barriers to treating patients diagnosed with depression. The data analysis found that, while time restrictions were not a barrier to treatment, time was a barrier to providing education to patients. The data analysis further identified a necessity for nurse practitioners to participate in continuing education. All of the descriptive survey quantitative methods studies also reported a need for continuing education for nurse practitioners in one or more areas as part of the studies' findings.

Groh's (2013) survey study focused on the implications for nurse practitioners in rural areas. Groh reported that nurse practitioners are commonly the primary care providers in rural areas due to a shortage of physicians. The research focused on self-reports from 140 women in a rural area who self-reported depression. Data obtained from the women showed that women accurately identified symptoms of depression. Groh indicated that, based on the study's results, nurse practitioners in rural areas should be knowledgeable about the most effective methods to diagnose and treat depression.

The literature reviewed in this section focused specifically on nurse practitioners' identification and treatment of depression. The following section reviews general literature related to nurse practitioners. General literature relating to depression and accepted treatment methods for depression are also reviewed in the following section.

General Literature

This section reviews literature related to nurse practitioners and depression. The first part provides a job description for nurse practitioners, the education and training required, and how nurse practitioners compare to physicians. The second part defines depression and discusses various nonpharmacological treatments used to treat depression.

Nurse Practitioners

The National Institutes of Health (as cited in Mannheim, 2012) defined a nurse practitioner as "a nurse with a graduate degree in advanced practice nursing" (para. 1). Educational requirements to become a nurse practitioner begin with earning a Bachelor of Science in Nursing or other undergraduate degree and becoming licensed as a registered nurse. Most states also require a master's degree in nursing and national nurse practitioner certification for consideration to be licensed. Weber et al. (2012) reported that educational requirements for psychiatric mental health nurse practitioner programs were changing due to national certification requirements and practice requirements.

Nurse practitioners are licensed by individual states and licensure requirements vary widely. Most states require nurse practitioners at minimum to have a master's degree and certification from a "national nursing organization such as the American Nurses' Association, Pediatric Nursing Certification Board, and others)" (Mannheim, 2012, para. 8). Some states allow nurse practitioners to practice independently while in other states nurse practitioners must work with a medical

doctor to prescribe medications or be licenses. A few states do not license or recognize practice by nurse practitioners.

As with licensure, states regulate the types of activities that the nurse practitioner can perform. According to Mannheim (2012), possible health care activities include the following: “taking health histories; physical examinations; ordering laboratory tests and procedures; diagnosing, treating, and managing diseases; writing prescriptions and coordinating referrals; providing handouts on disease prevention and healthy life styles, performing certain procedures, such as a bone marrow biopsy” (para. 2). The activities can occur in a variety of settings including primary care offices, private practice, hospital settings, and behavioral health settings. Nurse practitioners are expected to become an important health care provider resource (Fund & Swanson-Hill, 2014; Naylor & Kurtzman, 2010).

Fund and Swanson-Hill (2014) reported that the health care in the United States has been undergoing changes that necessitate expanding the nurse practitioners’ role in a variety of settings. Nurse practitioners were reported to be a viable alternative to physicians. Naylor and Kurtzman (2010) reviewed literature relating to the necessity for and effectiveness of care provided by nurse practitioners. Due to a shortage of physicians (Center for Workforce Studies, 2012), nurse practitioners have become increasingly necessary to fill the gap in health care. Additionally, nurse practitioners have been found be more cost-effective than physicians (Bauer, 2010).

Other researchers have investigated the quality of care provided by nurse practitioners. Stanik-Hutt et al. (2013) determined that nurse practitioner care was

comparable to care provided by physicians. Reuben et al. (2013) found that geriatric patients diagnosed with depression responded as well to treatment by nurse practitioners as they did to general practice physicians. The next part of this section reviewd general literature related to depression and depression treatment modalities. A definition of depression was provided along with a description of common treatments. Additionally, information about specific nonpharmacological treatments was provided.

Depression and Treatment Modalities

Clinical depression, also referred to as major depressive disorder, is a severe mental illness whose presentation includes dysfunctional emotions, maladaptive behaviors, and poor cognition. Individuals diagnosed with clinical depression commonly complain of fatigue, sleep disturbances such as insomnia, feelings of worthlessness or inappropriate guilt, loss of concentration or decisiveness, or recurring thoughts of death or suicide (National Institution of Mental Health, n.d.). Clinical depression, a mood disorder, has been the third most common cause for hospitalization of 18 to 44 year olds. Approximately 6.7% (14.8 million) American adults are diagnosed with clinical depression (Duckworth, 2013), which results in a significant economic impact.

The negative economic impact of depression in the workplace has been documented since Kessler's et al. study in 1999. In 2013, Writters et al. reported data from a Gallup poll that indicated that absenteeism of workers diagnosed depression cost American companies $23 billion. In a large quantitative study, Beck et al. (2011) evaluated the connection between a depression diagnosis and a loss in productivity. The 771 patients diagnosed with depression who reported being employed on a part-time or

full-time basis completed two instruments. One of the instruments measured the severity of depression symptoms and the other measured work productivity. Results of the survey showed a relationship between depression symptom severity and work productivity loss. Work productivity decreased incrementally with each 1-point increase in the severity of depression symptoms. Beck et al. recommended that employers consider providing treatment for all workers diagnosed with depression.

The American Psychiatric Association (as cited in Gelenberg et al., 2010) guidelines for treating major depressive disorder suggested using medications, psychotherapy, somatic therapies, or a combination of medication and psychotherapy. As this project focused on nurse practitioners' attitudes toward nonpharmacological treatments, the literature review did not include literature related to pharmacotherapy or somatic therapies. Rather, the literature review focused on psychotherapy and the various approaches used in the psychotherapy process.

Psychotherapy is "a process whereby psychological problems are treated through communication and relationship factors between an individual and a therapist" (Herkov, 2014, para. 1). Herkov (2014) described various approaches to psychotherapy that included the following: psychodynamic, interpersonal, and cognitive-behavioral. A therapist using a psychodynamic approach to psychotherapy will help the patient understand the historical basis of the problems and to understand how the present may be a repeat of past experiences. The goal of a psychodynamic approach is to help the patient resolve past issues in order to fully function in the present. An interpersonal approach is similar to the psychodynamic approach but focuses on changing self-

defeating patterns in relationships in the present. The cognitive-behavioral approach is task oriented in that the therapist helps the patient to identify and change maladaptive thoughts and behaviors (Herkov, 2014). All of the psychotherapy approaches may occur in individual sessions or in a small group of patients who are experiencing similar symptoms or who have the same diagnosis.

Group psychotherapy has become a frequently used therapy model. Kleinberg (2012) proposed that group therapy provided (a) a safe setting in which patients can practice new behaviors, (b) support and encouragement for group members, (c) a format for group members to be role models for each other, (d) a way for the therapist to observe how each member responds to the other members, and (e) cost effective therapy. A group therapy session includes members who are at various stages of treatment, which gives hope to members who are new to the group. One goal of group therapy is to help members accept responsibility for their thoughts, behaviors, and choices and that only by accepting personal responsibility can change occur. Kleinberg demonstrated that group psychotherapy was an effective treatment modality for depression.

Researchers (Cuijpers et al., 2010; Lynch, Laws, & McKenna, 2010) completed meta-analyses of literature related to psychotherapy as a treatment for depression. Lynch et al. (2010) focused on the effectiveness of the cognitive-behavioral approach in psychotherapy in treating depression. The analysis concluded that cognitive behavior therapy reduced symptoms and relapse of depression. Cuijpers et al. (2010) conducted meta-analyses of research related to the effectiveness of psychotherapy in the treatment of depression. Cuijpers et al. focused on literature related to general psychotherapy used

to treat chronic depression and dysthymia, a milder form of depression. The analysis showed psychotherapy had a small significant effect on depression when compared to a control group. The analysis suggested that a minimum of 18 psychotherapy sessions was required for optimal results. Further, the analysis suggested that pharmacotherapy combined with psychotherapy was more effective than only psychotherapy.

This section of the literature review focused on general literature related to nurse practitioners and on depression and treatment modalities. The review identified the economic impact of depression and affirmed that nurse practitioners are trained to effectively treat depression. The next section presents information about the theoretical framework the forms the foundation of this project and the contextual framework around which the project is organized.

Contextual and Theoretical Frameworks

This section discusses the theoretical framework that provides the foundation for this project and the contextual framework that organizes the project. Miles, Huberman, and Saldaña (2014) suggested that the conceptual framework provided a structure for existing knowledge that would be used to describe how the phenomenon under consideration has progressed and the theoretical framework provided an explanation of the phenomenon. As this project focused on nurse practitioners' attitudes toward treatment modalities for clinical depression, the American Psychiatric Association (2010) guidelines for the treatment of depression provided the contextual framework while attitude theory provided the theoretical framework.

Since the 19th century psychologists have proposed that attitudes influence human behavior (Briñol & Petrty, 2012). Two definitions were commonly used in the reviewed literature. The first definition suggested that attitudes internal, stating that an attitude "is a relatively enduring organization of beliefs, feelings, and behavioral tendencies towards socially significant objects, groups, events or symbols" (Hogg & Vaughan, 2005, p. 150). The second definition suggested that an attitude can positively or negatively influence behavioral choices and states: "an attitude is a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor" (Eagly & Chaiken, 1993, p. 1). Each of the definitions was pertinent to this project designed to describe nurse practitioners attitudes toward various treatment modalities for depression. Additionally, the definitions indicated that an attitude had three components: affect, behavior, and cognition.

The affective component related an individual's feelings or emotions about an object or event and influences the behavioral and cognitive components (Eagly & Chaiken, 1993). For this project, how a nurse practitioner felt about depression and about the person with symptoms of depression affected the decisions about whether to diagnose the person with depression and, if diagnosed, what treatment to provide. Nurse practitioners who might be concerned about the side effects of the drugs used to treat depression might be inclined to recommend group or individual counseling before prescribing a medication. Conversely, a nurse practitioner who has an attitude that counseling is not effective for treating depression might only prescribe medication. A nurse practitioner's attitudes about depression, however, might be influenced by the prior

knowledge and the context within which the decision to diagnose and treat depression exists.

The American Psychiatric Association guidelines for treating persons diagnosed with a major depressive disorder provided nurse practitioners information about diagnosing and treating major depressive disorder and provided a contextual framework for making treatment decisions (Gelenberg et al., 2010). While the guidelines were developed specifically for individuals diagnosed with major depressive disorder, they were also relevant to the treatment of persons exhibiting symptoms of milder depressive disorders (Gellenberg, 2010). As this project focused on the treatment phase, the guidelines related to treatment were used as the contextual framework.

The aim of treatment for individuals diagnosed with depression is to help them to function as before they developed symptoms. Treatment options included "pharmacotherapy, depression-focused psychotherapy, the combination of medications and psychotherapy, or other somatic therapies such as electroconvulsive therapy (ECT), transcranial magnetic (TMS), or light therapy" (Gelenberg et al., 2010, p. 17). While pharmacotherapy was recommended as part of the initial treatment of a severe major depressive disorder, depression-focused psychotherapy may be the only treatment needed for persons diagnosed with mild to moderate major depressive disorder and less severe forms of depression.

The guidelines identified several types of psychotherapy determined to be effective for treating depression that could be used in individual and group formats. The psychotherapies, which were previously discussed in this section, included "cognitive

behavioral therapy (CBT), interpersonal psychotherapy, psychodynamic therapy, and problem-solving therapy" (Gelenberg et al., 2010, p. 17-18). Health providers prescribing psychotherapy either in an individual or group format should consider the severity of the symptoms of depression and other health conditions of the person. For example, psychotherapeutic interventions should be the first choice for pregnant women or those who might become pregnant. Other factors recommended for consideration included the following: the person's preferences, prior response to interventions, availability of professionals experienced with the psychotherapy recommended, and treatment goals.

The guidelines (Gelenberg et al., 2010) recommended that the primary care provider monitor patients progress and adjust treatment as needed. If a patient does not respond to psychotherapy alone, pharmacotherapy may be added. The guidelines further recommended that the provider monitor treatment adherence to determine adequacy of treatment and adjust as necessary. For patients who have not shown improvement after 8 to 16 weeks of treatment, the guidelines recommended that the primary care provider consider consulting with another professional to determine the best course of treatment.

As described, the guidelines provided a contextual framework within which to evaluate the nurse practitioner participants' survey responses relating to treatment preferences for individuals diagnosed with depression. Attitude theory provided a framework for understanding the emotional, behavioral, and cognitive processes that influenced treatment decisions made by nurse practitioners. Together the frameworks provided the foundation for this project.

Summary

This chapter reviewed literature pertinent to the project. The review included literature specifically related to nurse practitioners role in treating individuals diagnosed with depression. General literature related to nurse practitioner training and practice activities was also reviewed. Additionally, general literature related to depression, the economic impact of the disorder, and treatment methods for depression were reviewed. The final section provided information about the theoretical framework that provided the foundation for the project and about the contextual framework that organized the project. The next section provides detailed information about the methodology, the population and sample selection, data collection procedures, data analysis, and ethical considerations for the project.

Section 3: Collection and Analysis of Evidence

Introduction

The primary purpose of this project was to gain an understanding of nurse practitioners' attitudes toward nonpharmacological interventions for individuals diagnosed with clinical depression. This section discusses the project design, the population and sampling procedures, data collection, and data analysis.

Project Design/Methods

This project employed a quantitative nonexperimental descriptive survey research design to assess nurse practitioners' attitudes toward for the treatment of clinical depression. Lodico, Spaulding, and Voegtle (2010) indicated descriptive survey research was to "describe behaviors and to gather people's perceptions, opinions, attitudes, and beliefs about a current issue" (p. 26), which was the aim of this project. The survey design provides a method to describe the attitudes of the sample numerically (Creswell, 2013).

Population and Sampling

The population for this project was obtained from the AANP (2013-2014). The AANP supports research by graduate students by providing access to names and addresses for nurse practitioners who belong to the organization. The association allows "a one-time use rental of a specified NP sample, drawn from the AANP membership for approved research" (AANP, 2013-2014, para. 3). I am a student member of the AANP and sent all necessary documents to the AANP once Institutional Review Board (IRB) from Walden University was obtained (IRB approval number 07-06-15-0087512).

Following the AANP guidelines, I rented 1,500 names and addressed of nurse practitioners who had a psychiatric specialty designation. The 1,500 individuals became the population for this project. The project proposal stated I would rent 150 names from the AANP. However, when I finalized the process, I was informed that the association only rented the entire membership list, which resulted in the 1,500 number of invitations sent.

A purposeful sampling technique was employed to solicit participants from the identified population. Purposeful sampling is appropriate when the research requires participants to have experience with the phenomena being investigated (Creswell, 2013). Each of the 1,500 individuals in the identified population were invited to participate in the project. Sixty-three nurse practitioners completed the online survey questionnaire and became the sample for the study.

The postcard invitation (see Appendix A) was sent by the United States Postal Service to invite individuals identified by the AANP to participate in the study. The invitations included information about the project, my e-mail and telephone contact information, and the link to the online survey. The invitation also explained that no personally identifying data would be collected and that taking the survey constituted informed consent.

Data Collection

Data collection began at the time the invitations to participate were sent. As stated in the previous section, the survey questionnaires were available and completed on the SurveyMonkey (2013) website. Information about the survey instrument follows.

Instrument

I developed the five-part survey questionnaire used in this project. The questionnaire included an introductory section that explained the purpose of the study and four additional parts: demographic information; attitude toward interventions for individuals with depression; individual and group therapy/counseling session information; and other nonpharmacological interventions (see Appendix B). The demographic section included open-ended questions and *yes* or *no* questions. The attitude toward interventions for individuals with depression section included 11 statements to which participants were asked to indicate level of agreement using a 4-point Likert scale: 1 = *strongly disagree*; 2 = *disagree*; 3 = *agree*; and 4 = *strongly agree*. The 4-point scale was selected to obtain a clearly positive or clearly negative attitude toward each item. Burns and Grove (2009) suggested that using a 4-point scale could provide a clearer interpretation of the responses.

The next section included questions about the use and frequency of individual and group therapy/counseling sessions provided in the participant's work setting. The final section asked participants to list other types of nonpharmacological interventions provided in their work setting to individuals diagnosed with clinical depression. The questionnaire provided a section for comments.

Validity and reliability for the instrument were addressed. As the study was a nonexperimental descriptive case study, I used the guidelines for assessing validity and reliability in qualitative research for the instrument. Reliability as defined by Yin (2011) refers the replicability of the results of the study instrument. Yin suggested that clearly

defined procedures helped to assure replicability of the measure. The methodology section provides specific, step-by-step instructions for conducting, which assures replicability of the study.

Face and content validity were established for the instrument. Researchers (Creswell, 2013; Miles, Huberman, & Saldaña, 2014) reported that face validity referred to how the questions appeared to relate to the concept being measured, while content validity related to how well the questions were consistent with the topic. In order to establish face and content validity, the questions were vetted by three nurse practitioners to assure the questions were clearly written and understandable. The three professionals had more than 10 years of experience treating individuals diagnosed with clinical depression. The nurse practitioners had worked in inpatient psychiatric hospitals. The questionnaire was modified prior to submission to Walden's IRB committee based on feedback from the three nurse practitioners.

Protection of Human Subjects

The project design assured minimal risk to participants and provided protections to the participants. First, I submitted a request for IRB approval from Walden University and received approval for the project. Second, my contact information and written statement regarding the project's purpose were provided on the correspondence with the population and reiterated on the survey questionnaire for individuals choosing to complete the survey. Third, no personally identifiable information was collected on the survey questionnaire. Each survey questionnaire was assigned an identification number. Fourth, completing the survey signified consent. The U. S. Department of Health and

Human Services (2009) stipulated that written consent could be waived when the project presented minimal risk to participants. Lastly, I will keep all data collected confidential and secured for 3 years, at which time, the data will be destroyed appropriately (paper documents shredded and computer data files erased).

Data Analysis

Descriptive statistics including means and standard deviations were calculated for participants' responses to all parts of the survey questionnaire. No other statistical analysis such a *t* test, ANOVA, or Pearson *R* or Chi-square were calculated as the project was not an inferential or causal-comparative research design. Demographic information and information about use of individual and group counseling was reported as frequency and percentage data. Means and standard deviations were calculated for each of the Likert scale items. Standard deviations showed the variability of the responses from the participants' mean scores (Lodico et al., 2010). The statistical analysis was calculated using an Excel spreadsheet. Results of the data analyses were presented in a narrative report. Tables were created to visually depict the results.

Summary

This section has discussed the research design for this project that assessed nurse practitioners' attitudes toward nonpharmacological interventions for individuals diagnosed with clinical depression. The population and sampling procedure were also presented. The survey instrument used to collect data from participants was described. Data collection through the SurveyMonkey website and data analysis processes were presented.

Section 4: Findings and Recommendations

Introduction

The primary purpose of this DNP capstone project was to describe nurse practitioners' attitudes toward nonpharmacological interventions in the treatment of clinical depression. The following five objectives related to the purpose of the project:

- Gather information from nurse practitioners about their knowledge about and use of nonpharmacological interventions including individual and group therapy as well as pharmacotherapy treatments for depression in inpatient and outpatient settings.
- Describe the extent to which the participants have been involved in treating individuals diagnosed with clinical depression.
- Identify implications for nurse practitioner practice and training based on the results.
- Make recommendations for further research related to nurse practitioners and the treatment of individuals diagnosed with depression.
- Add to the nurse practitioner literature.

This section presents the study's findings and implications the findings have for practice. The section includes recommendations for further research and identifies strengths and limitations of the project.

Findings

This project employed a quantitative nonexperimental descriptive survey research design to assess nurse practitioners' attitudes toward nonpharmacological

interventions for the treatment of clinical depression. I obtained data from a sample of nurse practitioners who belonged to the AANP and completed an online survey administered via the SurveyMonkey website. As a student member of the AANP, I rented a list of members' addresses and mailed a postcard invitation to participate. During the 2 weeks the survey was open, 66 AANP members completed the questionnaire. Of the 66, 63 met inclusion criteria. Demographic information collected in the first part of the survey questionnaire revealed that the majority of participants were female (85%), older than 40 years of age (54%), and White (81%). Table 1 shows a summary of gender, age, and ethnicity of the 63 participants.

Table 1

Summary of Participant Demographics

Demographic	Number of Responses	%
Gender		
Female	54	85
Male	9	14
Age		
21-29	4	6
30-39	11	17
40-49	16	25
50-59	18	29
60+	14	22
Ethnicity		
White	51	81
Black	5	8
American Indian	1	2
Hispanic	1	2
Multiple Races	5	8

Table 2 shows a summary of participants' credentials.

Table 2

Summary of Participants' Credentials

#	Credentials	#	Credentials
1	RN, BSN, MSN, FNP-BC, PMHNP-BC	33	MSN, APRN, PMHNP-BC, NE-BC
2	BS, BA, BSN, MSN, FNP-BC	34	Family Nurse Practitioner, Adult Psychiatric Mental Health NP, DNP candidate
3	APRN, DNP candidate	35	RN, PMHNP
4	Psychiatric NP, MSN	36	CRNP, RN
5	RN, Bsc, MSN, APRN- Family Health, DNPc	37	MSN, FNP-BC, Adult PMHCNS-BC, Adult PMHNP-BC
6	Board certified Family Nurse Practitioner - CNM	38	MS, MSN, APN
7	Nurse Practitioner Psychiatry	39	RN, MPH, MSN, NP
8	PMHNP-BC, ACNS-BC, RN, MSN	40	APRN, FNP-C, PMHNP-BC
9	FNP, MSN, BSN	41	MSN
10	ARNP-C, RN, MSN, BSN	42	NP AANP
11	RN, PHN, FNP-C	43	BA, BFA, MBA, BSN, RN, DNP, PMHNP-BC
12	RN, MS, NP-P	44	MBA, BSN, RN
13	FNP	45	BA, BS, RN, MS, PMHNP
14	BSN, MS, NP, Doctoral Student (DNP)	46	RN, MSN, FNP
15	DNP, FNP-BC	47	RN, MSN, PMHNP-BC
16	RN, BSN, PMHNP, DNP	48	DNP, MSN, MSW, PMHNP-BC, LCSW
17	PMH-NP. ADULT NP	49	APRN, Rx, MSN
18	RN FNP WHNP	50	RN, ARNP, MSN, FNP
19	PhD FNP-BC	51	rn,fnp,msn
20	BSN, MSN, PMHAPRN	52	RN, DNP, ACNP-c
21	BSN, RN, ARNP, PMHNP-BC	53	MSN, CRNP-C, PMHNP, BSN, RN
22	DNP, PMHNP-BC	54	DrNPc, APRN, OMH-CNS/FNP, BC
23	RN-BC APRN pending	55	PHD/NP/PMHCNS-BC
24	M.N., PMHNP-BC	56	MS, APRN, NP-C
25	FNP-C FPMHNP-BC	57	CRNA,CRNP
26	DNP MSN PMHNP PMHCNS	58	FPMHNP
27	FNP, NP-C	59	PMHNP BC
28	ARNP, ND, PhD	60	RN, APN
29	ANP-C, FNP-C, RN-BC, MSN, BA	61	ARNP, NRCME
30	PMHNP, FNP, DNP	62	APRN, FNP-C, PMHNP-BC
31	MSN, ANP-BC (RN too)	63	MSN, RN, PMHNP-BC
32	RN ANP-C BSN MS ND		

As shown in Table 2, participants reported having one or more health profession credentials, which qualified them to participate in this study. Participants were well educated with 62 (98%) reporting their highest degree to be a graduate degree while one participant (2%) reported a bachelor's degree to be the highest degree earned.

Survey questions inquired about participants' years of experience as a nurse practitioner, current employment, and years in current employment setting. The majority of participants (35, 62%) reported between 1 9 nine years of nurse practitioner experience. Table 3 shows a summary of participants' years of nurse practitioner experience.

Table 3

Summary of Nurse Practitioner Experience

Years of Experience	Number of Responses	Percentage
4or less	22	39
5 to 9	13	23
10 to 19	11	19
20 to 29	7	12
30 or more	4	7

Note. $N = 57$; Six participants did not provide information about years of experience.

Participants reported working in a variety of health care settings including hospitals, private practice, clinics, corrections, nursing homes, mental health departments, rehabilitation centers, and with Veterans Affairs. Ten participants reported being unemployed at the time they completed the survey. The majority of participants

participated working in a hospital (16, 25%) or in a private practice (13, 21%). Table 4 shows a summary of participants' current employment settings.

Table 4

Summary of Current Employment Settings

Setting	Number of Responses	Percentage
Hospital	16	25
Private practice	13	21
Clinic	12	19
Currently not employed	10	16
Corrections	6	10
Nursing Home	2	3
Veterans Affairs	2	3
Department of Mental Health	1	2
Rehabilitation Center	1	2

Note. $N = 63$

Participants reported working in their current positions from 1 to 30 years. Table 5 shows a summary of years employed in current employment setting.

Table 5

Summary of Years Employed in Current Employment Setting

Years	Number of Responses	Percentage
20 or more	4	8
10 to 19	6	11
5 to 9	13	25
4 or less	30	57

Note. $N = 53$; The number of responses does not include participants reporting not currently employed.

As shown in Table 5, the majority of participants (30, 57%) reported being in their current employment setting for 4 or less years.

The last question in the demographic section inquired as to whether the participants currently treated individuals diagnosed with depression and about the treatment modalities they used to treat depression. Table 6 shows a summary of participants' responses.

Table 6

Summary of Treatment Modalities used to Treat Persons with Depression

Activity	Yes	No
I am currently involved in treating persons with depression.	59 (94%)	4 (6%)
I use group therapy/counseling to treat persons with depression.	20 (32%)	43 (68%)
I use individual therapy/counseling to treat persons with depression.	46 (73%)	17 (27%)
*I am satisfied working in a psychiatric unit.	40 (70%)	17 (30%)

*Fifty-seven of the 63 participants indicated they worked in a psychiatric unit. However, the responses were inconsistent with the employment settings reported in Table 4.

The second part of the questionnaire asked about participants' knowledge of, and attitudes toward, depression treatment modalities. First, participants were asked to rate their knowledge of the following three treatment modalities: (a) psychotropic medication, (b) individual therapy, and (c) group therapy. The rating scale choices were 1 = *no knowledge*, 2 = *some knowledge,* 3 = *moderate knowledge*, and 4 = *comprehensive knowledge.* Table 7 shows a summary of participants' responses.

Table 7

Summary of Participants Reported Knowledge of Treatment Modalities

Treatment Modality	No Knowledge	Some Knowledge	Moderate Knowledge	Comprehensive Knowledge
Psychotropic medications such as anti-depressants and other pharmacological treatments	0 (0%)	3 (5%)	13 (20%)	47 (75%)
Individual, one-on-one therapy sessions (or similar non-pharmacological treatment) with qualified health care worker	2 (3%)	9 (14%)	18 (29%)	34 (54%)
Group therapy sessions (or similar non-pharmacological treatment) with a qualified health care worker.	6 (10%)	13 (21%)	26 (41%)	18 (29%)

Note. $N = 63$

Calculated descriptive statistics (mean and standard deviation) provided information about the level of knowledge reported by participants and the uniformity of their responses. Table 8 shows a summary of the descriptive statistics for participants' knowledge of treatment modalities.

Table 8

Descriptive Statistics for Participants Reported Knowledge of Treatment Modalities

Treatment Modality	*Mean*	*SD*
Psychotropic medications such as anti-depressants and other pharmacological treatments	3.71	.551
Individual, one-on-one therapy sessions (or similar non-pharmacological treatment) with qualified health care worker	3.33	.842
Group therapy sessions (or similar non-pharmacological treatment) with a qualified health care worker.	2.89	.900

The low standard deviations reported in Table 8 indicated that participants' responses were uniform for all three identified treatment modalities. As shown in Tables 7 and 8, the majority participants (47, 75%, $M = 3.71$, $SD = .551$) reported having comprehensive knowledge about the psychotropic medication treatment modality. The majority of participants (34, 54%, $M = 3.33$, $SD = .842$) also reported having comprehensive knowledge about the individual therapy with a qualified heal care worker modality. Results for the group therapy sessions with a qualified health care worker indicated that participants were less knowledgeable about this treatment modality than the other two modalities ($M = 2.89$, $SD = .900$).

Participants' attitudes toward the three treatment modalities were measured with an 11-statement Likert scale survey (see Appendix B). The statements related to (a) which treatment modalities should be used to treat individuals diagnosed with depression; (b) outcomes of the treatment modalities, and (c) effectiveness of combining two or more of the treatment modalities. Participants were asked to rate their agreement with each statement with 1 = *strongly disagree*, 2 = *disagree,* 3 = *agree*, and 4 = *strongly agree*.

Data analysis for the ratings include calculating frequencies and percentages of responses for each question and calculating means (*M*) and standard deviations for each statement to determine participants' attitudes toward each statement (*M*) and the uniformity of participants' responses (*SD*). Table 9 shows the summary of the frequencies and percentages of the responses and Table 10 shows the summary of the means and standard deviations.

Table 9

Summary of Participants' Attitude Ratings for Treatment Modalities

Item	Strongly Disagree	Disagree	Agree	Strongly Agree
1. NP treatments for clinical depression should be used more often	0 0%	9 14%	23 37%	31 49%
2. Non-pharmacological interventions for clinical depression should be used before pharmacological interventions	2 3%	19 30%	27 43%	15 24%
3. Psychotropic medication is the treatment of last resort for persons with clinical depression	14 22%	31 49%	10 16%	8 13%
4. Individual therapy/counseling should be used in the treatment of persons with depression	0 0%	11 18%	33 52%	19 30%
5. Group therapy/counseling should be used in the treatment of persons with depression	2 3%	35 56%	22 35%	4 6%
6. Persons with depression show improvement after engaging in individual therapy/counseling sessions	1 2%	15 24%	35 56%	12 19%
7. Persons with depression show improvement after engaging in group therapy/counseling sessions	2 3%	37 59%	17 27%	7 11%
8. Individual therapy/counseling is preferred over group therapy/counseling for treating persons with clinical depression	0 0%	17 27%	33 52%	13 21%
9. Group therapy/counseling is preferred over individual therapy for treating persons with clinical depression	5 8%	49 78%	8 13%	1 2%
10. Persons with clinical depression should participate concurrently in group therapy/counseling and individual therapy/counseling for best outcomes	2 3%	21 33%	27 43%	13 21%
11. Treatment for persons with clinical depression should include pharmacological treatment, individual therapy/counseling, and group therapy/counseling for best outcomes	0 0%	7 11%	22 35%	34 54%

Note. $N = 63$

Table 10

Descriptive Statistics for Participants' Attitude Ratings for Treatment Modalities

Item	Mean (*M*)	*SD*
NP treatments for clinical depression should be used more often	3.40	.794
Non-pharmacological interventions for clinical depression should be used before pharmacological interventions	2.30	.797
Psychotropic medication is the treatment of last resort for persons with clinical depression	2.24	.928
Individual therapy/counseling should be used in the treatment of persons with depression	3.13	.684
Group therapy/counseling should be used in the treatment of persons with depression	2.44	.657
Persons with depression show improvement after engaging in individual therapy/counseling sessions	2.90	.712
Persons with depression show improvement after engaging in group therapy/counseling sessions	2.37	.703
Individual therapy/counseling is preferred over group therapy/counseling for treating persons with clinical depression	2.90	.712
Group therapy/counseling is preferred over individual therapy for treating persons with clinical depression	2.10	.499
Persons with clinical depression should participate concurrently in group therapy/counseling and individual therapy/counseling for best outcomes	2.78	.792
Treatment for persons with clinical depression should include pharmacological treatment, individual therapy/counseling, and group therapy/counseling for best outcomes	3.43	.689

The standard deviations shown in Table 10 indicate that participants' responses were uniform across all questions. Regarding the use of non-pharmacological (NP) interventions for the treatment of depressions, the data in Tables 9 and 10 showed the following:

- The majority of participants believed that NP treatments should be used more frequently to treat depression ($M = 3.40$, $SD = 7.94$) with 52 (86%) selecting agree or strongly agree.

- The majority of participants agreed or strongly agreed (42, 77%) that NP should be used be used before pharmacological treatments for individuals diagnosed with depression. However, 33 (67%) disagreed or strongly disagreed that NP should be used before pharmacological interventions (*M* = 2.30, *SD* = .797).
- The majority of participants also strongly disagreed or disagreed (54, 71%) that pharmacological interventions should be the treatment of last resort (*M* = 2.24, *SD* = .928)
- The majority of participants believed that individual therapy/counseling should be used in the treatment of depression with 52 (82%) selecting agree or strongly agree (*M* = 3.13, *SD* = .6.84).
- Participants' responses indicated mixed attitudes toward group therapy/ counseling being used to treat depression with 35 (52%) of participants selecting *disagree* while 22 (35%) selected *agree* (*M* = 2.44, SD = .657).
- The majority of participants believed that persons with depression showed improvement after engaging in individual therapy/counseling with 35 (56%) selecting *agree* and 12 (19%) selecting *strongly agree* (*M* = 2.90, *SD* = .712).
- The majority of participants believed that persons treated for depression did not improve after engaging in group therapy/counseling with 37 (59%) selecting disagree and two (3%) selecting strongly disagree (*M* = 2.37, *SD* = .703).

- The majority of participants indicated that individual therapy/counseling is preferred over group therapy/counseling for the treatment of depression with 33 (52%) selecting *agree* and 13 (21%) selecting *strongly agree* ($M = 2.90$, $SD = .712$).
- The majority of participants indicated that group therapy/counseling was not preferred over individual therapy/counseling for the treatment of depression with 49 (78%) selecting disagree and five (8%) selecting strongly disagree ($M = 2.10$, $SD = .792$).
- Participants' responses indicated mixed attitudes as to whether persons with depression should participate concurrently in group therapy/counseling and individual therapy/counseling for best outcomes with 27 (43%) selecting *agree* and 13 (21%) selecting *strongly agree* while 21 (33%) selecting disagree and two (3%) selecting *strongly disagree* ($M = 2.78$, $SD = .792$).
- The majority of participants believed that treatment for persons with depression should include pharmacological treatment, individual therapy/ counseling, and group therapy/counseling for best outcomes with 22 (35%) selecting *agree* and 34 (54%) selecting *strongly agree* ($M = 3.43$, $SD = .689$).

The third part of the survey questionnaire focused on the number of individual and/or group therapy/counseling sessions normally prescribed for a person diagnosed with depression and on the percentage of persons diagnosed with depression prescribed for individual and/or group therapy. The section included four questions that were not forced choice. Of the 61 participants who responded to the questions, most gave

information rather than a numerical value for their responses. Thus, no descriptive data were calculated. The questions and examples of participant responses follow.

The first question asked," How many individual therapy/counseling sessions are normally prescribed for a person diagnosed with depression?" Three participants responded that the number of sessions would depend on the person's insurance coverage. Six participants indicated that they either were not qualified to provide therapy or worked in a setting that referred patients for counseling services. Six participants reported it depended on the patients' needs or the patients' willingness to participate. Numerical values for the number of sessions prescribed ranged from zero to weekly for 52 weeks. The larger number of sessions prescribed were reported by participants who indicated they worked in an in-patient hospital setting.

The second question asked, "How many group therapy/counseling sessions are normally prescribed for a person diagnosed with depression?" Only six participants provided a number as a response. The number of group sessions reported ranged from four to 32. Participants who worked in in-patient hospital or psychiatric clinic settings reported the larger number of group sessions. Four participants reported that prescribing group therapy/counseling was a rare occurrence. Three participants reported that patients were not usually receptive to group therapy. Two participants reported that insurance companies often would not cover group therapy/counseling, which was another barrier to prescribing group therapy for patients. The other participants reported that "it varies" or "zero."

The third question asked, “Approximately what percentage of persons with depression is prescribed individual therapy/counseling?” Seven of the 61 responding participants reported that that none of the persons diagnosed with depression in the setting where they worked prescribed individual therapy/counseling. The other 54 responding participants, 40 responded with percentages ranging from 50% to 100% of patients would be recommended or encouraged (not prescribed) to attend group therapy/counseling sessions. Five participants responded with percentages ranging from 10% to 30% of patients diagnosed with depression would be prescribed group therapy/counseling. The other participants provided answers such as “Prescribed doesn’t happen, mostly due to insurance issues. Advised happens;” and “Patients refuse group therapy at intake.”

The fourth question asked, “Approximately what percentage of persons with depression is prescribed group therapy/counseling?” Of the 61 responding participants, 41 reported that, in their current work setting, none of the persons diagnosed with depression was prescribed group therapy/counseling. From 5% to 10% of patients diagnosed with depression were prescribed group therapy/counseling in their current work setting were reported by 12 participants. Seven participants indicated that between 25% and 100% of persons diagnosed with depression in their current work setting were prescribed group therapy/counseling. The higher number of prescribed group therapy/ counseling sessions was from participants who worked at in-patient psychiatric hospital or clinic settings. One participant explained, “100% due to the setting and programming offered at this facility.”

The fourth part of the survey questionnaire asked participants to list non-pharmacological interventions other than individual and group counseling provided in their current or most recent work setting. Fifty-nine of the 63 participants responded to this question and identified a variety of mon-pharmacological interventions. Some participants identified more than one other intervention. Nutrition/exercise, the most frequently identified intervention, was reported by 24 participants. Fourteen participants reported behavioral interventions. Other interventions that were identified by one to five participants were meditation (5), music therapy (4), bibliotherapy (2); herbal therapy (2), light therapy (2), art therapy (2), occupational therapy (2), spirituality (2), holistic (1), journaling (1), massage (1), and acupuncture (1).

The last part of the survey questionnaire asked participants to provide any additional comments. Twenty-five participants provided additional comments. Seven participants reported that they believed that the combination of medication and individual therapy was the most successful treatment modality for individuals diagnosed with depression. The following comments related to group therapy:

- I think group therapy is not as well understood as individual therapy.
- In the community where I practice, there are very limited therapy groups.
- I've seen group as good for patients after symptoms start to subside, but not before.
- Resources to provide group therapy are not available.
- Our practice offers very few groups because they were so poorly attended.

Other participants made general comments about the treatment options available for individuals diagnosed with depression and the settings in which they worked.

- Corrections have limited resources, which is just terrible.
- Detention center – very limited resources.
- I work at a recovery center with multiple resources.
- I found that people with depression all too often have inactive lifestyles. However in our culture, all too often people want a pill. Compulsory community service for those on disability who suffer from depression would go a long way in addressing their depression symptoms.
- This is an area that is sorely underfunded and poorly treated with 'just' pharmaceuticals. In my experience, cognitive/behavioral therapy is the best approach—but the nearest CBT practitioner is several hours away. No good way to handle this in the current context (and I fear it will get worse).

The survey revealed that nurse practitioners shared a generally similar view to non-pharmacological interventions against depression. Most participants believed a coordinated program that included a combination of medication and individual therapy/counseling was the most effective treatment for individuals with depression. Respondents preferred individual therapy/counseling to group therapy/counseling. Reasons given for the disparity between the two treatment options were: (a) participants were less familiar with group therapy/counseling than with individual therapy/counseling; (b) individuals diagnosed with depression often opted out of group interventions at intake or did not attend sessions when prescribed; (c) therapeutic groups

were not readily available; and (d) insurance companies often did no cover group interventions. Participants identified nutrition/exercise and behavioral therapy as other frequently used NP treatments for depression.

Discussion

I identified strengths and limitations for this DNP project. Strengths of the project were the quantitative non-experimental design for the study and the descriptive statistics that could be calculated. The frequency and percentages provided a numerical comparison the participants' responses for each question. The means and standard deviations provided a way to evaluate the consistency of responses for each question. The sample size of 63 provided an adequate sample for an exploratory study to determine how knowledgeable nurse practitioners were about NP interventions for the treatment of depression and their attitudes about the NP interventions. Another identified strength was the survey design, which included open-ended questions in addition to Likert scale items.

I identified four limitations for the study. The first limitation was that there was no way to clarify or verify responses with participants because I had not obtained any personally identifying information from the participants. While the survey was a strength, it also was a limitation in that participants' may have had a response bias to always report one choice, rather than considering carefully all the choices. Another limitation related to the survey was that I had chosen not to include a neutral option on the Likert scale items.

The last limitation I identified related to the sample size. Although the sample size was adequate for an exploratory study, the number of respondents did not reflect the effort that went into advertising and creating the opportunity for response. Out of the

1,500 potential participants identified through the list of members' names and addresses rented from AANP, only 66 responded and 63 completed the questionnaire. The participants were contacted through postcards sent through the USPS. Less than 15 postcards were returned to me, meaning that 99% reached their intended destination and about 90% were virtually ignored by potential respondents. Had I had the opportunity to do this project again with unlimited time and resources, I would instead opt for contact via e-mail through an endorsement of the AANP; this option would prove less cumbersome for participants who would not have to change interface from postcards to SurveyMonkey online. Further, I would consider incentivizing the survey by providing prizes towards nursing practices throughout the United States, which might have increased participation.

Implications

This section discusses implications for the findings of this DNP project. The first implication is that the findings lend themselves the general trend within the practice to treat away from pharmacological interventions, yet possess the findings to influence the practice in a profound way. Nurse practitioners may serve a pivotal role in the comprehensive treatment and plan of care of depression in a way that is distinct from physicians. Whereas physicians are devoted to returning patients to therapeutic levels through pharmacological treatment, nurse practitioners, through their expertise in non-pharmacological treatments, can coordinate with therapists and patients to develop an optimal experience for patients. The findings from this study suggest that best practice in

treating persons diagnosed with depression would be to include individual therapy as a treatment modality.

The second implication is that nurse practitioners might benefit from learning more about group therapy/counseling as a treatment modality for depression. Additional training or coursework related to group therapy might help nurse practitioners develop insight into the nuances of treatment, which might increase nurse practitioners' acceptance and use of the modality. Nurse practitioners who work at in-patient settings or settings with adequate resources might be able to increase the use of group therapy/counselling when treating patients diagnosed with depression.

Section 5: Dissemination Plan

Analysis of Self

As a scholar, this work has been nothing short of a labor of love. The hours I spent on the project's design and implementation—particularly in the midst of the AANP—gave me a sense of integrity and strong moral beliefs in the production of my work. I complete this section in earnest, knowing that it is a culmination of my doctorate studies in Nursing Practice and a new beginning in my personal approach to the treatment of depression in my workplace.

Summary

Approximately 6.7% (14.8 million) American adults are diagnosed with clinical depression (Duckworth, 2013), which results in a significant, negative impact on the United States economy. Previous literature reported that nurse practitioners could be a valuable resource in providing high quality (Groh, 2013) and cost-effective (Bauer, 2010; Stanik-Hurt et al., 2013) primary care, which included treating individuals diagnosed with depression. However, I did not find any research that investigated how nurse practitioners viewed their role in treating depression or their perceptions about using non-pharmacological interventions to treat depression. This quantitative non-experimental descriptive survey research project assessed nurse practitioners' knowledge of and attitudes toward the treatment of clinical depression to address the lack of knowledge about the topic.

I solicited participants through the AANP. Sixty-three nurse practitioners completed an online survey questionnaire through the SurveyMonkey website. Data

analysis found that participants reported being less knowledgeable about group therapy/counseling than individual therapy/counseling and medications used to treat depression. The findings also revealed that participants believed that a combination of medication and individual therapy/counseling was the most effective treatment modality for treating individuals diagnosed with depression. The findings identified barriers to prescribing group therapy/counseling to treat depression: (a) patients' resistance to participating in group treatment, (b) lack of group therapy providers, and (c) lack of insurance coverage. I believe the most important implication from my project is the need to educate nurse practitioners about the efficacy of group therapy/counseling and to encourage them to obtain training to be able to provide group therapy to clients and patients diagnosed with depression.

My dissemination plan includes providing the project report to the AANP as well as through personal contacts. My work as a practitioner and scholar will continue to inform other nurse practitioners and will likely bring about an opportunity for implementing my findings in clinical settings. My work as a professional will allow me to coordinate with each member of a clinical team to produce parity between pharmacological and non-pharmacological interventions treating depression.

References

American Association of Nurse Practitioners. (2013-2014). Request for data collection: Sampling AANP membership and AANP conference attendees. Available from http://www.aanp.org/images/documents/research/researchsamplingagreement.pdf

Anthony, J. S., Baik, S., Bowers, B. J., Tidjani, B., Jacobson, C. J., & Susman, J. (2010). Conditions that influence a primary care clinician's decision to refer patients for depression care. *Rehabilitation Nursing, 35*(3), 113-122. doi: 10.1002/j.2048-7940.2010.tb00286.

Bauer, J. C. (2010). Nurse practitioners as an underutilized resource of health reform: Evidence based demonstration of cost-effectiveness. *Journal of the American Academy of Nurse Practitioners, 22*(4), 228-231. doi:10.1111/j.1745-7599.2010.00498.x

Beck, A., Crain, A. L., Solberg, L. L., Unützer, J., Glasgow, R. E., Maciosek, M. V., Whitebird, R. (2011). Severity of depression and magnitude of productivity loss. *Annals of Family Medicine, 9*(4), 305-311. doi:10.1370/afm.1260

Blackford, J. U., & Love, R. (2011). Dialectical behavior therapy group skills training in a community mental health setting: A pilot study. *International Journal of Group Psychotherapy, 61*(4), 645-57. doi:10.1521ijgp2011614645

Bredow, D. L. (2014). *A study of depression care perceptions in Texas primary care nurse practitioners* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses (UMI No. 3623933).

Briñol, P., & Petty, R. E. (2012). The history of attitudes and persuasion research. In A.

Kruglanski & W. Stroebe (Eds). *Handbook of the history of social psychology* (pp. 285-320). New York, NY: Psychology Press.

Burns, N., & Grove, S. K. (2009). *The practice of nursing research: Appraisal, synthesis, and generation of evidence* (6th ed.). St. Louis, MO: Saunders, Elsevier.

Center for Workforce Studies. (2012). *Recent studies and reports on physician shortages in the US.* American Association of Medical Colleges. Retrieved from https://www.aamc.org/ download/100598/data/

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Thousand Oaks, CA: Sage.

Cuijpers , P., van Straten, A., Schuurmans, J., van Oppen, P., Hollon, S. D., & Anderson, G. (2010). Psychotherapy for chronic major depression and dysthymia: A meta-analysis. *Clinical Psychology Review, 30*(1), 51-62. doi:10.1016/j.cpr.2009.09.03

Duckworth, K. (2013). Mental illness facts and numbers. *National Alliance on Mental Illness (NAMI).* Available from http://www.nami.org/factsheets/mentalillness_factsheet.pdf

Eagly, A. H., & Chaiken, S. (1993). *The psychology of attitudes*. Ft. Worth, TX: Harcourt Brace Javanovich.

Frisch, U., Hofecker-Fallahpour, M., Stieglitz, R., Riecher- Rössler, A. (2012). Group treatment for depression in mothers of young children compared to standard individual therapy. *Psychopathology* (online), *9,* 46, 94-101. doi:10.1159/000338633

Fund, M., & Swanson-Hill, A. (2014). Cost-effectiveness of nurse practitioner care.

Kansas Nurse [serial online], *89*(1), 12-15.

Gelenberg, A. J., Freeman, M. P., Markowitz, J. C., Rosenbaum, J. F., Thase, M. E., Trivedi, M. H., Van Rhoads, R. S. (2010). *Practice guideline for the treatment of patients with major depressive disorder* (3rd ed.). Arlington, VA: American Psychiatric Association.

Given, L. M. (2008). *The Sage encyclopedia of qualitative research methods*. Los Angeles, CA: Sage.

Groh, C. J. (2013). Depression in rural women: Implications for nurse practitioners in primary care settings. *Journal of the American Association of Nurse Practitioners*, *25*(2), 84-90. doi:10.1111/j.1745-7599.2012.00762.x

Herkov, M. (2014). Psychotherapy: What is psychotherapy? PsychCentral (online). Available at http://psychcentral.com/lib/what-is-psychotherapy/000676

Hogg, M., & Vaughan, G. (2005). *Social psychology* (4th ed.). London, England: Prentice-Hall.

Kessler, R. C., Barber, C., Birmbaum, H. G., Frank, R. G., Greenberg, P. E., Rose, R. M., . . . Wang, P. (1999). Depression in the workplace: Effects on short-term disability. *Health Affairs, 18*(5), 163-171. doi:10.1377/hlthaff.18.5.163

Lodico, M. G., Spaulding, D. T., & Voegtle, K. H. (2010). *Methods in educational research: From theory to practice* (2nd ed.). San Francisco, CA: Jossey-Bass.

Lynch, D., Laws, K. R., & McKenna, P. J. (2010). Cognitive behavioral therapy for major psychiatric disorder: Does it really work? A meta-analytical review of well-controlled trials. *Psychological Medicine, 40*, 9-24.

doi:10.1017/S003329170900590X

Mannheim, J. K. (2012). *Nurse practitioner.* MedlinePlus: A service of the U. S. National Library of Medicine. National Institutes of Health. Available from http://www.nlm.nih.gov/medlineplus/ency/article/001934.htm

Miles, M. B., Huberman, A. M., & Saldaña,, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Thousand Oaks, CA: Sage

National Institute of Mental Health. (n.d.). Depression. Retrieved from http://www.nimh.nih.gov/health/topics/depression/index.shtml

Naylor, M. D., & Kurtzman, E. T. (2010). The role of nurse practitioners in reinventing primary care. *Health Affairs, 29*(5), 893-899. doi:10.1377/hlthaff.2010.0440

Raosoft. (2004). Sample size calculator. Available at http://www.raosoft.com/ samplesize.html

Sandahl, C., Lundberg, U., Lindgren, A., Rylander, G., Herlofson, J., Nygren, Å., & Åsberg, M. (2011). Two forms of group therapy and individual treatment of work-related depression: A one-year follow-up study. *International Journal of Group Psychotherapy, 61*(4), 538-55. doi:10.1521ijgp2011614538

Stanik-Hutt, J., Newhouse, R. P., White, K. M., Johantgen, M., Bass, E. B., Zangaro, G., . . . Weiner, J. P. (2013). The quality and effectiveness of care provided by nurse practitioners. *Journal for Nurse Practitioners, 9*(8), 492-500. doi: 10.1016/j.nupra.2013.07.004

SurveyMonkey. (2013). *Privacy policy*. Retrieved from http://www.surveymonkey.com/mp/ policy/privacy-policy/#creators

Weber, M., & Snow, D. (2006). An introductory clinical core course in psychiatric management: an innovative lifespan course blending all nurse practitioner majors. *Perspectives in Psychiatric Care*, *42*(4), 245-251. doi: 10.1111/j.1744-6163.2006.00089.x

Yin. R. K. (2014). *Case study research: Design and methods* (5th ed.). Thousand Oaks, CA: Sage.

Appendix A: Invitation to Participate

Attitudes toward Non-pharmacological Interventions for Individuals diagnosed with Clinical Depression	
What: I am interested in your attitudes toward treatment modalities used in the treatment of individuals diagnosed with clinical depression for my capstone project for my DNP. Your participation in this survey will help to describe nurse practitioners' attitudes toward and use of various depression treatment modalities. The results will provide information that may be useful to nurse practitioner training programs and practicing nurse practitioners. **Survey**: Please log on to the web address below and complete the survey, which should take 15 to 20 minutes to complete. ▪ **Survey Web Address: https://www.surveymonkey.com/r/TX3LCC6** ▪ **Or e-mail me at**: XXXX	**Details:** A potential risk of loss of confidentiality is inherent in all e-mails, downloading, and internet transactions. Your completion of the survey serves as your informed consent. All survey responses are anonymous and no input will be connected to your name or personal information. All data will be reported in the aggregate and no personally identifying information will be included in the reporting of the study results. **Contact:** Please e-mail me at XXXX. if you have questions or need additional information. **Thank you for your participation!** **Joseph Ocran**, DNP Candidate Walden University Doctor of Nursing Practice

Appendix B: Survey Questionnaire

Nurse Practitioners' Attitude Questionnaire: Treating Depression

Developed by Joseph Ocran, 2014

Introduction

Thank you for agreeing to participate in my DNP capstone project: Mental Health Professionals' Attitudes Toward Nonpharmacological Interventions for Individuals Diagnosed with Clinical Depression

Please be honest and candid with your responses. Your anonymity is assured as each survey will be assigned a number based on submission date and time. I will use your contact information only if it is necessary to verify or clarify responses. After the data have been affirmed, I will delete all personal contact information. All responses will be kept confidential. Data will be reported only in aggregate.

Your electronic submission of the survey indicates your informed consent. If you have any difficulties accessing the survey or have other questions, please contact me: XXXX.

The questionnaire has four parts: demographic information; attitude toward interventions for individuals with depression; individual and group therapy/counselling session information; and other nonpharmacological interventions

Part A. Demographic Information

Gender: Male Female | **Age:** | **Ethnicity:** | **Highest Degree:**

Credentials (Please list all):

Total Years of NP Experience:

Current Employment and Years Employed:

Please respond "yes" or "no" to the following questions:

	Yes	No
1. I currently am involved in treating persons with depression.		
2. I use group therapy/counselling to treat persons with depression.		
3. I use individual therapy/counselling to treat persons with depression.		
4. I am satisfied working in a psychiatric unit.		

Part B: Knowledge of and Attitude toward Interventions for Individuals with Depression

Please indicate your knowledge level of the treatment modalities identified in the following statements based on the following scale: 1 = *no knowledge,* 2 = *some knowledge*, 3 = *moderate knowledge*, and 4 = *comprehensive knowledge*

Treatment Modality	No Knowledge	Some Knowledge	Moderate Knowledge	Comprehensive Knowledge
1. Psychotropic medications such as anti-depressants and other pharmacological treatments				
2. Individual, one-on-one therapy sessions (or similar non-pharmacological treatment) with qualified health care worker				
3. Group therapy sessions (or similar non-pharmacological treatment) with a qualified health care worker.				

Please indicate your degree of ***agreement*** with the following statements based on the following scale: 1 = *strongly disagree*, 2 = *disagree*, 3 = *agree*, and 4 = *strongly agree*

Statement	Strongly	Disagree	*Agree*	Strongly
1. Non-pharmacological treatments for clinical depression should be used more often than currently				
2. Non-pharmacological interventions for clinical depression should be used before pharmacological interventions				
3. Psychotropic medication is the treatment of last resort for persons with clinical depression				
4. Individual therapy/counselling should be used in the treatment of persons with depression				
5. Group therapy/counselling should be used in the treatment of persons with depression				
6. Persons with depression show improvement after engaging in **individual therapy/counselling** sessions				

7. Persons with depression show improvement after engaging in **group therapy/counselling** sessions				
8. Individual therapy/counselling is preferred over group therapy/counselling for treating persons with clinical depression				
9. Group therapy/counselling is preferred over individual therapy for treating persons with clinical depression				
10. Persons with clinical depression should participate concurrently in group therapy/counselling and individual therapy/counselling for best outcomes				
11. Treatment for persons with clinical depression should include pharmacological treatment, individual therapy/counselling, and group therapy/counselling for best outcomes				

Part C: Individual and Group Therapy/Counseling Session Information

Question	Response
1. In your current employment setting how many **individual** therapy/counselling sessions are normally prescribed for a person with clinical depression?	
2. In your current employment setting how many **group** therapy/counselling sessions are normally prescribed for a person with clinical depression?	
3. In your current employment setting, approximately what percentage of persons with depression are prescribed **individual** therapy/counselling?	
4. In your current employment setting, approximately what percentage of persons with depression are prescribed **group** therapy/counselling?	

Part D: Other Nonpharmacological Interventions for Treating Depression

Please list non-pharmacological interventions other than individual and group counseling that are provided in your current work setting.

Please use the space below for any additional comments you would like to make.

Thank you for completing the questionnaire.

Joseph Ocran, DNP Candidate