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Use of the COPE Intervention for Depressed Adolescents

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USE OF THE COPE INTERVENTION FOR DEPRESSED ADOLESCENTS

Lindsey Rae Jelsma

A Dissertation Submitted to the Graduate Faculty of

GRAND VALLEY STATE UNIVERSITY

In

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Abstract

Depression disorders often present during adolescence. Depression can lead to difficulties with relationships, problems in school, and associated high risk behaviors. The goal is to identify and treat depression as soon as possible. The purpose of this project is to implement a cognitive-behavioral based intervention called Creating Opportunities for Personal Empowerment (COPE) to depressed adolescents. Previously, the COPE program has been implemented in outpatient and school settings. This intervention was implemented to adolescents in an inpatient psychiatric hospital. Effectiveness, acceptability, and feasibility were evaluated.

Twenty-five adolescents, majority female, ages 12-18 participated in this project. The participants completed all seven sessions of the COPE intervention. They received this intervention along with their normal treatment regimen during their inpatient stay at the hospital. The adolescents received a pre- and post-evaluation using Beck's Depression Inventory-2nd Edition and the Personal Belief Scale. Both the adolescents and the staff that helped with recruitment completed an evaluation at the end of the project. Data analysis was performed using SPSS with descriptive statistics and *t*-tests. Results showed there was a significant difference between the pre- and post-evaluations, showing improved depression scores and better confidence to manage and cope with stress. The evaluations of the project were positive. The participants found the program helpful and would recommend the program to others. The staff thought the program appeared easy to use and had heard positive feedback from the participants. The results are limited due to the small sample size and the inability to control for the other treatment modalities the adolescents were receiving during their inpatient stay.

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CHAPTER 1

INTRODUCTION

Tens of millions of people are affected with a mental health disorder and only a few of these people seek treatment (National Institute of Mental Health [NIMH], 2011). Mental health diseases result in more disabilities than any other disease group in developed countries, including cancer and heart disease (World Health Organization, 2012). Depression is one of the most common mental health disorders. The Center of Disease Control and Prevention (2011) estimates that 1 in 10 adults will suffer from depression. The exact cause of depression is unknown, but it is thought to be caused by a combination of genetic, biological, environmental, and psychological factors (NIMH, 2011).

A recent national survey shows that close to 9% of adolescents suffer from major depressive disorder or have depressive symptoms that impair their normal functioning (Merikangas et al., 2010). This is an increase of 3% since the survey reported by these authors three years earlier. The reason for this increase is unknown. In the same survey Merikangas et al. (2010) estimated “the economic burden of mental health disorders on American youth and their families approaches a quarter of a trillion dollars” (p. 988). These disorders require early identification so that an appropriate treatment plan can be implemented. Early identification can be made on a routine screening by their primary care provider and/or a parent’s or school teacher’s concern.

Depression disorders often present during adolescence (Mehler-Wex & Kolch, 2008). Stress factors can play a large role in the depressive disorders experienced by adolescents. The most important factors are: loss of a parent (through death, divorce, or separation), conflict in a relationship (within the family and with friends), single parenthood, mental or physical illness in

a parent, low self-esteem, trouble with school, and learning disorders (Mehler-Wex & Kolch, 2008). Depression can lead to difficulties in relationships with family and peers, a decreased functioning at school and at home, and associated behaviors such as suicide attempts, early parenthood, and drug abuse (Swartz et al., 2010; Whisman, 2008; Williams, O'Connor, Eder, & Whitlock, 2009). Typical symptoms of adolescent depression include loss of drive or interest, social withdrawal, problems with self-esteem, irritability, violent temper, and sometimes suicidality (Mehler-Wex & Kolch, 2008). It is very important to identify depression as early as possible to prevent these sequelae. The advanced practice nurse (APN) can play an integral part in identifying and treating the adolescent with depression.

Depression is a persistent feeling of sadness that lasts for two weeks or longer. The combination of symptoms interferes with peoples' ability to work, sleep, study, eat, and find enjoyment in normally enjoyable activities. This can lead to people not being able to function to their normal ability, including missing days of school or work, finding relationships stressful, and interfering with a person's other normal activities. The diagnosis by the person's primary care provider or psychologist/psychiatrist can be made after a thorough history and physical (Mehler-Wex & Kolch, 2008). The *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (*DSM-IV-TR*; American Psychiatric Association, 2000) is often used to deliver a diagnosis of Major Depression Disorder (MDD).

Depression often coexists with other comorbidities. The most common associated comorbidities are anxiety disorders, alcohol or substance abuse, and other major medical disorders including diabetes, heart disease, arthritis, etc. (Lenz, Coderre, & Watanabe, 2009). Depression is a treatable illness. Treatment options include medication and psychotherapy. The earlier treatment can begin, the more effective it is.

The goals of treatment for depression are: reduce stress, increase positive activities, increase awareness of available resources, increase social interaction, learn problem solving strategies, and increase self-confidence and self-esteem (Mehler-Wex & Kolch, 2008). Most treatment can be managed on an outpatient basis. In mild depression in adolescents, treatment can mainly be managed by psychosocial treatment. If depression is worse, a multimodal approach may be necessary which includes psychotherapy and possibly pharmacotherapeutic interventions (Mehler-Wex & Kolch, 2008). Inpatient care is only necessary when persons are a threat to themselves or others.

The most common diagnoses associated with inpatient mental health treatment for adolescents with depression are behavioral, emotional, and substance abuse. Criteria for admission include suicidal thoughts, suicide attempt, or being a threat to self or others (Greenhill & Waslick, 1997). The length of stay depends on the severity of symptoms. The foci of treatment are on crisis stabilization and triaging to different levels of care, either long term or short term. The average time spent in the inpatient setting for an adolescent with suicidality is one to two weeks. The decision to hospitalize can be influenced by family stability, other available resources, and insurance.

Cognitive behavioral therapy (CBT) and interpersonal therapy are shown to be the most effective for adolescents (Schramm et al., 2011). CBT is the most effective type of psychotherapy used to treat depression in adolescents. Mehler-Wex and Kolch (2008) describe the focus of CBT as “dealing with depression triggers, activation, learning problem solving, stress management and self-management techniques, and modifying negative thoughts” (p. 153). The focus of interpersonal therapy is on interpersonal conflict resolution and social competences (Cuijpers et al., 2011).

The use of pharmacotherapy to treat depression is dependent on different factors. The client should be assessed for the severity of illness, the symptoms of depression, how long the symptoms have been present, any other comorbidities, and thoughts of suicidality or psychosis (Cheung, Zuckerbrot, Jensen, Stein, & Laraque, 2011). In most situations it would be appropriate to start medication after four weeks of symptoms. In starting an antidepressant the provider must consider the age appropriateness of the medication and reassess and monitor the patient in two weeks from the start of the medication and on a regular basis watching for both improved symptoms and side effects.

It is estimated that only 25% of youth who need mental health treatment are actually receiving it (Lusk & Melnyk, 2011). The reasons for this include lack of trained professionals, limited access to care, stigma associated with mental health disorders, and the cost of treatment. Oftentimes, for adolescents, this treatment either interferes with school time or other competing demands (e.g. after-school activities or work) that may need to take precedence.

One program demonstrating success is Creating Opportunities for Personal Empowerment (COPE), an evidenced based practice (EBP) intervention created by Bernadette Melnyk (Melnyk, 2007; Melnyk et al., 2009), includes components of effective psychotherapy for depressed adolescents. COPE is a manualized educational and cognitive behavioral skills building program that can easily be delivered by the APN in seven, 30 minute sessions. These sessions are typically delivered one session per week for seven weeks. These sessions discuss how to handle feelings, stresses, and communication. The intervention delivers the tools used to cope with the different factors that could be contributing to the depression.

The COPE program has been effectively used in community settings including high schools and group sessions (Melnyk, 2007; Melnyk et al., 2009). Recently, COPE has been used

successfully in treatment of depressed adolescents in an outpatient setting (Lusk & Melnyk, 2011). In this outpatient setting, adolescents reported a decrease in depression, anxiety, anger, and destructive behavior. The adolescents also reported improvement in self-concept and personal beliefs about managing negative emotions. The goal of COPE is to empower individuals to manage their own thoughts and feelings.

Adolescent depression is an issue that needs to be assessed and addressed in a timely manner. The APN can make a difference using an EBP treatment plan as soon as the issue of depression is identified. Early treatment will hopefully prevent problems in school, trouble with relationships, and the development of other comorbidities. The purpose of this dissertation project is to evaluate the effectiveness, acceptability, and feasibility of implementing COPE in one-on-one sessions in an inpatient setting with hospitalized depressed adolescents.

Effectiveness as an intervention for depression will be based on symptom improvement.

Acceptability will be measured at the end of the project using an evaluation that will assess the satisfaction of the adolescent participants and the adolescent health care team in regards to the COPE program. Feasibility will be measured by appropriate and timely referral of participants, completion rates of all seven sessions that make up the COPE curriculum, and adequate time and space to deliver each session.

CHAPTER 2

LITERATURE REVIEW

Adolescence is a crucial time for development. During this time period adolescents are experiencing changes in cognitive, social, and emotional development that if done successfully can provide the basis for a healthy and productive future (Dunn, 2009). Depression is a major medical problem that affects adolescents and prevalence ranges from 3.2% to 8.9% (Mehler-Wex & Kolch, 2008).

Depression has a multifactorial etiology which includes genetics, neurobiological, somatic, and personality related factors (Mehler-Wex & Kolch, 2008). Studies have shown that a family history of depression increases the child's chances of also developing depression. Biologically there is not a clear understanding of what causes depression. There are hypotheses that suggest that the body might have a decreased amount of serotonin, a lowered concentration of norepinephrine metabolites, neurogenesis in the hippocampus causing a disruption in cellular structure and function, a disruption of dopaminergic transmission, or a disorder of the hypothalamic-pituitary-adrenal axis (Mehler-Wex & Kolch, 2008). There is also a link to environmental factors including abuse, neglect, loss of a parent, a troubled relationship between the parents or a divorce, a chronic illness of a parent, low socio-economic status, or migration (Lenz, Coderre, & Watanabe, 2009).

The risk for depression in adolescence is confounded with the many developmental changes that occur during this developmental period. For many adolescents their role is changing at home and with their peers, they are having changes in their physical and sexual development, they are taking on more responsibilities, and are trying to separate themselves from their parents (Lenz, Coderre, & Watanabe, 2009). Depression can lead to difficulties in relationships with

family and peers, a decreased functioning at school and at home, and associated behaviors such as suicide attempts, early parenthood, and drug abuse (Swartz et al., 2010; Whisman, 2008; Williams, O'Connor, Eder, & Whitlock, 2009).

Along with the increasing prevalence rates of depression in adolescents, the chronicity of the disease is also important to consider. Typically the depression episode does not last as long as a depressive episode in adulthood. However, a future depressive episode can occur. It is estimated that persistence and/or recurrence can be expected: 25%, 40%, and 72% relapse after 1, 2, or 5 years, respectively (Mehler-Wex & Kolch, 2008).

Depression is also linked to a higher risk of other psychiatric disorders (Angold & Costello, 1993), substance abuse, and suicide (Gould et al., 1998). Merikangas et al. (2010) further report that the economic effects of mental disorders from American youths and their families approaches a quarter of one trillion dollars, making this a significant burden on the American population. Indirect costs include substance abuse, academic problems including school drop-outs, high risk sexual activity, and physical health problems. The major risk with depression is the increased occurrence of suicide, which is currently reported as the third leading cause of death in the adolescent population (Minino, 2010).

While depression is a treatable disease, many people are not getting the evidenced-based treatment that they need. Current treatments for depression include two types of psychotherapy, interpersonal therapy (IPT) and cognitive-behavior therapy (CBT), and the use of antidepressants. Most commonly used antidepressants are selective serotonin reuptake inhibitors ([SSRIs], Bridge et al., 2007; Weisz, McCarthy, & Valeri, 2006). However, all too often, due to poor geographic distribution of mental health professionals, the necessary therapy or medication management is not available.

Interpersonal Psychotherapy

Interpersonal psychotherapy (IPT) is a structured, time limited form of psychotherapy. In IPT the mental health worker is actively involved in the session, encouraging patients to regain control of their mood and functioning. This type of treatment focuses more on building relationships through communication and developing problem solving techniques. Cuijpers et al. (2011) performed a meta-analysis focusing on the use of IPT as an independent treatment modality and in combination with pharmacotherapy. The authors gathered studies from the years 1966 through January 2010 searching in PubMed, PsychINFO, EMBASE, the Cochran Central Registry of Controlled Trials, and Dissertation Abstracts International. The search terms *psychological treatment* and *depression* were used. Inclusion criteria used in this analysis included randomized controlled studies using IPT in the treatment of adolescents and adults who had unipolar depressive disorder or an increase in depression symptoms as compared to the participants on a waiting list, usual care, placebo, psychological treatment, pharmacological treatment, combination treatment of IPT and pharmacotherapy, or maintenance studies that later randomized to IPT or another treatment. Exclusion criteria were IPT treatment with participants with subthreshold depression. The interventions that were included in the analysis are: IPT compared to standard or no treatment, other psychotherapies, pharmacotherapy, combination treatment, and placebo.

A total of 38 studies were included, with a total of 4,356 patients (1,338 in IPT conditions, 812 in control conditions, 713 in pharmacotherapy conditions, 468 in other psychotherapy conditions, 510 in combination treatment with ITP and pharmacotherapy, and 515 in maintenance studies). Seventeen of these studies treated adults, six treated adolescents, and four treated older adults. In 14 of these studies a manual to deliver the IPT was used and 19 other

studies had the manual adapted to fit their study population better. There were 16 studies that compared IPT to standard or no treatment (waiting list, usual care, or placebo) with an average of 92 participants. The overall effect size of these was 0.63. There were 10 studies that compared IPT to other psychotherapies with an average of 74 patients. The overall effect size was 0.04 in favor of IPT, but did not have a significant p-value ($p=0.40$). In the 10 studies that compared IPT and pharmacotherapy there were an average of 82 participants. The overall mean effect size was 0.19 in favor of pharmacotherapy. The different types of antidepressants used were SSRIs and tricyclics, having effect sizes of 0.39 and 0.02 respectively. The 10 studies that compared IPT and pharmacotherapy to pharmacotherapy alone had an average of 80 participants. The effect sizes calculated indicating the difference between these two treatment modalities was 0.16 in favor of the combination treatment. The last set of studies compared maintenance pharmacotherapy with combination treatment (IPT and pharmacotherapy maintenance treatment). There were a total of five studies in this category. Four of these studies presented depression recurrence rates and the fifth study only presented means and standard deviations for patients, therefore odds ratios were calculated. The odds ratio of this study was 122.77 (this study only reported means and standard deviations), which was a significant difference than the others calculated whose odds ratio ranged from 1-3.75 and therefore was not used in further analyses. The remaining studies that were analyzed generated an odds ratio of 0.37 which indicates that the combination therapy is better than pharmacology alone in preventing a recurrence.

Conclusions based on this meta-analysis show that IPT had a greater efficacy when compared to control groups, other psychotherapies, and placebo. This meta-analysis also showed that pharmacotherapy had a greater efficacy than IPT. Specifically SSRI treatment might be

more efficacious than IPT. The results also show that combination therapy was better than pharmacotherapy alone. In regards to the maintenance treatment the meta-analysis supported IPT and pharmacotherapy as better at preventing a recurrence compared to pharmacotherapy alone. Another interesting result from this meta-analysis was the comparison of the IPT manual versus the adapted manual. The results showed lower effect sizes for the original IPT manual than the studies that used an adapted manual.

There are many limitations to this study. First is the quality of the studies that were eventually used; only nine of the 38 met all of the criteria. Second, many of the studies had small numbers thus affecting their ability to show significant results. Third, the authors identified some publication biases and when necessary tried to adjust the effect sizes accordingly.

This meta-analysis showed the effective use of IPT treatment in a variety of settings. It was used effectively with both adults and adolescents. It also showed the use of a manual, in both original and adapted versions. The results of the meta-analysis strongly support the efficacy of IPT in the treatment of depression. This analysis concluded that IPT and CBT when compared in some of the studies were equally effective overall in the treatment of depression (Cuijpers et al., 2011). This analysis also looked at multiple studies that used the concurrent therapy of IPT and pharmacotherapy and the results showed greater efficacy when both are used versus either single modality of treatment.

A meta-analysis conducted by Weisz et al. (2006) compared 35 studies using psychotherapy (both IPT and CBT) for treatment of child and adolescent depression. For the purpose of this meta-analysis, psychotherapy was defined as “an intervention designed to alleviate depressive disorders or elevated levels of depressive symptomatology through structured or unstructured interaction or a training program” (p. 135). This meta-analysis used

peer reviewed, non-peer reviewed, and dissertation work. Studies were obtained through computer searches on PsychINFO, Dissertation Abstracts International, and MEDLINE using keywords *depression*, *dysthymia*, and *major depression*. Publications were classified as treatment outcome, clinical trial, single blind, or double blind design. The search also limited the criteria to child/adolescent populations, ages less than 19 years old. To be thorough the researchers examined reference lists in the relevant articles, hand searched journals from which at least five psychotherapeutic studies were identified, and contacted the authors with questions about their studies and if they knew about any other relevant studies.

Inclusion criteria for the final meta-analysis included: participants being selected because of increased depressive symptoms, diagnosis of major depression disorder or dysthymic disorder (a mood disorder characterized by mild depression), or research diagnostic criteria diagnoses of minor or intermittent depression. To be included the participants in the studies had to be randomly assigned to treatment conditions. The intervention being tested had to be used to treat depressive symptoms or disorders. If separate articles were published using the same data set, the articles were combined. Single subject designs were not included.

The most clinically significant result of this meta-analysis compared to previous meta-analyses showed the mean effect of psychotherapy to be 0.34 as compared to an average of 0.99 for previous meta-analyses. Analyzing this to Cohen's benchmarks, small (0.20), medium (0.50), and large (0.80), this mean effect is between small and medium, while the earlier meta-analyses found a large effect size. The reason the authors suggest for this result is that they chose to include non-peer reviewed articles and dissertation work in their meta-analysis. These studies would not always have a higher effect size. This information would suggest that psychotherapy can be beneficial but because of the small to medium effect, it should also be used in conjunction

with other treatment modalities. Based on the modest mean effects of this meta-analysis, the authors suggest that, further studies and evaluations need to be done. New treatments and or strengthening current treatment will be beneficial to the treatment of depression.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy is the gold standard for the treatment of adolescent depression. CBT can be delivered either individually or in a group setting. It is usually time limited and spread out over several weeks. There are many manuals available to help in the delivery of this method. CBT techniques and the general sequence of delivery include psychoeducation and mood monitoring, pleasant activity scheduling and behavioral activation, cognitive restructuring, and other CBT skill-building techniques such as relaxation and improving social skills (Vitiello, 2009; Weersing & Brent, 2006). During the education piece of the treatment the parents and adolescents are educated on the characteristics of depression and how CBT is used as a form of treatment. The first aspect that is taught is identifying and monitoring the individual's moods, thoughts, and behaviors. Next, activities to help get the teen engaged in the treatment activity are introduced. These activities are designed to help the teens gain confidence in achieving or mastering the task at hand. This helps the teens recognize what a rewarding environment feels like in hopes they are able to continue to produce new behavioral activation strategies. Next is working with cognitive restructuring. This is achieved by teaching the adolescent to examine thoughts and then process them so the future consequences can be seen. Finally, other CBT techniques are introduced along the way, for example, deep breathing, tips for conflict resolution, improving social skills, and teaching general problem solving techniques. CBT is well established as an effective means of treatment for adolescents with

depression and anxiety (Dugas & Koerner, 2005; Powers, Jones, & Jones, 2005; Weersing & Brent, 2006; Weersing, Iyengar, Kolko, Birmaher, & Brent, 2006).

The goal of CBT is to target the cognitive distortions and change behavior to help manage thoughts and feelings during depression and help prevent future episodes by teaching the skills to acknowledge one's own thoughts and feelings and the ability to modify these feelings in order to regulate behavior (Weersing & Brent, 2006). The skills building approach helps the adolescent handle ongoing problems and create goals for the future. The technique of using CBT in multiple, short sessions and using a homework approach to help solidify the concepts is a developmentally appropriate approach to this age group (Lusk & Melnyk, 2011). According to McCarty and Weisz (2007) there are 12 components of psychotherapy that are considered the most effective. These 12 components include (a) achieving measurable goals/competency, (b) adolescent psychoeducation, (c) self-monitoring, (d) relationship skills/social interaction, (e) communication training, (f) cognitive restructuring, (g) problem solving, (h) behavior activation, (i) relaxation, (j) emotional regulation, (k) parent psychoeducation, and (l) improving the parent-child relationship. CBT based interventions should include as many of these components as possible in order to deliver the best therapy.

CBT is a well-studied nonpharmacological intervention in the treatment of depression in the adolescent population. It has been used alone and in combination with medication. There are many studies that highlight its efficacy with depression at levels varying anywhere between mild to severe.

One study by Brent et al. (1997) compared three different psychosocial treatments that are used to treat adolescents with major depressive disorder (MDD). These treatments were: Cognitive Behavioral Therapy (CBT), Systemic Behavior Family Therapy (SBFT), and

Nondirective Supportive Therapy (NST). These treatments were delivered in the outpatient setting. Inclusion criteria for individuals in this study included normal intelligence, ages between 13 and 18 years at time of recruitment, living with at least one parent or guardian, DSM third edition, revised (III-R) criteria met for MDD, and an intake Beck Depression Inventory (BDI) score of 13 or more. Exclusion criteria included psychosis, bipolar disorder, obsessive-compulsive disorder, eating disorder, substance abuse within the last six months, ongoing physical or sexual abuse, pregnancy, or other chronic medical illness. One hundred twenty-two patients were eligible and 107 agreed to be randomized to one of the three treatment groups. Subjects were recruited between October 1, 1991 and May 31, 1995. Incentives to be involved in the study included free treatment and a participant payment at the completion of evaluations. A suicide attempt and patients still seriously symptomatic at midpoint (BDI score greater than 13 or having persistent MDD symptoms) were either removed from the study or recommended to receive pharmacotherapy (this reflects usual clinical practice), which therefore made them ineligible to be involved in the study.

Treatment was delivered by trained therapists. The active phase of treatment included 12 to 16 sessions during a 12 to 16 week timeframe. The booster phase consisted of two to four sessions which the patients received in as many months. For the purpose of their article, only the active phase was reported.

Patients were randomized to one of three treatment groups. In all three groups patients received family psychoeducation about affective illness and families were invited to openly discuss questions and concerns regarding the depression diagnosis. Interviews with the patient were performed at three points: intake, the 6th session, and at treatment conclusion. An attempt

was also made for those who did not finish the protocol to still be interviewed at the time that would have been the end of their treatment.

The BDI was used to measure depression symptoms. The School Age Schedule for Affective Disorders and Schizophrenia, Present and Lifetime Versions (K-SADS-P/E) was used to help confirm the diagnosis of MDD along with the DSM-III-R. The K-SADS-P/E was also used to assess suicidality. Functional impairment was assessed using the Children's Global Assessment Scale (CGAS).

Of the 107 subjects, 10 were excluded due to previous exclusionary criteria, 8 dropped out, 4 never initiated treatment, and 7 were removed based on clinical grounds. The researchers used an intent to treat approach in this study and therefore all eligible participants were included regardless of their compliance with protocol. The data were analyzed using 103 subjects, excluding only 4 who did not initiate treatment. The final analysis included only 93 subjects due to the subjects that were removed from the study at a later time.

Between the three treatment groups a mean number of sessions were assessed. In the CBT group there were 37 subjects and a mean of 12.1 sessions. In the SBFT group there were 36 participants and the mean number of sessions were 10.7. The NST group had 35 participants and a mean number of sessions of 11.2. The demographics between the groups were very similar. The mean age was 15.7 (CBT), 15.4 (SBFT), and 15.7 (NST). The percent of the group that was female was 75.7, 77.1, and 74.3 respectively. The percent of the group that was white was 75.7, 88.6, and 85.7 respectively.

The presence of depressive symptoms was measured. The CBT showed a more rapid response in the treatment to time effect in the interview rated depression symptoms ($X^2=6.15$, $df=2$, $p=.05$) than SBFT ($X^2=4.74$, $df=1$, $p=.03$), and NST ($X^2=4.84$, $df=1$, $p=.03$). Using the BDI

a group difference was detected in the rate of decline of self-rated symptoms. The BDI treatment x time interaction effect results were $X^2=5.70$, $df=2$, and $p=.06$. There was also a significant pairwise difference between CBT and SBFT (treatment x time interaction effect, $X^2=5.10$, $df=1$, $p=.02$).

The achievement of clinical response was defined by a BDI score of less than 9 that is sustained for at least three consecutive sessions and lasts until the end of treatment. The CBT group showed a better response over SBFT ($X^2=4.84$, $df=1$, $p=.03$). Remission was defined by the absence of MDD and three consecutive BDI scores of less than 9. Remission rates are as follows: the CBT group was 60%, SBFT was 37.9%, and NST was 39.4%.

Suicidality was also measured but did not show a significant difference between the groups using the K-SADS-P/E. All three groups did show decreases in suicidality ($X^2=21.78$, $df=1$, $p < .001$).

Functional impairment was the last outcome measured using the Children's Global Assessment Scale (CGAS). There was no treatment-time interaction or a group difference in the proportion of subjects with a CGAS less than 60 at the end of treatment. All three groups did show improvement ($X^2=11.26$, $df=1$, $p < .001$).

In this study, CBT was the most efficacious treatment over SBFT and NST for adolescent depression. One limitation to this study was the exclusion of subjects who had a suicide attempt. These subjects were often treated at a hospital and then admitted to an inpatient psychiatric facility, often treated with antidepressants, and then were ineligible for the study. This limits the generalizability to more serious subjects. Along with excluding suicidal patients, those with other psychiatric disorders, substance abuse, and ongoing physical or sexual abuse were excluded also making the findings less generalizable. During this study the therapist had a less than normal

case load to ensure high quality and fidelity of the study, however this also affects the transferability of the study to a more normal caseload and work environment. Last, the authors mentioned that the decisions to remove subjects based on clinical reasons or protocol violations were not made blind to the treatment condition, thus possibly causing bias while done in the best interest of the patients.

A meta-analysis was performed by Reinecke, Ryan, and DuBois (1998) that critically reviewed literature that examined CBT for the treatment of adolescent depression. The purpose of this meta-analysis was to “determine whether (1) cognitive behavioral approaches are effective in alleviating depressive symptomatology among adolescents, (2) results obtained are consistent across studies, and (3) treatment gains are maintained over time” (Reinecke, Ryan, & DuBois, 1998, p. 27). The authors looked at literature from 1970 to February 1997. They used three methods to obtain the studies: computerized searches of databases, review of references from certain studies, and a manual search of relevant journals.

The Reinecke, Ryan, and DuBois (1998) defined CBT as “interventions that seek to promote emotional and behavioral change by teaching children to change thoughts and thought processes in an overt, active, and problem oriented manner” (p.27). Inclusion criteria included: English language studies conducted between 1970 and 1997, which used a CBT based intervention consistent with the definition described above, and that compared CBT to a randomly assigned control group including only adolescents aged 19 or younger.

Variables that were examined included sample size, location of delivered intervention (clinic or school), age of subject, type of treatment, number of sessions, outcome measures, and effect sizes. The authors used the DSTAT software program to calculate effect sizes and homogeneity statistics. The authors also mention that the Hedges’ procedure (a correction

formula used to adjust effect sizes of small samples to correct for bias) was used when necessary on effect sizes in this study.

Six studies are reported in this meta-analysis. These studies used a variety of tools to measure their outcomes. These tools include: BDI, Reynolds Adolescent Depression Scale, Bellevue Index of Depression, Children's Depression Inventory, Modified Scale for Suicidal Ideation, Research Diagnostic Criteria, and Mood and Feelings Questionnaire. The number of sessions/length of therapy ranged from 6-14 sessions ranging in length of time of 45 minutes to two hours. Mean ages of subjects ranged from 11.2-19.2 years. Follow-up data were also collected and this time frame ranged from one month to 24 months. Effect sizes were calculated for the posttest and follow-up data and described in detail. Overall the effect size calculated for the posttest differences were significant ($d = -1.02$, 95% CI= -1.23 to -0.81) meaning that CBT may be efficacious in the treatment of adolescent depression. Effect sizes for the follow-up data were also calculated and found to be significant ($d = -0.61$, 95% CI= -0.88 to -0.35) meaning the effects of treatment were maintained over time.

A few limitations of this study were mentioned by the authors. First, generalizability to other therapists is difficult since in this study the therapists had smaller than normal caseloads and a small sample size. Many of these studies also used subjects that had lower depression scores and many of the subjects were recruited from school and not a clinical setting. Therefore it is difficult to assume the same effects would be seen in more clinically depressed patients. Another limitation mentioned was that CBT was often contrasted with relaxation or a wait list group and not against another form of psychotherapy. Many of the studies used self-reported measures and therefore some of the data are more subjective. Finally, many of the studies used a range of cognitive and behavioral interventions and these varied from study to study. The authors

recommend a study comparing a standard CBT intervention against other forms of psychotherapy to obtain more data on the effectiveness of CBT.

Overall, CBT appears to be an efficacious form of psychotherapy used to treat adolescent depression. There are many forms and forums within which the intervention can be delivered.

Combination of Antidepressant Treatment and Cognitive Behavioral Therapy

Adolescents can be effectively treated with SSRIs such as fluoxetine, citalopram, and sertraline. Fluoxetine has been shown to be the most effective and has been approved for the treatment of depression in children ages 8 years old and older for the longest time (Emslie et al., 1997; Emslie et al., 2002). Most importantly, for antidepressant therapy to be successful the client must be compliant, dosed appropriately, and treated for an appropriate amount of time (Lenz, Coderre, & Watanabe, 2009). Studies such as the Treatment for Adolescents with Depression Study (TADS), the Adolescent Depression and Psychotherapy Trial (ADAPT), and the Treatment of Resistant Depression in Adolescents (TORDIA) study, all showed effectiveness using medication to treat depression. These studies are important to examine as they relate to the use of CBT and the use of pharmacological interventions to treat depressed adolescents.

Many of the following articles are large scale studies that evaluated different treatments for depression. These articles discuss the use and efficacy of the use of therapy, pharmacology, and a combination of both treatment modalities.

Treatment for Adolescents with Depression Study (TADS)

The purpose of the TADS study was to evaluate the short term (12 week) and long term (36 weeks) effectiveness of four different treatment regimens for depressed adolescents (TADS Team, 2004). The different treatment arms were the use of fluoxetine, CBT, a combination of fluoxetine and CBT, and a pill placebo group. The sample size was 432 subjects, ages 12-17

years with a *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* diagnosis of major depressive disorder. Other inclusion criteria included: antidepressant-free before start of the study, receiving outpatient treatment (versus inpatient care as this would confound the study), IQ greater than 80, and a Children's Depression Rating Scale greater than 45 at baseline. Exclusion criteria included: bipolar disorder, severe conduct disorder, substance abuse, developmental disorder, suicidality or homicidality, concurrent treatment with psychotropic medication, two previous failed SSRI trials, a failed trial of CBT, intolerance to fluoxetine, confounding medical condition, non-English speaking patient or parent, and pregnancy. Participants were recruited through clinics, advertisements on the radio, television, and newspapers, primary care providers, other mental health providers, and school and juvenile justice facilities.

Once eligibility was established, subjects were randomly assigned to one of the four treatment groups. To measure the primary outcomes, the Children's Depression Rating Scale-Revised (CDRS-R) and the Clinical Global Impressions-Improvement Scale (CGI-I) were used. The secondary outcomes used individual evaluation by the evaluator, parent, adolescent, and clinician for a rated measure of Major Depressive Disorder (MDD), improvement and impairment status, and return for all scheduled assessments. Assessments of the subjects were made at baseline, 12-weeks, 24-weeks, and 36-weeks to obtain measurements. At the time of exit from the study, a debriefing was done with the patient and family to discuss treatment and any further recommendations.

Results of the primary outcomes used the CDRS-R and CGI scales. Using the CDRS-R, the researchers compared the treatment arms to placebo. The total scores across 12 weeks of treatment are reported using adjusted means. The CBT with fluoxetine group had adjusted mean

scores of 60.79, 38.10, and 33.79 at baseline, week six, and week 12, respectively. For the fluoxetine alone group these results were 58.94, 39.80, and 36.30 respectively. The CBT alone group had scores of 59.64, 44.63, and 42.06 respectively. Finally, the placebo group had adjusted mean scores of 61.18, 44.90, and 41.77 respectively. These results showed that the three other treatment arms were statistically significant when compared between groups with the combination group having a p-value of 0.001, the Fluoxetine alone group had a p-value of 0.02, and the CBT alone group with a p-value of 0.01. When the combination group was compared to CBT alone this yielded a p-value of 0.01 and when compared to Fluoxetine alone a result of a p-value of 0.02. When Fluoxetine and CBT alone were compared it showed that fluoxetine was superior to CBT alone with a p-value of 0.01.

Using the CGI all rates were adjusted for clinical sites. The rates of response were 71.0% (95% CI, 62%-80%) for the combination group, 60.6% (95% CI, 51%-70%) for the fluoxetine alone group, 43.2% (95% CI, 35%-52%) for the CBT alone group, and 34.8% (95% CI, 26%-44%) for placebo. Planned pairwise contrasts showed that the combination ($p=0.001$) and Fluoxetine alone ($p=0.001$) treatments were superior to placebo and CBT alone. CBT alone was not significant ($p=0.20$) compared to placebo.

The authors highlighted three main limitations of this study. The first being the patients' knowledge of which type of treatment they were receiving. Especially those in a group receiving CBT, this type of treatment cannot be masked. Also the participants in the CBT group knew they were not receiving any medication. Second, the contact time between the treatment clinicians and expectancy effects were not equal amongst the different groups and therefore true equality was not achieved for all groups. Third, patients with a recent or high risk of suicide behavior at

the beginning of the study and substance abuse problems were excluded from the study thus potentially affecting the results when assessing for self-harm in this study.

The TADS study showed the positive effects of using CBT to complement pharmacological treatment for depression. After 12 weeks of treatment the greatest rate of improvement was seen in the combination group. Researchers saw that the patients in the combination group required a smaller dose of fluoxetine, had less suicidal ideation, and showed improved functioning. This combination method is, of course, more costly than any single treatment modality. However, when looking at the long term economic cost of depression and suicide the combination treatment might be more cost effective overall.

Adolescent Depression and Psychotherapy Trial (ADAPT)

The purpose of the ADAPT study was to compare the use of SSRI medication versus the combination of SSRI plus CBT among adolescents with moderate to severe major depression (Goodyer et al., 2008). This trial had a total of 208 adolescent patients enrolled. The ages of the participants ranged from 11-17 years. This study took place in the United Kingdom and the participants were recruited from six different child and adolescent mental health services. This study took place between the years 2000-2004. The researchers used the Health of the Nation Outcome Scales, a Mood and Feelings Questionnaire, the Revised Children's Depression Rating Scale, the Children's Global Assessment Scale, and the Clinical Global Impression Improvement Scale as their measurable outcomes.

The study participants were randomly assigned to the two treatment options. There were 103 adolescents in the SSRI alone treatment group and 105 adolescents in the SSRI and CBT treatment group. The main SSRI used was fluoxetine. If side effects occurred or if the drug was ineffective a different SSRI was prescribed. The CBT was offered weekly for the first 12 weeks

and then every other week for 12 more weeks. The CBT was delivered by trained personnel proficient in CBT.

Data were reviewed at 12 weeks and included 202 out of the 208 patients that started with the study, and at 28 weeks which included 193 out of the same 208 patients from the start of the study. All primary and secondary outcome measures comparing the two arms showing time-treatment interaction and treatment effect were not significant; Health of the Nation outcome scale had p-values of 0.38 and 1.00, the Children's Depression Rating Scale-Revised showed p-values of 0.79 and 0.19, the Mood and Feelings Questionnaire showed p-values of 0.37 and 0.32, and the Children's Global Assessment Scale showed p-values of 0.76 and 0.91 respectively. By 28 weeks most of the participants in each treatment arm (57/94 in the SSRI alone group and 52/98 in the combination group) were showing improvement. Only 16/94 subjects in the SSRI group and 24/98 subjects in the combination group were showing no response or worsening symptoms. An ordinal logistic random effects model analysis for Clinical Global Impression Improvement Scale showed an odds ratio of 1.01 with a 95% confidence interval of 0.97 and 1.05, a p-value of 0.67 for time-treatment interaction and an odds ratio of 1.28 with a 95% confidence interval of 0.81 to 2.01, with a p-value of 0.29 for average treatment effect was also reported. These results did not show significant results between the groups.

At the end of this study while all patients showed improvement, there was no significant difference in the two treatment arms. The researchers hypothesize that they might not have seen the same difference as they did in the TADS because of the way patients were enrolled in ADAPT, the severity of their disease was likely greater, the treatment was delivered by "real world" staff as opposed to research staff, and adolescents with other co-morbidities that were excluded in the TADS group were enrolled in the study (Goodyer et al., 2008). A limitation

mentioned by the researchers is the lack of a control arm, which they deemed unethical to deny treatment to patients who were so ill. Also they mention the low attendance rates of the CBT sessions, despite efforts to maintain the therapeutic treatment, as a limitation to the results in that treatment arm. Even though there are no outcome measurements that show that one is more effective than the other, the researchers can support some level of equality between the two or at least suggest the need for further study.

Treatment of Resistant Depression in Adolescents (TORDIA)

The purpose of the TORDIA study was to compare medication management and combination therapy (Brent et al., 2008). This study enrolled 334 adolescents ages 12-18 who were diagnosed with major depressive disorders. These adolescents were previously unsuccessfully treated with an SSRI medication. Many of the study participants also had other co-morbid disorders including anxiety, post-traumatic stress disorder, oppositional/conduct disorder, and dysthymia. This study occurred at six academic and community clinics in the United States between 2000-2006.

This study utilized the Children's Global Assessment Scale, Clinical Global Impression-Severity, Children's Depression Rating Scale, the Suicidal Ideation Questionnaire, and Beck's Depression Inventory as their instruments for measurable outcomes. The patients were randomly assigned to four different treatment types. One was to switch to a different SSRI (paroxetine, citalopram, or fluoxetine), another was a switch to another SSRI and CBT, the third was a switch to venlafaxine, and the fourth was a switch to venlafaxine and CBT. In these groups adjunctive therapy was allowed, for example sleeping pills or medication given to control anxiety.

One result showed that CBT and a switch to either medication regimen versus medication alone was more effective, showing 54.8% and 40.5% both using a confidence interval of 95%,

with a significant p-value of 0.009. There was no significant result in the response rate between venlafaxine and a switch to a different SSRI, showing 48.2% and 47.0%, using a 95% CI, and a p-value of 0.83. The results showed that a switch to either medication regimen plus CBT showed the greatest improvement.

There are a few limitations to this study that need to be noted. The sample largely contained adolescents with a greater chronicity and suicidality which is sometimes indicative of a poorer response rate to supportive therapy. This sample was not ethnically diverse and was comprised mostly of Caucasian subjects (greater than 80%). Another limitation mentioned by the authors included not knowing if the addition of CBT would have been beneficial despite the medication change due to the study design.

The final results of TORDIA were similar to the results of the ADAPT study in regards to combined medication and CBT therapy. The TORDIA patient population was also similar to the ADAPT patient population in that it was comprised of more severe cases, had greater co-morbidities, and had failed previous treatment efforts. The studied populations are similar to the patient population proposed for the current project in that they will reside in an inpatient treatment facility where there are more severe cases, higher suicidality, and a previous history of treatment efforts.

Combined treatment seems to be an effective option in most cases. However, there are significant limitations to concurrent forms of therapy including resources and cost. It often requires two clinicians, one prescribing and managing the medication and another to deliver the psychotherapy (Vitiello, 2009). In many cases this is not feasible.

These studies demonstrated different techniques used to treat adolescent depression. It appears that there is modest support for the combination of both medication and CBT as the most

effective treatment. This sometimes can be difficult for providers to be able to both prescribe the necessary medication and provide therapy. A standardized manual to help deliver this therapy will help provide the tools necessary for the provider to use.

Creating Opportunities for Personal Empowerment

An evidenced-based CBT intervention called Creating Opportunities for Personal Empowerment (COPE) was created by Bernadette Melnyk (2007) as an easily delivered and effective means of treatment for adolescents. COPE is a seven session, manualized, brief cognitive-behavioral skills building intervention. The curriculum focuses on the antecedent event that triggers thinking, the beliefs or thoughts about the event, and the consequences of the beliefs or thinking that occurs in the form of emotions and behaviors. The sessions discuss the connection of thinking and feeling and teach ways to manage stress and cope with situations. The sessions also teach problem solving techniques and goal setting. This intervention has been used to treat adolescents in school and outpatient settings (Melnyk et al., 2007; Melnyk et al., 2009; Lusk & Melnyk, 2011). COPE has been used in group, individual, and classroom settings. To date, the COPE manual has not been implemented in an inpatient setting as proposed in this study.

The COPE intervention was used first as part of a 15-session intervention called “COPE/Healthy Lifestyles Thinking, Emotions, Exercise, and Nutrition (TEEN) Program” that was aimed at improving both physical and mental health (Melnyk et al., 2007). This study looked at both suburban and urban overweight adolescents. The researchers wanted to determine the feasibility of COPE Healthy Lifestyles TEEN Program, gain feedback to refine the program, and assess for efficacy by measuring participants’ weight and body mass index (BMI).

A total of 23 overweight teens participated in Phase 1 and Phase 2. Phase 1 was a pre-experimental design and used 11 urban adolescents. The goal of this first phase was to determine feasibility of the intervention and to obtain feedback from the participants on the program and related activities. Phase 2 was designed as a randomized controlled pilot study and used 12 suburban adolescents. The goal of this phase was to establish a protocol and obtain data to determine efficacy of the intervention. The COPE/TEEN intervention is 15 sessions that include the cognitive-behavioral skills building program and physical activity. Participants were recruited by members of the research team who were stationed at booths outside of the school cafeteria. Those interested received information regarding the study and also completed a self-report tool to assess age, height, weight, and contact information. Inclusion criteria included body mass index (BMI) greater than or equal to 25 and ages 15-18. If the teen met the criteria for the study the parents were then contacted by telephone to inform them of the opportunity to participate in the study.

A meeting time was scheduled with the teen and parents where more information was given and consent/assent was obtained. For those who were enrolled the adolescents' weight and BMI were obtained at baseline. Adolescents also completed a demographic questionnaire at the beginning of the study. A program evaluation was obtained at the end of the study. The sessions occurred after school, twice a week for six weeks, and then once a week for three weeks. These sessions averaged 60-90 minutes, along with 20-30 minutes of physical activity for those in the intervention group. Assignments and journal logging are used to keep track of goals and progress of the adolescents. The intervention group received the manualized COPE session. The control group received an adapted version of Red Cross Safety Program to control for the time and attention being spent with the intervention group. For both groups, parent meetings were held

four times. For the intervention group the parent sessions included information on how the parents can help and support the teen in this process and how they can help their child reach their goals. For the control group, the four parent meetings discussed normal adolescent education and safety.

In the urban teen group six of the 11 teens dropped out of the study before its completion. These teens stated that there were too many conflicting after school responsibilities, specifically naming babysitting younger siblings and work. Also none of the parents attended the parent information sessions. The parents named responsibilities at home or work as their conflicts.

In the suburban teen group the seven teens were randomized to the intervention group, and five to the control group. Results of the intervention group showed that the seven teens in the suburban high school group lost a total of 32 pounds whereas the five participants in the control group gained 11 pounds. This was a significant difference with a p-value of $<.05$. In comparison to the urban study six of the seven adolescents attended all of the intervention settings and completed the entire program and all of the parents attended the parent sessions. The intervention group was very satisfied with the program, saying that the information was helpful and this education should be shared. Parents also had positive comments about the intervention. Control group attendance of participants and parents in the sessions provided were not mentioned in the article.

Overall, the COPE group experienced a greater weight loss and decreases in BMI than the control group (Melnyk et al., 2007). This study helped the researchers identify how well COPE was received. Participants liked the study but retention was difficult due to competing demands of other after school activities. Retention was identified as a limitation to the study (Melnyk et al., 2007). In the urban setting the intervention was not well attended. Six of the

eleven participants from the urban setting dropped out stating they had too many other conflicts. Lessons learned from this study include after-school programs can be a challenge because of a teen's job, homework, sports, or other family commitments. Recruitment was difficult, even though mall gift certificates and bus passes were rewarded to the participants. In this particular study, the sample size was low and there is no long term follow-up used to determine the sustainability of the intervention.

Next Melnyk et al. (2009) used the same program of "COPE/Healthy Lifestyles TEEN Program" for Hispanic adolescents enrolled in a health class at a school located in a southwest metropolitan region. The purpose of this study was to evaluate the efficacy of the "COPE/Healthy Lifestyles TEEN Program," the healthy lifestyles beliefs and choices, and the physical health of Hispanic adolescents. This study was a cluster randomized controlled pilot study with a sample of 19 Hispanic adolescents. These students were enrolled in one of two health classes. Teens were between 14-16 years old. The instruments used included: Healthy Lifestyle Belief Scale (assesses beliefs about various facets of maintaining a healthy lifestyle), Nutrition Knowledge (assessing knowledge of portion sizes, eating habits, and health), Healthy Lifestyle Choice Scale (measures healthy lifestyle choices), Beck Youth Inventory (Second Edition; BYI-II; measures five constructs: depressive symptoms, anxiety symptoms, anger, disruptive behavior, and self-concept), Anthropometric Measures (measured at baseline and post intervention and included, height, weight, and waist circumference), and laboratory work (measured at baseline and post intervention and included hemoglobin A1C, high density lipoproteins, low density lipoproteins, and triglycerides).

The COPE TEEN intervention was tested against an Attention Control Intervention. The attention control intervention program included common adolescent needs and questions

(common adolescent health concerns including acne, safety, and first aid). Parental consent and adolescent assent were obtained. The students were in either one of two health classes being offered at this school. The classes were randomly assigned as the intervention room or attention room by flipping a coin. Students and parents were blind to experimental group assignments. These two classes were taught by two different instructors. The participants were recruited by members of the research team who discussed their project the first day of health class. The lessons were delivered 2-3 times a week over the 9 weeks.

Seventeen of the nineteen adolescents completed baseline and post intervention data collection. Paired sample t-tests were used showing a decrease in depression, decrease in anxiety, and an increased commitment to making healthy choices. A subgroup analysis was done for the adolescents with BMI percentiles ≥ 85 . This subgroup comprised 58.3% (n=7) of COPE group. This group showed an increase in beliefs and healthy lifestyle choices, an increase in nutrition knowledge, a decrease in depressive symptoms, an increase in high density lipoproteins (HDLs), decrease in hemoglobin A1C, and a decrease in triglycerides. There was no decrease in weight or BMI percentage. Eighty-three percent of the COPE participants completed the evaluation at the end and 67% found the information helpful. This program showed the COPE group had improvement in their depressive and anxiety symptoms, choices for a healthier lifestyle, and nutrition knowledge (Melnyk et al., 2009). Limitations of this study are the small sample, no long term assessment, and its inclusion of only one ethnicity. Most students said they liked the intervention and would not change anything about it. Using this intervention during the regular school day helped with retention of participants (Melnyk et al., 2009).

In another study Lusk and Melnyk (2011) used the COPE intervention in a community mental health setting during routine mental health outpatient medication checks. The purpose of

this study was to assess the feasibility and effects of this intervention in this setting. This study looked at fifteen, 12 to 17 year old adolescents who were accessing mental health care at the center. The center is located in a small rural area in southwestern region of the United States. These adolescents presented to the center for an intake assessment performed by a masters/graduate level therapist. At this point they would be assessed for study eligibility and then asked to enroll if they had any symptoms of depression. Exclusion criteria included history of thought disorder, acute psychosis, and mental retardation. After the study was described to the parents and teens, parental consent and teen assent were obtained.

COPE was delivered once a week for 30 minutes in individual sessions. All fifteen participants completed all seven sessions. If for some reason they missed a week the sessions were resumed the following week. The content was delivered exactly as written. The sessions were all delivered individually during the evening at the clinic. Parents were encouraged to attend some or all of the sessions, depending on what they and their teen were comfortable with.

The Personal Belief Scale-Teens was used to assess beliefs and confidence about the teens' ability to manage stress and cope with various stressors. The Beck Youth Inventory (BYI; second edition) which is made up of five 20-item scales (Beck Youth Depression Inventory, Beck Youth Anxiety Inventory, Beck Youth Anger Inventory, Beck Youth Destructive Behavior Inventory, and Beck Youth Self-Concept Inventory) measured these different concepts of behavior and emotion. A post-COPE evaluation was used for both the teens and the parents to evaluate how they liked the overall program. An intervention quiz was also used pre- and post-intervention to assess whether the key content of the program was acquired.

The sample of fifteen adolescents was all White, non-Hispanic, which was consistent with the local demographics. Ten of these adolescents scored extremely high in at least one of

the BYI subscales at baseline. According to Lusk and Melnyk (2011) “scores this elevated indicate the participants in this study comprises a population with psychiatric distress” (p. 231). Results of depression scores from the BYI showed a decrease, pre-COPE M=58.33, SD=11.80 and post-COPE M=46.13, SD=7.47, $t(14) = 4.75$, $p \leq .0005$ (two-tailed). A decrease in anxiety ($p = .018$), anger ($p = .006$), and destructive behavior ($p = .000$) and an increase in Self-Concept ($p = .001$) and Personal Belief Scores ($p = .000$) had significant p-values in the post assessments. The evaluations from parents and teens included comments on how the intervention was helpful. It helped the teens to identify strengths and weaknesses, helped them learn how to deal with difficult emotions and situations, and helped improve relationships with friends and families. Parents thought their teens enjoyed the program and they witnessed their teens applying the skills they acquired.

This study performed by Lusk and Melnyk (2011) using the COPE intervention during routine mental health outpatient medication checks revealed “significant decreases in depression, anxiety, anger, and destructive behavior as well as increases in self-concept and personal beliefs about managing negative emotions” (p. 226). The seven, 30-minute sessions were easy and convenient to deliver in this setting, making it easy for the client and parents to be involved. This brief intervention was also easy for the advanced practice nurse to deliver in the time limitation that often occurs during these appointments. This intervention includes the main components of CBT within the seven sessions.

Limitations to this study include the lack of a control group and the lack of ethnic diversity in the sample. These are similar constraints noted in earlier studies with COPE as well (Melnyk et al., 2007; Melnyk et al., 2009). Further research on this topic includes trying to

implement the COPE in different populations, including school, primary care, and other community mental health areas.

The purpose of this dissertation project is translating the COPE intervention to depressed adolescents at an inpatient psychiatric hospital. The patients will receive the manualized intervention during their hospitalization. Permission from Melnyk has been obtained to implement the COPE intervention in this setting.

Inpatient Treatment

Characteristics of people with mental health disorders can vary. According to results from a survey performed by Meltzer, Gatward, Goodman, and Ford (2003) people who have mental health disorders that require hospitalization are more likely to have a lower income, have a single parent, and are male. Persons with mental disorders are more likely to have problems with the police, are punished more frequently, have relationship issues with family and friends, and have more school and work absences. They are also more likely to smoke, drink alcohol, and use cannabis. These actions can have long term consequences. Further, several of these behaviors may be amenable to change with a program such as COPE. Adolescents with mental disorders requiring hospitalization may learn skills in this way to improve their lives going forward.

Individuals are usually admitted to an inpatient facility because they are a danger to themselves or others, have a severe mental disorder, need medical treatment, are having self-care deficits, or their caregivers need some respite time (Bowers, Chaplin, Quirk, & Lelliott, 2009). The function of an inpatient psychiatric facility is to offer containment, a supervising presence, treatment, and overall management for the patient (Bowers et al., 2009). While the patient is hospitalized, the care team does a thorough mental and physical assessment. At times there may be need for de-escalation or restraint. While being with the patients, the staff can assess the needs

of the patients and continue to monitor their progression to get a more thorough understanding of their mental state. The staff tries to build trusting relationships with the patients to help empower them and offer support when needed. Often staff is assigned to manage the different aspects of the patient's care including admission, discharge, care coordination, medication, and therapy. Usually, this is a multidisciplinary team of physicians, advanced practice nurses, social workers, registered nurses, nutritionist, and support staff.

Deliberate self-harm is one of the top five reasons for admission into inpatient psychiatric facilities. Self-harm includes a suicide attempt and self-injury without suicidal intent. People who self-harm most frequently report an increase in stressful life events as a reason for the behavior. Other reasons include: relief of unwanted feelings, emotional regulation, feeling depressed or all alone, negative feelings toward oneself, and a need for distraction. Those with psychiatric disorders are at an increased risk for suicidal behavior and deliberate self-harm (de Kloet et al., 2011). These psychiatric disorders include major depression, anxiety disorders, eating disorders, impulse-control disorders, addictions, and psychotic and personality disorders. The presence of more than one of these disorders increases the risk of injurious behavior. Other risk factors include: history of sexual abuse in childhood, experience of a major life event, multiple hospital admissions, and a previous episode of self-harm or suicide attempts. Self-harm behavior can increase a person's length of stay and number of admissions. The most common example of self-harm behavior is cutting, followed by poisoning (de Kloet et al., 2011).

The most common reason an adolescent is admitted to an inpatient psychiatric facility is for suicidal ideation and behavior (Greenhill & Waslick, 1997). The decision to hospitalize adolescents with suicidal ideation can be influenced by the resources that people have available to them, their family situations, and insurance.

Conclusion

The treatment of adolescent depression is a complex area of health care. The best ways to treat adolescent depression are combined psychotherapy and medication. More studies need to be performed to address the barriers that are present when adolescents cannot receive the appropriate care. The provider's time and accessibility to a location providing mental health care are two of the largest barriers. Interventions that are developed to overcome these barriers will help allow more adolescents to get the treatment they need. The COPE intervention is one example that can be used to help overcome these barriers.

CHAPTER 3

CONCEPTUAL FRAMEWORK

A doctorally prepared nurse practitioner will be prepared to influence practice using evidence-based practice (EBP), scholarship, and leadership to drive innovation. The Chronic Care Model, the Cognitive Theory of Depression, and the Promoting Action on Research Implementation in Health Services (PARIHS) model are the theoretical frameworks that guide this dissertation project. The Chronic Care Model (Wagner et al., 2001) will be used to demonstrate its usability by showing the links between different areas of care needed when treating a person with a chronic disease. The main disease that is being treated in this project is depression. Depression can be a chronic disease that needs to be addressed and monitored throughout a person's life. For purposes of this project the patients are in the inpatient realm but the depression will follow them after they are discharged and will need to be followed up in the outpatient setting. The Cognitive Theory of Depression (Beck, Rush, Shaw, & Emery, 1979) is the main theory that supports the COPE intervention (Melnyk, 2007). COPE is a cognitive behavioral skill building intervention that will help the adolescents gain the skills and confidence to empower themselves. The PARIHS model (Rycroft-Malone, 2004) helps guide evidence-based interventions into practice.

Adolescence is a crucial time period in development. Different developmental theories will also be reviewed to help describe and understand the cognitive changes of this age group (11-18 years) and how the use of a manualized cognitive behavioral skills building intervention is appropriate for use in this population.

Developmental Stage of an Adolescent

A child should be progressing through different stages of development through the ages of 11-18. There are many different formal stages of development described by Jean Piaget and Erik Erikson. Piaget (1969) describes four different stages of development; sensorimotor (birth to 2 years), preoperational (2 to 7 years), concrete operational (7 to 12 years), and formal operational (13 years through adulthood). During the sensorimotor stage, children learn about their environment through their actions and sensory and motor movements. In the preoperational stage children are trying to make more sense of reality. They are very egocentric in their thinking and reality is based on concrete objects. During the concrete operations stage children are able to cognitively perform mental operations in their head which requires organization and classifying experiences. In the formal operational stage children begin to think abstractly and can conjure different outcomes to problems. According to Piaget (1969) adolescents are moving from the concrete operational stage to the final stage of formal operations.

Adolescents first need to master the cognitive ability to organize their thoughts and work through increasingly complex information. During this stage the children's thought process becomes more logical and they start to think more "adult like." This helps the transition to the final stage. In the formal operational stage the reasoning and thought becomes more hypothetical and deductive reasoning is used. This helps people consider what the outcomes and consequences might be of their actions. People use problem solving techniques and consider their own thoughts and feelings and that of others. This type of thought is necessary when using the Cognitive Theory as a framework of the COPE intervention. The adolescents can see their own self and start taking ownership of their thoughts and feelings.

Erikson's psychosocial development is made up of eight stages, ranging from infancy all the way through late adulthood (Erikson, 1964). The stages related to children and adolescents are: trust versus mistrust (birth- 12 months), autonomy versus shame (12-36 months), initiative versus guilt (3-6 years), industry versus inferiority (6-11 years), identity versus role confusion (12-17 years), and intimacy versus isolation (17-30 years). The progression through the stages relies on the successful completion of the previous stage. Adolescents would fall into the stage of identity versus role confusion. In this stage adolescents are trying to figure out who they are and who they want to be. The most important relationships at this stage are those of their peers. Loss of friendships or relationships can cause stress and lead to depression. Seeking out identity is the key to this stage. With proper reinforcement and guidance the adolescent can successfully proceed to the next stage. COPE helps adolescents by providing them with some of the tools they need to get to know oneself and relate to their peers.

The focus on adolescents, aged 12-18, for this project is supported by the complexity of the developmental tasks at these ages. The cognitive shift from concrete to abstract provides an opportunity to influence thinking using the COPE intervention. The numerous emotional and relational tasks of this age group may also be influenced by using the COPE intervention.

Cognitive Theory of Depression

Beck's Cognitive Theory of Depression (Beck et al., 1979) guides the COPE intervention (Melnyk, 2007). Beck et al. (1979) described that cognitive symptoms (negative thoughts) precede the affective and mood symptoms of depression. This theory focuses on the idea that a person's perceptions of and thoughts about situations influence his or her emotional, behavioral, and physiological reactions. These reactions can vary depending upon the person's current psychological state. These thoughts can be distorted when the person is stressed or distressed.

When a person is presented with a situation, automatic thoughts are triggered (Beck et al., 1979). These triggered responses can be negative core beliefs such as hopelessness and unloveability. Thoughts like these influence emotional, behavioral, and physiologic responses to the situation and are particularly concerning to the adolescent population who are sometimes quick to judge and respond.

Beck et al. (1979) describes a cognitive triad as the self, experiences, and the future. This means that how individuals view themselves, the world, or the future contributes to the development of depression. Oftentimes a triggering event can set off these disturbed feelings, such as hopelessness and the feeling of not being able to be loved. How individuals react to the situation can influence the responses to these thoughts and feelings. In turn, these thoughts influence emotional, behavioral, and physiologic responses to the situation. For example, adolescents being bullied by their peers can affect how they view themselves and therefore decrease their self-confidence and how they interact in the world and cause them to not see themselves as successful in the future. This triad explains how these different aspects can interact with each other and lead to depression and the mood symptoms. This theory helps to identify these thoughts and feelings and how it affects the individual.

Beck is also known for developing cognitive behavioral therapy (Butler & Beck, 1995). This type of therapy directly treats patients by intervening to change these automatic thoughts and behaviors that are potential triggers to the unpleasant emotions. By altering the experience or schema, the emotion and response should decrease in the intensity of emotion and thus decrease the number of depressive episodes.

The COPE intervention teaches cognitive behavioral skills that the adolescent can use to help deal with the triggers and/or response to a situation that potentially lead to the negative

emotions. The COPE intervention uses Beck's fundamentals of cognitive theory to build the program. It uses the idea of self-empowerment to help the adolescent deal with any situation that presents itself in hopes to treat the current and alleviate future depressive episodes.

Chronic Care Model

The Chronic Care Model (CCM) refocuses care from disease and treatment to personal empowerment by increasing the clients' confidence and skills to be able to manage their condition (Wagner et al., 2001). This model was developed with the support from the Robert Wood Johnson Foundation and their efforts to improve the quality of care for chronic illnesses. A common framework, shown to be useful in diverse health care organizations was derived from an extensive literature search. It was then promoted nationally in order to reach as many health plans and provider groups as possible (Wagner et al., 2001). The CCM model has been successfully used to deal with patients with chronic physical illnesses and behavioral/psychotic conditions (Blakely & Dziadosz, 2008). Whoever is delivering this care to clients' needs to be sure to have the appropriate resources and expertise to provide the clinical and psychological management. The CCM is built on the concept that the interactions between provider and client are encouraging and productive (Wagner et al., 2001).

There are six elements to the CCM. They are: health care organizations, community resources, self-management support, delivery system design, decision support, and clinical information system. These all fit together to be a framework for delivering the best care for the client.

The first element of health care organization refers to needing the support of the organization in order to support management of chronic care. A new program must be consistent with the organization's mission and values. It also needs to meet regulatory guidelines that mandate inclusion of goals and measurements of outcomes. In addition, the organization must be

committed to making change based on the data provided by quality improvement projects and monitoring of quality indicators. Senior leadership must enable the change required and be ready to break down barriers.

The second element is community resources. Organizations that provide care to clients should have linkages with the community resources that are needed by the populations that they serve. Rarely does one organization have all of the internal resources needed to take care of patients. Outside resources and programs can be a value-added element to providing necessary care management. These linkages support continuity of care. It is imperative that all of the resources are grounded by the principles of the chronic care model.

The third element is the support of self-management. Increasing a person's confidence and skills to manage one's own disease has been shown to be effective in treating multiple different chronic illnesses, e.g. diabetes and asthma (Wagner et al., 2001). These types of interventions "generally emphasize the patient's crucial role in maintaining health and function and the importance of setting goals, establishing action plans, identifying barriers, and solving problems to overcome barriers" (Wagner et al., 2001, p. 74). The person now needs to try and incorporate this self-management with the necessary health care team. This relationship will support the long term success of care management.

The fourth element is delivery system design. This delivery system demands planning and coordination by multiple caregivers in order to maximize care management. This aspect focuses on teamwork and an expanded scope of practice to support chronic care delivery. For example, if people have a question regarding their medication then pharmacists would be utilized for their expertise and be connected with the clients. This type of delegation can be done by a member of the health care team and the client working together.

The fifth element is decision support. An example of this would be the use of registries and summary reports to track organizational data. This supports the integration of evidenced based guidelines into daily practice. Use of registry data can enhance communication with medical specialists and mental health centers. Electronic communication or telemedicine is also an avenue for communication and the provision of continuity of care.

The sixth element is clinical information systems. This refers to computer registries that provide information based on patient populations that produce relevant client data. It also supports evidenced-based guidelines, and can demonstrate quality improvement. The conversion to electronic health records and other electronic methods of work are still in development stages. This could be a potential barrier for some resources necessitating alternative methods of communication.

Many people suffer from chronic illnesses. Coping with chronic illness may lead to depression and can affect any person regardless of their age or gender. It can be life-long, ebbing and flowing with time. The current health care system is not structured to take care of people with chronic illnesses. Most of the time people are seen by a provider for an acute problem with the expectation that there is a finite solution. These intermittent, as-needed visits, are not conducive to the individual needing long term support. Persons with chronic needs require management of their clinical health. Practitioners need to provide psychological support, and offer the necessary information regarding their disease process to understand what to expect and what they may need. Treating a person with a chronic illness requires an appropriately organized delivery system that is based on a foundation of communication with the person as well as access to the necessary community resources (Wagner et al., 2001).

When a client meets with a provider in any setting the client's history and data need to be reviewed. The interaction between the provider and client needs to be open and honest, establishing a trusting relationship. The client's knowledge and skills also need to be assessed based on the appropriate diagnosis and treatment plan. At this point appropriate goals can be set and further interventions can be prescribed. These interactions will be more productive if the client is an active, engaged participant. The patient is then more likely to follow the regimen and show good outcomes (Wagner et al., 2001). The care teams also need to be knowledgeable about the client and have the necessary information and resources available to them to provide the most effective well-rounded management. Most of the interventions prescribed to people with chronic illnesses include increasing their knowledge, skills, and confidence which aid in their taking ownership of their disease.

Holm and Severinsson (2012) used these six elements of the CCM to aid in the management of depression. Depression can be a mentally and physically disabling condition that is associated with poor self-care, difficulty with relationships, adverse medical outcomes, increased mortality, and risk of suicide (Lenz, Coderre, & Watanabe, 2009). Many chronic conditions are not being managed with evidenced-based treatments and therefore many people are not getting the best treatment available.

This is an effective model to be used in an organization that treats and manages people with psychiatric conditions. Blakely and Dziadosz (2008) used the CCM to deliver behavioral health services at a community treatment and rehabilitation center in a Midwestern city. They chose this model because it supports the client in achieving better outcomes if the individual is able to self-manage his or her condition. The theory is that psychiatric conditions do not have to be a life-long disability, but instead can be amenable to treatment and successful lifelong

management. Outcomes of improved adaptation and social functioning are the goals. Immediately involving the client allowed the individual to be empowered from the beginning and was the first step taken. Second, the appropriate treatment plan was prepared to treat the disease and minimize complications. Evidenced-based treatments were utilized as appropriate. Third, the treatment plan was reviewed by all those involved, keeping the client at the forefront of this planning. The treatment plan was then implemented and monitored throughout the given time frame. The fourth element was the continuation of follow-up and management. Depending on the client's level of involvement, the clinicians used interventions like phone calls, home visits, and motivational interviewing techniques to keep the clients engaged. The use of the fifth and sixth element was not specifically discussed by Blakely and Dziadosz (2008). The agency and project team utilized the CCM to plan and implement a project used to help treat clients with a variety of psychiatric conditions.

Each health care organization, regardless of its size is part of the larger community of health care. The CCM helps depict every organization as an essential piece in this community. The most effective chronic disease management involves many community resources and an organized way of delivering this care. The CCM "is like an evidenced-based guideline: a synthesis of system changes to be used to guide quality improvement" (Wagner et al., 2001, p.76). Most importantly this model reinforces the necessity for the provider to help empower the patient and family to manage their own chronic disease, help them establish realistic goals, help them identify barriers, and then help them identify ways to overcome these barriers. This will enable patients to take responsibility for themselves (Wagner et al., 2001).

Promoting Action on Research Implementation in Health Services (PARIHS) Framework

Recently in healthcare there has been a push for getting evidenced-based care that is clinically effective to the bedside of the patients. This can be a complicated and demanding task. The Promoting Action on Research Implementation in Health Services (PARIHS) model is a framework used to implement evidenced-based practices (Rycroft-Malone, 2004). This framework was originally published by Kitson, Harvey, and McCormack in 1998 and since has been further researched and developed. This framework comprises three core elements that interplay and are interdependent of each other. These three elements are: evidence, context, and facilitation. These elements are then further described with their related sub-elements. It is proposed that “for implementation of evidence to be successful, there needs to be clarity about the nature of the evidence being used, the quality of context, and the type of facilitation needed to ensure a successful change process” (Rycroft-Malone, 2004, p. 298).

Within the model, evidence is defined as “knowledge that is derived from various sources and includes the strength and nature of the evidence as perceived by multiple stakeholders” (White & Dudley-Brown, 2011, p.40). The sub-elements of evidence are: research from studies and clinical practice guidelines, clinical experiences or related professional knowledge, patient preferences and experiences, and information or data derived locally (Rycroft-Malone, 2004).

Context is defined as “the environment or setting in which the proposed change or translation of research is to be implemented” (White & Dudley-Brown, 2011, p. 40). Context is also comprised of three sub-elements. These elements include: organizational culture, leadership, and evaluation. It also pays attention to the availability of resources to undertake the implementation.

This framework defines facilitation as “the technique by which one person makes things easier for others, helps others toward achieving particular goals, encourages others and promotes action” (White & Dudley-Brown, 2011, p. 40). Successful facilitation is achieved by a person that supports individuals to change their thinking, attitudes, and work. The facilitator must have the appropriate skill and character attributes including: openness, supportiveness, approachability, and reliability (White & Dudley-Brown, 2011). There are three elements of facilitation: purpose, role, and skills/attributes. These elements can be placed on a continuum of low to high, with the high side of the continuum relating to higher success of the implementation. Essentially, the most successful project will have robust evidence, the project will match professional consensus and patient need, and be implemented in a context where the culture supports change, has strong leadership, and has evaluative systems to evaluate the effectiveness.

Summary

The use of these conceptual frameworks and theories are guides used to form, implement, guide, and translate the COPE program for depressed adolescents. The Chronic Care Model demonstrates the need for more interventions for chronic illnesses and these interventions can be delivered in any setting that treats these chronic illnesses. The Chronic Care Model was used successfully in a mental health setting in a Midwestern city; similar to what this project is suggesting (Blakely & Dziadosz, 2008). The treatment of mental illnesses is one aspect of a person’s health care and has an impact on the effectiveness of other treatments. The COPE is appropriate to use for adolescents based on the theories of development from Piaget and Erikson. Adolescents are looking for help and just need the tools to help increase their self-confidence. The cognitive theory guides the intervention itself, but also is important for the person. The most successful treatments are the ones that the person is fully invested in and sees the benefits that

can be provided. The PARIHS framework is a guide for the implementation of the evidenced based project in a health care setting.

The conceptual frameworks described will be used to guide the use of the COPE intervention for depressed adolescents while in an inpatient psychiatric facility. Depression can be a chronic disease and the sooner it can be managed the better chance people have at achieving a healthy life. These frameworks all interact based on the setting, disease being treated, the basis for the intervention, and delivery to the developmentally appropriate patients. With the delivery of an intervention that teaches cognitive skills and helps build self-esteem and confidence, not only will the patients be able to manage their depression better, but they will be learning how to handle their life better and be more in control. The adolescents will know about the resources available to them as set up by the primary care team and mental health team. The adolescents will use the skills being taught to them to achieve a healthy transition into adulthood.

CHAPTER 4

METHODS

The purpose of this dissertation project is to evaluate the effectiveness, acceptability, and feasibility of implementing the Creating Opportunities for Personal Empowerment (COPE) program in one-on-one sessions in an inpatient setting with hospitalized depressed adolescents. The target population was adolescents (ages 12-18) with depression because the COPE Teen manual is designed for this age group. This one-on-one treatment was delivered along with the normal treatment regimen prescribed by the patient's team at the inpatient mental health hospital. A variety of tools were used to evaluate the outcome measures. Effectiveness was evaluated based on pre- and post-scores from the Beck Depression Inventory (a standardized scale used by the institution) as a measure of symptom improvement. A tool called the Personal Belief Scale was completed by the participants and used to assess for effectiveness and acceptability. Acceptability was measured using an evaluation tool that assesses the satisfaction from the participants and the involved members of the adolescent care team. Feasibility was measured by appropriate and timely referral of participants, completion rates of all seven sessions, adequate time and space to deliver each session, and perceptions from the staff.

Study Site

The location for this intervention was an 82 bed mental health facility in a Midwestern city. Sixty of the beds are designated adult; 22 are for adolescents. This hospital provides inpatient and outpatient psychiatric treatment for both adults and adolescents. This hospital treats patients who are private pay, insured, or state funded. This location was chosen based on its convenient location and the specific population of interest. The dissertation facilitator also had a

prior relationship and experience at this location during a semester interning with the adolescent group mental health treatment team.

Treatment services are provided for psychological trauma, co-occurring disorders, and eating disorders. A variety of techniques are used to treat the adolescents. All patients receive both one-on-one therapy and group therapy delivered by different members of the treatment team. Other forms of therapy utilized include pharmacotherapy, art therapy, drama therapy, and family therapy. Dialectical behavioral therapy is a frequently used treatment modality.

A typical day for an adolescent includes scheduled meal times for breakfast, lunch, and dinner. Group therapy is scheduled in the morning and afternoon. Throughout the day the adolescent meets with a social worker, the physician, and the nurse to review treatment, offer one-on-one therapy, and perform a medication check. The adolescent receives 5-7 hours of organized therapy per day. During the inpatient stay it is also typical that a family meeting and/or a family therapy session is performed. More than one of these can be done if needed. This provides the opportunity for the family, patient, and treatment team to discuss current treatment, create new treatment goals, and start planning for discharge.

There is a team of people who work primarily with the adolescents. This group is comprised of three social workers, a nurse practitioner, two registered nurses, and a physician. Members of this group work closely together to meet the physical and mental health needs of their patients.

There is a separate part of the hospital for the adolescent patients. This area is separated by locked doors. All rooms are semi-private. This area also has consultation rooms, a quiet room, one large lounge, and three smaller lounges. At the center of this area is a work station where the

nurse and technicians who staff the unit are located. This area holds the patients' charts, staff computers and phones.

Study Population and Sample

Patient Participants

Adolescents admitted to this facility range in ages from 12-18, occasionally there are special circumstances when children younger or patients over the age of 18 are admitted to the adolescent unit. The unit has both male and female patients; they are paired together in sleeping rooms by gender. The acuity of patients admitted to the adolescent unit typically ranges from low to medium. Higher acuity patients are placed at other facilities. Each case is assessed for the safety of the patient being admitted, for the safety of other patients in the unit, and the safety of the staff. In some cases a higher acuity patient can be detrimental to the culture of the unit and treatment for others. Treatment plans are individualized and follow-up care is typically done outside of this facility.

The most common diagnoses that are treated in the adolescent unit include major depression disorder, generalized anxiety disorder, substance abuse, psychosis, and eating disorders (anorexia and bulimia). Other diagnoses like bipolar and manic depression are seen less commonly, and, if seen, they are in early stages. Patients are typically inpatient for 10-12 days.

Inclusion criteria for this project included: ages 12-18 years, diagnosis of depression, and English speaking. Exclusion criteria included diagnosis of bipolar, manic depressive disorder, psychosis, and eating disorder. For this project 25 adolescents who completed all seven sessions were included in the data analysis.

Participants in this project are adolescents aged 12-18 years. Age and gender characteristics are described in Table 1. The mean age of the participants was 15 years (range 12-

18 years). Of the 25 adolescents who completed the program, females represented 92% ($n=23$) of this sample and males represented the other 8% ($n=2$). Also of these 25 participants 80% ($n=20$) were white, not of Hispanic origin.

Table 1

Age and Gender of Sample

Age (years)	Male ($n=2$)	Female ($n=23$)
12	1	0
13		2
14		5
15	1	8
16		3
17		4
18		1

Seventeen participants (68%) self-reported their mental health diagnosis. The most common diagnosis reported by the adolescents was depression ($n=17$). Participants could list more than one diagnosis. Table 2 describes the other diagnoses that the adolescents stated. Some of the diagnoses that participants indicated were past diagnoses and therefore did not exclude them from participating in this project. There were eight participants that did not answer this question. For some, they may have received a first time mental health diagnosis during their admission.

Table 2

Self-Reported Mental Health Diagnoses

Mental Health Diagnosis	Number of Self-Reported
Depression	17
Anxiety	10
ADHD	6
Bipolar	1
Eating Disorder	1
Other	1

Staff Participants

On a typical day there is one charge nurse, one medication nurse, and three mental health workers on the unit. In addition to this staff, a recreation therapist works with the adolescents and provides some group therapy in the mornings and afternoons. The nurse manager also functions as the charge nurse on the unit most days. There are three social workers that work exclusively with the adolescents. There is one primary psychiatrist who oversees the adolescents in the inpatient unit and partial program.

The staff members who helped with recruitment were asked to evaluate the program. A total of four staff members evaluated the COPE intervention. They included the three social workers and the nurse manager for the adolescent unit. These four staff members all work in the adolescent unit full time.

Intervention: COPE for Teens/Young Adults

The COPE for Teens/Young Adults workbook was used in this project. This program consists of seven sessions that last about 30 minutes per session. This cognitive behavioral skills building program was used to help adolescents with depression. The program is based on the principles of cognitive behavioral therapy and therefore consists of cognitive restructuring, problem solving, and behavior change.

The sessions can be delivered in either group sessions or one-on-one sessions. For this project they were delivered on a one-on-one basis. Each of the sessions begins with a review of the previous session. At the end of the session the next homework is assigned. The homework is designed to reiterate the lesson learned and personalizes the concepts to the teen's life. The homework reinforces the content and allows for practice of the skills. At the end of each session a goal setting and self-monitoring log is completed. Each goal relates to the concepts taught in that session. The teens are asked to rate if they feel worried, stressed, happy, sad, angry, irritable, and calm. The teen rates these different feelings from 0 "not at all" to 10 "a lot." This helps the teen and the COPE facilitator track the teen's emotional state and can be discussed further if appropriate.

In session 1 the thinking/feeling/behaving triangle is described. The teens learned how these concepts are connected and how they can affect feelings and behavior. The teens learned about the antecedent (trigger event), the belief (the feeling following the triggering event), and then the consequences (the feelings and behaviors). This is also referred to as the ABCs. In this session the concept of positive self-talk was introduced and practiced. This helped the teens focus on encouraging thoughts and praise.

Session 2 is based around positive thinking and forming healthy thinking habits. Self-esteem was described. The differences between positive and negative self-esteem were discussed. This session focused on thinking positively. The belief was when people start to think more positively they have better self-esteem and they feel and act more positively. This meant that the adolescents had to recognize what unhealthy habits are in their life and how change can be integrated.

Stress and coping is the focus of session 3. Each of the concepts were defined and then described. The physical and emotional responses to stress were discussed. Behaviors like overeating, arguing, and using drugs and alcohol can often mean that people are stressed. Recognizing these behaviors can help the teens recognize how they respond to stress. Next, both healthy and unhealthy ways of coping were discussed. If the stress is not properly dealt with the situation can eventually lead to depression and/or anxiety. The session ended by helping the teens recognize these concepts in their lives and the coping technique of abdominal breathing was taught and practiced.

Session 4's focus is on problem solving and setting goals. A case scenario is given and the teens work through the problem and help set goals for the person in the scenario. Next, problem solving and the four step process that is used are described. The teens needed to learn how to problem solve using a four-step approach. The four-step approach includes: identify the problem, identify the cause of the problem, start thinking of possible solutions to the problem by working through the pros and cons of each possible solution, and then identifying the best solution. Another scenario was described and the teens worked through the situation using this approach.

In session 5 the teens learn how to deal with emotions in healthy ways using positive thinking and effective communication. A technique called mental imagery was taught to help the teens relax and control their thoughts and feelings. To help further solidify the self-empowerment skills the teens were using, self-control strategies were reviewed and the DNP facilitator helped the teens identify which technique worked best for them. Some of these healthy coping strategies included listening to their favorite music, exercise, writing in a journal, or having quiet time. The last concept discussed was effective communication. Aspects of effective communication include active listening, body language, tone of voice, facial expression, physical closeness, and word choice. The teens were taught to use more “I” statements so that the people they are communicating with do not feel like they are being put on the defensive. At the end of the session the teens were given the opportunity to practice these new skills.

Session 6 focuses on coping with stressful situations. The teens first reviewed the ABCs and the thinking-feeling-behaving triangle. The teens then practiced the skills being taught by role playing in different situations. The homework after this session had the teens imagine different situations in which they would have to utilize these new skills they have been taught.

Session 7, the final session is titled “Pulling It All Together for a Healthy YOU!” The teens were asked if they have had the opportunity to use any of the skills taught during these sessions. The rest of the session focused on reviewing the concepts and was filled with words of encouragement for the teens. No official homework was assigned after this session but the teens are challenged to use the skills as much as possible in daily life.

The COPE Teen workbook was used for this age group. Dr. Melnyk approved the use of this workbook and allowed copies to be made of the sections that required writing (Appendix A). The entire workbook composed of seven sessions was reviewed with the teen by the DNP

student during his or her hospital stay. The one-on-one delivery was generally accomplished over a period of four to seven days with no more than two sessions happening on a single day.

The COPE program is designed to be delivered exactly as printed in the manual. Every word of the lesson is delivered. For consistency sake the person who delivers the COPE program completes a training session, which the DNP student completed. In the one-on-one sessions the teens' personal experiences may be added in addition to the scenarios in the manual. The associated homework was performed in the evening during the adolescent's journal time as per normal routine at the facility. Their own personal writing about this intervention was kept in the folder that they keep with them throughout their treatment at the facility.

Instruments

Characteristics of the sample were obtained from the participant on the Participant Information tool (Appendix B). Information collected on this tool included: age, gender, mental health diagnosis(es) as identified by the subject, school involvement, grades in school, stressors, and sleep habits. Beck's Depression Inventory was used to measure depression at baseline and then again at the completion of the intervention to assess for effectiveness. Also obtained at the completion of the COPE intervention was the Personal Beliefs Scale and an evaluation of the COPE tool to assess for effectiveness and acceptability. An evaluation questionnaire was given to the social workers and the nursing manager in the adolescent unit to assess their thoughts of the COPE course and process of implementation to assess for feasibility and acceptability.

Beck Depression Inventory-2nd Edition (BDI-II)

The BDI-II is a 21-item self-report instrument intended to assess the presence and severity of symptoms of depression as listed in the Diagnostic and Statistical Manual of Mental Disorders-IV (American Psychiatric Association, 2000). This instrument is commonly used to

measure depression in research. The Beck Depression Inventory was first introduced in 1961 (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and then revised in 1971 and copyrighted in 1978 (Beck, Rush, Shaw, & Emery, 1979). It focuses on the 21 symptoms and attitudes commonly seen in people with depression. These include mood, pessimism, sense of failure, lack of satisfaction, guilt feelings, sense of punishment, self-dislike, self-accusation, suicidal wishes, crying, irritability, social withdrawal, indecisiveness, distortion of body image, work inhibition, sleep disturbance, fatigability, loss of appetite, weight loss, somatic preoccupation, and loss of libido. This tool is used on this inpatient unit to assess for symptoms of depression. This tool is also consistent with Melnyk's (2007) and Melnyk and others' (2009) measures.

Nineteen of the 21-items are scored based on a four point (0-3) scale; two of the items have seven options. After totaling the results the score will fall into one of four ranges that indicate level of depression: 0-13 minimal range, 14-19 mild, 20-28 moderate, and 29-63 severe. The BDI-II was chosen for use in this dissertation project because the implementation facility had possession of the instrument. The BDI-II has a high level of internal consistency with an alpha coefficient of .86 (Beck & Steer, 1984). A test of reliability was performed using the data collected in this project and the Cronbach alphas were .94 on the pre-intervention BDI-II and .92 on the post-intervention BDI-II measures.

Personal Belief Scale

The Personal Belief Scale (PBS, Appendix C) was created by Melnyk by adapting other tools that she had used in previous studies (Melnyk 2007; Melnyk et al., 2009). This tool is a 12-item instrument that assesses the beliefs/confidence of the participants' ability to manage and cope with stress. The responses are based on a 5-point Likert type scale that ranges from 1 (strongly disagree) to 5 (strongly agree). The final score is a summation of all items and can

range from 12-60, with a higher score indicating a stronger belief in the ability to manage stress and deal with the negative emotions.

Melnyk has reported content validity using eight adolescent health specialists (Lusk & Melnyk, 2011). The reported Cronbach alphas have ranged from .76 to .85 in previous studies (Melnyk et al., 2009; Lusk & Melnyk, 2011). In this project the Cronbach alphas were .76 on the pre-PBS and .86 on the post-PBS.

Evaluation for COPE

The evaluation for COPE was given to the adolescents. The evaluation consisted of items in the form of closed questions that use a Likert-type scale, open ended questions, and multiple answer questions (Appendix D). The Likert-type items asked the participant to rate each of the sessions from 0 (not at all helpful) to 4 (very helpful). The open ended questions asked the participants what they did or did not find helpful in the COPE program. The multiple answer questions asked the participants to identify new skills that they learned and which of these skills they are currently using. The choices included: positive thinking, the ABCs, positive self-talk and other methods discussed in the program. The last of the open ended questions asked if the participants knew of anyone that they think would benefit from the COPE program, if they would recommend it to others, and if they can think of anything else that should be added to the program. These evaluations have also been used in Melnyk's previous studies using COPE.

Feasibility of COPE

To assess for feasibility, different aspects of the recruitment procedures, delivery of the intervention, and successful completion of the program were evaluated. Other aspects of the study were described in addition to the formal instruments. These include the number of adolescent participants and the ease of recruitment, the ability to complete all seven sessions

during the inpatient stay, and how well did the site's physical plan and configuration facilitate the implementation of this project. The intervention was delivered along with many other interventions to help treat the adolescent's mental health needs. These other factors were not controlled in this study and therefore it is not possible to attribute the results to the sole effect of the intervention.

Procedures

Recruitment

During the first week of implementation the DNP student attended morning rounds daily with the team to help identify potential clients. After the first week, the COPE facilitator and the team decided it would be better to speak with the medical social workers and nurse manager on the unit daily to assess eligibility status of the patients. The staff was becoming more comfortable with identifying the eligible adolescents. With minimal changes to the daily census, attending rounds on every patient admitted did not aid in recruitment after the first week. However, it did aid in increasing the familiarity of the staff with the project.

Originally the medical social workers were going to introduce the project to potential clients during their intake assessment. In some cases this was true, but most of the time the DNP student introduced the project to the adolescent to see if he/she were interested after identification by the social workers or nurse manager. During this meeting the DNP student met with the potential participant to describe the intervention and project (Appendix E) using the script for recruitment (Appendix F) and offered an outline of the session content (Appendix G). If the client wished to participate, the adolescent was asked to sign the Permission to Contact form (Appendix H) allowing the DNP student to contact his/her parent or guardian to obtain consent. Using the script for phone consent (Appendix I), parent consent (Appendix J) was

obtained for all adolescents. Assent (Appendix K) from the adolescent was then obtained. After parental consent and adolescent assent the COPE program was implemented in one-on-one sessions during the adolescent's inpatient stay as described. These sessions occurred during the day.

Methods of Implementation for Staff

The staff was introduced to the COPE program and their role in this DNP's project during a presentation. In order for the staff to understand the COPE program, research using the program was described. Each session was reviewed and then the instruments that were used to evaluate its effectiveness and acceptability were discussed. A copy of the COPE manual and the various tools were available for review.

Acceptability and feasibility of the COPE program from the perspective of the staff was obtained through the use of a study specific evaluation tool (Appendix L). Questions regarding staff members' perspective of the ease, usefulness, and effectiveness of delivering this intervention were assessed. Informed consent (Appendix M) was obtained from the staff members who helped identify participants and evaluate this study.

Human Subjects

Approval by the GVSU Human Research Review Committee was obtained prior to the start of this project (Appendices N & O). The intervention was approved by the leadership team at this mental health facility (Appendix P). The potential benefits of this project included gaining new coping techniques that the adolescents could use to help manage their depression and improve their symptoms. Risks were minimal but included potential emotional and psychological distress. Protection was in place to deal with these risks. The adolescents were already in an inpatient hospital, if their symptoms worsened they received the usual care provided by the

hospital. The COPE program could also be stopped if recommended by the treatment team. The potential clients and families were made aware of the project and informed consent/assent was obtained. To ensure confidentiality all identifying patient information is stored at the psychiatric hospital in a locked office. The de-identified information was coded and is stored at Grand Valley State University in a locked filing cabinet in Kirkhof College of Nursing research office. All electronic information is stored on an encrypted flash drive and is also stored in the locked filing cabinet in the locked office. All information will be kept in a secure, locked area for a minimum of three years as per standard procedure.

There was no compensation or incentive plan for the adolescents or families to participate in this study. There were no financial benefits for the DNP student. The clients' insurance was not billed for any of these services. All of these aspects were described in the consent and assent forms (Appendices J and K).

CHAPTER 5

RESULTS

This dissertation project involved the implementation of an evidenced-based program called Creating Opportunities for Personal Empowerment (COPE). This project was implemented with adolescents on an inpatient mental health hospital. Previously, the COPE program has been implemented in an outpatient mental health setting, a primary care setting, and a school setting (Melnyk, 2007; Melnyk et al., 2009; Lusk & Melnyk, 2011). The goal of this project was to assess the effectiveness, acceptability, and feasibility of the COPE program in one-on-one sessions in an inpatient setting.

The purpose of this chapter is to discuss the results of this project. Effectiveness was measured using the Personal Beliefs Scale (PBS) and Beck's Depression Inventory-II (BDI-II). Acceptability was measured using evaluations from the participants in the study and staff who helped with recruitment. Feasibility was measured by assessing timely referrals of participants, completion rates, assessment of the adequacy of time and space to deliver the program, and evaluation of the effectiveness of the intervention in this particular setting. Microsoft Excel and The Statistical Package for the Social Sciences (SPSS) version 20.0 were used for data entry and analysis.

Participants

For this project 28 adolescents enrolled in the COPE program. Twenty-five teens completed all seven sessions and their information was included in the data analysis. Two of the 28 total that enrolled were not able to complete the program. In one case the participant only had one session left on the day of her discharge but her other care needs (safety contract, goal setting, and family meeting) took precedence to the final session. Her discharge was not going to be

delayed in order to complete this last session. The other adolescent who did not complete was enrolled in the program a few days into her inpatient stay and made fast progress so that discharge occurred in fewer than the average length of stay (7-10 days). The other adolescent electively withdrew from the program.

The 25 participants used in the data analysis completed all seven COPE sessions. The majority of the participants in this project were Caucasian (80%) and female (92%).

Efficacy

Efficacy was measured using BDI-II and PBS tools. Each participant completed these tools at the beginning and then again at the completion of the program, thus obtaining a pre- and post- intervention score. The BDI-II is a 21-item inventory that assesses depression symptoms. Scores were totaled for the interpretation of this tool, with a lower number indicating fewer depression symptoms that a person is experiencing.

Fifteen of the adolescents had total pre-BDI-II scores that were higher than 29. This put them in the severe depressions range (Beck, Steer, & Brown, 1996) at the beginning of the program. Before the COPE intervention the adolescents primarily had high depression scores using the BDI-II. After the COPE intervention the post-BDI-II scores were mostly in the minimal to mild category for depression as described in Table 3.

Table 3

Total BDI-II Scores, Levels of Depression (n=25)

Levels of Depression	Pre-COPE frequency (<i>n</i>)	Percentage (%)	Post-COPE frequency (<i>n</i>)	Percentage (%)
Minimal (0-13)	4	16	17	68
Mild (14-19)	1	4	4	16
Moderate (20-28)	5	20	3	12
Severe (29-63)	15	60	1	4

Six participants did not answer the last question on the BDI-II that inquired about their sex drive. The assumption is that they felt that it did not apply to them or that they did not feel comfortable answering this question. Of the other 19 participants that did answer this question, 18 of them scored a 0 and only one of them scored a 1. A series mean (a common technique used when there is missing data) was used to give a score for the six participants that did not answer. The series mean was 0. Overall this was used to compile the total BDI-II score.

The PBS tool is a 12-item questionnaire used to measure the participants' views of their lifestyle. Total scores were added. A higher score indicated a stronger belief about ability to cope and manage stress. A series mean was also used to tally the score for one participant's pre-PBS score, since one item was skipped. In order to include the pre-PBS data from this participant, the decision to use the series mean of 3 was made.

A paired sample t-test was performed to test for improvement (decrease in scores) in depression scores using the pre and post BDI-II data. A paired sample t-test was also performed to assess for improved scores on the PBS (increase in scores). Using a p-value significance of $p <$

.05 the results of both tests were statistically significant with a p-value of .000 as shown in Table 4.

Table 4

Paired Sample t-Test

Instrument	Range	Mean	Mean Difference in Score	<i>t</i>	p (two-tailed)
Pre-BDI II	(2-47)	29.04			
Post-BDI II	(0-32)	10.00	19.04	7.267	.000
Pre-PBS	(26-53)	38.88			
Post-PBS	(44-60)	51.32	-12.75	-8.294	.000

This analysis of BDI-II scores demonstrated a significant decrease of depression symptoms in all participants from pre- to post- intervention. There was a statistically significant decrease in depression scores (BDI-II) from pre-COPE ($M = 29.04$, $SD = 13.75$) to post-COPE ($M = 10.00$, $SD = 8.90$), $t = 7.27$, $p = .000$ (two-tailed). The mean decrease of BDI-II was 19.04, with a 95% confidence interval ranging from 13.63 to 24.45. Overall mean scores dropped and the differences were significant ($p = .000$) for improved depression scores from pre to post intervention.

A significant increase in the PBS scores was obtained from pre- to post-intervention with a significant p-value of .000. The PBS scores were also statistically significant from pre-COPE ($M = 38.88$, $SD = 6.89$) to post-COPE ($M = 51.32$, $SD = 5.08$), $t = 8.26$, $p = .000$ (two-tailed). The mean increase of PBS was 12.44, with a 95% confidence interval ranging from 9.33 to

15.55. An increase in PBS scores from before the intervention until after demonstrates that the participants had more beliefs that they were able to cope and manage stress.

Acceptability

Acceptability was measured using evaluations from the participants and staff. Many of the questions on the evaluations helped indicate whether or not the participant found the program useful and potentially helpful to others. The staff evaluation asked if they had any feedback from the participants and if they thought this program was realistic in that particular setting.

Participant Evaluations

On the participant evaluation of the intervention the first question asked “Overall, did you find the 7 COPE sessions helpful?” All 25 participants (100%) answered in the affirmative to this question. The participants did have a chance to elaborate and reflect on skills that they found most useful. Some participants mentioned specific skills that helped them deal with their thoughts and feelings by name, such as, positive thinking, coping skills, breathing techniques, guided imagery, effective communication, and “I” statements. Other participants answered with application statements like “it helped me deal with my family during our family session” and “it gave me a different perspective on how I see things and now I can think before I react.”

The next set of questions on the evaluation asked specifically about each session. The questions asked the participant to rank the helpfulness of each session from “not at all helpful,” “a little helpful,” “somewhat helpful,” “moderately helpful,” or “very helpful.” Table 5 describes how the participants scored each session. All participants found the sessions to be helpful. While the participants found every session to be “a little helpful,” certain ones were more helpful than others. The session that the participants found as most helpful was session 6. Session 6 focuses on coping with stressful situations. For this session, 21 (84%) scored this as

being very helpful and the other 4 (16%) scored it as being moderately helpful. The next most helpful sessions were Sessions 3 and 5; both had 18 (72%) participants ranking it as “very helpful.” Session 3 focuses on stress and coping and session 5’s focus is on dealing with emotions in healthy ways using positive thinking and effective communication.

Table 5

Participant Ranking of Individual COPE Sessions (n=25)

	“Not at all helpful”	“A little helpful”	“Somewhat helpful”	“Moderately helpful”	“Very helpful”
Session 1	0	1	2	10	12
Session 2	0	0	0	8	17
Session 3	0	0	1	6	18
Session 4	0	0	2	6	17
Session 5	0	1	2	4	18
Session 6	0	0	0	4	21
Session 7	0	1	0	8	16

These results were also reflected on some of the individual questions and statements of the BDI-II and PBS, which had the most improvement from pre- to post- COPE. The highest improvements in the individual responses on the BDI-II were related to higher self-worth and being optimistic about the future. On the PBS instrument the statements that improved the most related to being able to handle emotions and situations. The responses that had the most improvement were related to self-empowerment, feeling more confident in oneself, and being able to deal with pressure and situations in more positive ways.

The adolescent participants were then given a chance to describe how they found the sessions to be helpful. A majority of them did provide a narrative that varied from “Taught me ways to deal with stress in healthy ways” to mentioning specific techniques that they used like deep breathing, “I” statements, effective communication, mental imagery, and positive self-talk. Only one person did not answer this question.

Another question on the evaluation asked what could be added to the program. These responses stated they would like to see sessions on how to better cope with anxiety and anger.

One of the last questions on the participant evaluation asked, “Would you recommend the COPE program to other students?” All 25 participants (100%) answered yes to this question as well.

The responses from the participants were overwhelmingly positive. The participants marked most of the techniques that were taught as being new skills and that they are currently using them. Having 100% of the students say they found the sessions to be helpful and that they would recommend this program to other adolescents suggest that the students approve of the program.

Staff Evaluations

The staff also had a chance to fill out an evaluation of the program. Evaluations were collected from the three social workers who work on the adolescent unit full time and the nurse manager from the adolescent unit. All four of these staff members indicated they had a chance to look at the workbook. One question asked if the contents of the COPE appeared easy to use. All responded affirmatively, even stating the workbook appears “concrete” and “easy to understand.”

The staff were also asked in these evaluations if they thought the patients benefited from the COPE program. Answers included: “[it] reinforced coping techniques,” “gave them a chance to process and reflect more on what will work for them,” “it was easy for them to give application to the tool,” and “it was a different therapeutic modality utilized so it was beneficial for the patients to receive something different.” The staff seemed to like the program and its ease in delivery. When asked if any of them had heard any feedback from the participants, they reported they had heard the participants mention that it was useful. Some recalled a participant stating “using the positive thinking statements when they felt anxious” was helpful. One staff member also commented on the specific treatment modality of the workbook and that it was a benefit to the participants’ treatment.

Feasibility

Feasibility is an important aspect of this dissertation project. Knowing that this program can be implemented in this type of setting and is sustainable is key in continuing to use programs like the COPE. Feasibility was measured by timely referrals of participants, completion rates, having adequate time and space to deliver this intervention and the staff’s responses to “How well does using a workbook with specific homework as a method of delivering therapy work in this setting?”

As previously mentioned 25 of 28 participants completed the COPE program. Two of the participants were not able to complete all of the sessions because they were discharged prior to completion. In both of these cases the participants were not referred to the DNP student until a few days into their stay and may have been discharged prior to the average 10 day length of stay. The participants who did complete the seven COPE sessions were recruited within one to two days of admission. When delivering these seven sessions, it was feasible to review more than one

session at a time. Sessions 2 and 3 were often combined because each session only took 15 minutes to complete and they seemed to flow well together. Before doubling up on any session the teen's permission was sought. Overall, there was an 89% completion rate.

The environment at the hospital was conducive to providing these one-on-one sessions. The adolescent unit has multiple offices, consultation rooms, and lounges that could be used as meeting places. If for some reason none of these rooms were available then the adolescent's room was used. Timing was a minor issue. The best time to meet with the adolescents was in the morning between breakfast and lunch, after their gym time, or before dinner. These time frames allowed plenty of time to meet individually with each adolescent without worrying about missing any of the meal times or gym time. Despite participants often being in a group session at the time of the COPE meeting, it was an acceptable procedure to pull them out to meet with staff members from the hospital and to participate in this project. Homework would be completed at night. This gave the adolescent adequate time and was minimally disruptive to the unit.

Examining the responses from the staff evaluation tool helped assess if the staff thought the program would be feasible in their work setting. All of the staff reported that the workbook with the assigned homework would be a method that could be feasible in this setting. When asked about a realistic time frame to deliver an intervention they responded 15-30 minutes ($n=3$) and 30-45 minutes ($n=1$). These time frames are consistent with the time it takes to deliver a session of the COPE program.

CHAPTER 6

DISCUSSION

This chapter will discuss the findings of this dissertation project and the implications for advanced nursing practice. One in every four to five youth meets the criteria for a mental health disorder that will eventually impair functioning during their life (Merikangas et al., 2010). Many of these adolescents are not receiving the treatment that they need. Early intervention and timely evidenced-based treatment are critical for the best outcome.

This dissertation project involved the implementation of the COPE program at an inpatient psychiatric mental health hospital in a Midwestern city from April-June 2014. The goal of the project was to evaluate the acceptability, feasibility, and effectiveness of implementing the program with depressed adolescents. The evaluation involved measuring depression symptoms using the Beck Depression Scale (BDI) and health beliefs using the Personal Belief Scale (PBS). These tools were obtained pre and post intervention. The participants completed an evaluation of the COPE program after the completion of all seven sessions. The social workers and nurse manager also completed an evaluation of the program.

This chapter will start by reviewing the findings from this dissertation project followed by a discussion of limitations. Next, the implications and influence of this project at the site and for advanced nursing practice will be examined. The role of the doctorally prepared nurse will then be discussed. Finally, the chapter will conclude with a review of this dissertation project.

Discussion of Findings

Several studies mentioned in Chapter 2 of this dissertation found the COPE program to be effective and very well accepted by the participants. The results found in this dissertation project align with those findings and further support the positive results of cognitive behavioral

therapy interventions. Results from this project show improved depression scores and better coping abilities along with positive evaluations indicating that participants and staff liked this cognitive behavioral based program. This project extends the applicability beyond outpatient and school settings to an inpatient psychiatric setting for adolescents.

Using the COPE Procedure with Inpatient Adolescents

Ages of the participants varied along the adolescent age spectrum. The mean age of the sample was 15 years. This age group aligned well with other studies that Melnyk has used with the COPE program.

This sample was primarily Caucasian and female. This appeared to be consistent with the inpatient group at the time in the inpatient psychiatric facility. However, exact characteristics of the population at the facility were not shared by the facility and thus this projects' sample cannot be compared to the actual demographics at the time of implementation.

As mentioned in Chapter 5, 15 of the adolescents had total pre-BDI-II scores that were higher than 29. This put them in the severe depression range (Beck, Steer, & Brown, 1996) at the beginning of the program. Scores like this indicate these adolescents were experiencing increased psychological distress. Obtaining a higher score in an inpatient psychiatric setting supports that these adolescents needed a more acute environment at that time. The average total post-BDI-II score was 10, thus dropping the sample's distress rating from the severe range to the minimal range. Along with completing the COPE program, the adolescents spent their time in intense therapy sessions. Their levels of depression improved as a result of this multifaceted treatment program which, at this point, added the COPE intervention. COPE has not been used to treat other mental health disorders (for example, psychotic or personality disorders) and therefore adolescents with these diagnoses were excluded.

The results collected on inpatient adolescents are new to the literature. Previous studies of the COPE program did not address the inpatient setting. However, like the outcomes of the studies from school and outpatient settings, the inpatient results also showed effectiveness as an adjunct to treating the adolescents' depression.

Effectiveness of COPE

Cognitive-behavioral therapy (CBT) has been called the gold standard for treating adolescent depression. Manuals are often used to help deliver this method of treatment. The COPE program is based on these principles. Similar to other studies that have used CBT (Vitiello, 2009; Weersing & Brent, 2006), COPE teaches the participant about depression and how one can personally handle thoughts and feelings by using cognitive restructuring. It also teaches other skills like relaxation and effective communication.

A paired-samples *t*-test was conducted to evaluate the COPE program and its seven, one-on-one sessions and the impact that it has on BDI-II and PBS scores. The BDI-II scores indicated a significant decrease in the depression symptoms that the adolescents were experiencing from the beginning of the program to the end. The increased PBS scores indicated that the adolescents had a higher belief in themselves to be able to handle life and stressors in a more healthy way.

The main goal of this intervention was to see an improvement in the participants' health and depression symptoms. The statistically significant results related to improved health, coping, and mental health suggests an accomplishment in that area. While success in symptom improvement and coping cannot be attributed to the COPE program alone, it was not detrimental to the treatment carried out by the facility. In fact, evidence suggests it was likely complementary. The results of this project offer further support that the use of CBT based interventions are successful in the treatment of adolescent depression.

Acceptability of COPE

Previous studies using the COPE program (Melnik et al, 2007; Lusk & Melnyk, 2011) reported participant acceptability. For this dissertation project acceptability was assessed using evaluations from the participants and staff. The results of these evaluations are highlighted in the following paragraphs.

The results from the participants' evaluations were overwhelmingly successful and positive. Every single participant indicated that they found the program helpful and would recommend it to others. The narrative provided by the participants used to describe how the program helped them had affirmative feedback and even applicable descriptions.

The participants were asked to rank the individual sessions. All participants found the sessions to be helpful. The most helpful sessions were 3, 5, and 6. These sessions focused on coping with stress, dealing with emotions in healthy ways, and effective communication. Based on the results of individual session rankings, no session should be eliminated.

Many responses indicated how the participants had already started using the skills being taught in their daily lives i.e. "I really like the 'I' statements," "coping skills, guided imagery, and breathing techniques have been the most helpful," and "they actually help me in life situations like family meetings." Other responses included "taught me ways to deal with stress in healthier ways," "helped me to be a better me," and "learned different ways to help me cope with the problem instead of getting really upset." None of the participants stated they would add anything else to the COPE program.

The staff evaluations also included positive feedback on the program. They were also able to hear feedback from the participants and could see how participants applied some of the techniques in their sessions.

Feasibility of COPE

In a clinical setting time can be precious. One of the benefits of the COPE program is the brevity of the sessions. Each COPE session was designed to be efficient and delivered in 30-minutes. A previous study by Lusk and Melnyk (2011) tacked on this intervention to outpatient medication visits. This study showed improved symptoms and evaluations indicated the program as being a positive experience for the teens. This was true in this dissertation project as well. Sessions were easily delivered in the allotted time frame and even allowed for more than one session to be delivered at a time based on the participant's preference for that day. In the experience of this project, sessions 2 and 3 were often delivered together and seemed to flow well. The DNP student tried to gauge the amount of time that the adolescent would be inpatient to ensure that the seven sessions could be completed during the admission. This required daily contact with the adolescents and social workers to determine participant progress and day of discharge. The communication was successful in that only two adolescents (of the 28 that enrolled) were not able to finish all seven sessions before their discharge.

Staff indicated on their evaluations that they thought the ideal time frame to deliver an intervention would be 15-30 minutes or 30-45 minutes. An intervention like the COPE would easily work into their normal workday. The program is set up to be delivered exactly as indicated in the workbook with opportunities for open discussion with the participant.

Another benefit to this program is its ease of deliverability in the physical setting. During this project the one-on-one sessions occurred in a variety of places. Most often the COPE facilitator and the adolescent met in one of the consult rooms. If a consult room was not available then the lounge, outdoor patio, or the adolescent's room was utilized. The teen's bed was useful for the session that included abdominal breathing and/or guided imagery. The adolescents

preferred to be lying on their bed for this session. They were able to lie flat, close their eyes, and enjoy the exercise. The session that included guided imagery was a favorite and was mentioned often in the evaluations as a technique that the individuals found helpful. The overall impression from both the staff and participant evaluations were that the program is easy to use and is beneficial.

This intervention is feasible within the concepts of the Chronic Care Model (CCM). The CCM supports interventions that can be delivered via different disciplines and in different venues (Wagner et al., 2001). Further, the CCM model supports the active engagement of the recipient of care, and integral part of the COPE. The COPE program has been used in one-on-one and group sessions, in school, primary care, and outpatient mental health settings. This project shows the successful use of this intervention in an inpatient setting. Depression can be a chronic disease and the CCM can be used to help bridge the gap of treatment for adolescents with depression. Their treatment will continue even after they are discharged and hopefully the skills that they learned from their participation in the COPE program will follow them as well.

The staff indicated that the COPE program appeared easy to use and the time frame of the sessions seemed reasonable for deliverability. Despite this, time might still be a barrier. This intervention would be in addition to all of their other responsibilities. For the COPE program the DNP student had to have special training in order to deliver this intervention. Trainings are offered a few times a year at Ohio State University and at various conferences throughout the United States. The hospital might find it difficult to allow time away for staff to get this training and the associated costs related to this.

Strengths and Limitations

In any study there are strengths and limitations. The purpose of this dissertation project was to implement an evidenced-based intervention in a setting where it could be assessed for effectiveness, feasibility, and acceptability. This project did not include a control group, nor did it control for other factors at the implementation site.

According to the National Institute of Mental Health (2014) females are more likely to have depression than males. One strength of this project was that the participant sample was majority female. This sample reflected the typical group of patients at the inpatient psychiatric hospital, both by observation and verbal confirmation by staff members.

Another strength of this project was that it was well received by the entire staff. The nurses and mental health workers' comments were positive, supportive, and encouraging. They were also helpful in identifying potential participants. The staff also commented to the DNP student when they heard or saw the participant using some of the learned techniques from the COPE program. The overall theme of the staff evaluations was that the program was well received and seemed feasible to be implemented in their setting.

If the entire COPE program itself cannot be adopted, then at minimum, the staff can still highlight and teach some of the other techniques mentioned in the participant evaluations. Some new techniques that many of the teens mentioned as being new and helpful included "I" statements, effective communication, and guided imagery.

One limitation to this study would be the small sample size. Although in many of the other studies using COPE, the sample size was very similar, ranging from 15-23 (Melnyk, 2007; Melnyk et al., 2009; Lusk & Melnyk, 2011). This was a reasonable sample size for the given timeframe. Twenty-five subjects is the minimum number needed for most statistical tests. It took

seven weeks total for the DNP student to have 25 participants complete the entire COPE program. A broader evaluation from the other mental health workers and the nurses on the unit would have added to the evaluation of this project.

It was not in the scope of this project to control for the other forms of treatment that the adolescents would be receiving during their inpatient stay. Because of this it is not reasonable to assume that the improvement in patient's symptoms can be solely attributed to the adolescents' participation in this study.

Another limitation identified in the project was the use of the BDI-II. The BDI-II is a very common tool used to assess depression symptoms; however a more specific adolescent tool does exist called the Beck Youth Depression Inventory. The youth version is the tool Melnyk has used in many of her other studies to assess depression in adolescents. Other common depression questionnaires for adolescents include the Mood and Feelings Questionnaire, Patient Health Questionnaire, and Children's Depression Inventory. The decision was made to use the BDI-II because the hospital already owns rights to use it. The BDI-II resembles the youth version; however, at least one question on sexual activity was difficult for the participants to answer.

Influence of Findings at Project Site

Two common complaints about mental health treatment are access and time to treat. An evidenced-based treatment for adolescent depression like the COPE program can be utilized in a variety of settings. For this dissertation it was the first time implementing this intervention in an inpatient setting and delivering these sessions in a shorter time frame (delivering more than one session at a time and within one week as opposed to once a week for seven weeks).

The Promoting Action on Research Implementation in Health Services (PARIHS) model was used as a framework to guide the implementation of this project at the clinical site. The

PARIHS model is often used to help bring evidenced-based interventions to the bedside (Rycroft-Malone, 2004). The three elements of the PARIHS model (evidence, context, and facilitation) were used. First, evidence was gathered on CBT based interventions. The COPE program, as an evidenced-based intervention that had proven to be helpful to treat adolescents with depression was selected. Next, the context or environment in which the program would be implemented was examined. The setting of an inpatient psychiatric unit for adolescents would be a new implementation setting, but seemed a reasonable setting to try to implement the COPE program. The leadership team at the psychiatric hospital gave their approval and the creator of the COPE program agreed that this project would be worthwhile. Last, facilitation was utilized between the DNP student implementing the project and the support from the interdisciplinary team from the psychiatric hospital.

This project was successful for many reasons. The COPE program has robust evidence showing that this manualized CBT workbook is effective in treating adolescent depression. The COPE facilitator (DNP student) and the staff at the hospital were in consensus that this project filled a need at their facility. Also, the culture in which this project was implemented was supportive of a new idea and to evaluate its effectiveness.

This program was successfully delivered in this setting within the allotted time frame. Because of the unique nature of the intensive treatment that people receive during an inpatient stay, it was feasible to deliver all seven sessions of the workbook during the hospitalization period. Participants were able to learn the techniques and immediately start applying them to their lives.

The set-up and flow of the adolescent unit made it easy to find adequate space and time to deliver the sessions. Participants were often excused from group sessions to meet. Having

sessions that lasted no more than 30 minutes was convenient so that the adolescent never missed an entire group session.

For sustainability purposes at the site, the COPE program could be implemented in a group format, as Melnyk (2007; Melnyk et al., 2009) has done in prior studies. Focusing on techniques rated as being more helpful (guided imagery, positive thinking, and coping skills) might also be useful for the facility to consider.

Another option for the facility is to deliver sessions that the adolescents found the most helpful. The different people who lead the groups can use lessons similar to the COPE sessions. The difficulty in using the COPE workbook would be delivering sessions out of order, as many of these sessions build on previous sessions and often refer to skills used in previous sessions. Permission from Melnyk would be required before delivering the COPE program in any way other than how it was designed.

With the proper training a variety of staff could deliver the COPE sessions. Dr. Melnyk offers this training to licensed providers and students. This would be an easy and effective way for the staff to interact and aid in the treatment for the adolescents admitted to the hospital. Feedback from the facility personnel, suggest that staff from nursing would be interested in being taught how to deliver these sessions. Project sustainability is a key aspect of the dissertation project. This facilitator would be happy to stay involved with the implementation site to be a champion for the COPE program or a similar program. At this time contact has been attempted to ask Melnyk if the COPE program sessions can be used as individual session with some modification and to inquire about future training dates for COPE.

At this time there is no policy or procedure that implements the COPE program in the treatment plan for the adolescents. The DNP student will stay involved with the implementation

site as requested while they deliberate whether or not to pursue the program. The site will have results of the project to help them make their decision.

Implications for Practice

The COPE program is a quick, easy, and effective intervention for treating adolescent depression (Lusk & Melnyk, 2011; Lusk & Melnyk, 2013). The evidenced-based cognitive behavioral therapy, based on the principles of the Cognitive Theory of Depression (Beck et al., 1979) teaches and enhances coping skills and delivers other techniques to help the adolescent deal with their depression. The advanced practice nurse (APN) is an ideal person to deliver this therapy. It allows APNs to use their skill and knowledge to the full extent of their ability which includes diagnosing and treating patients with mental health disorders.

This program gives knowledge and skills to adolescents and empowers them to better deal with their emotional state. These skills can and should be used throughout life. The APN is in a unique position to deliver an intervention like this in a variety of settings. The APN can meet adolescents wherever they are, such as the primary care office, an inpatient setting, or school. Bridging the gap between medicine and nursing is crucial for APNs and is what makes them stand out. The skills that are taught by the APN will help the adolescent live a more healthy life.

This project focused specifically on adolescents aged 12-18 years. Interventions, such as COPE, that are age appropriate and then appropriately tailored to the individual will be most effective.

Depression is often a disease that is chronic in nature. The Chronic Care Model (Wagner et al., 2001) was one of the theoretical frameworks used in this project. One thing that the Chronic Care Model emphasizes is empowering individuals to be active participants in their own health. The COPE program teaches the teens the skills to help them manage their own thoughts

and feelings in healthier ways. This framework also helped provide the links to this specific disease and how depression needs to be addressed in a variety of settings. The COPE program provides adolescents the basic skills to help them deal with their depression now and provides them with tools to utilize when certain thoughts return in the future.

The ultimate goal for APNs is to function to their maximum capacity based on their skill and knowledge. Providing an intervention like the COPE program can easily be delivered in a variety of settings in which APNs work. This will allow them to provide timely, evidenced-based care.

The Essentials of Doctoral Education for Advanced Nursing Practice

The dissertation process is designed to utilize the essential competencies as identified by the American Association of Colleges of Nursing (AACN, 2006). These competencies are designed to make the DNP a well-rounded nursing professional. Along with the AACN's competencies, Chism (2013) described the different roles of the DNP. These roles include: clinician, leader, educator, advocate, scholar, and innovator. The following section will describe how these competencies and roles were utilized in the dissertation process.

The essential scientific underpinning for practice is demonstrated in this project by addressing issues related to adolescent mental health needs and the use of an evidenced-based practice intervention. This essential also correlates with the DNP role of clinician. Chism (2013) describes this role to include collaboration, credibility, compassion, and care coordination. There were many instances during the development of the dissertation that professional discussions occurred among different types of clinicians. The strong clinical background of the future DNP helped promote credibility to the project. Both compassion and care coordination occurred directly with the adolescents who participated in the evidenced-based COPE program by

working one-on-one with the adolescents and discussing the interaction with the appropriate individuals when warranted.

The next essential, referred to as organizational and systems leadership (AACN, 2006), coincides with Chism's DNP role of leader. This essential and role was demonstrated by planning, organizing, and implementing the project at the site. The successful implementation and completion of the project took strong leadership skills including communication and determination. Meetings with the leadership at the implementation site were used to educate and to obtain the acceptance of some of the key stakeholders. The DNP student spent four months at this site and was able to work with the adolescent group. During these months, relationships were made with various staff members. The staff was invited to a lunch where the project was described and additional support was garnered from the team. This took organization and education to properly inform staff of their role in the project. The organization was easy to work with and wants what is best for their patient population. The DNP student was honored to be able to implement such an innovative program at this site. After the completion of this dissertation the student will return to the site to share the results and work collaboratively with the staff to work on sustaining the COPE program or a similar CBT intervention.

Healthcare policy for advocacy in healthcare is another essential utilized in this project. Acting in the role of an advocate created an opportunity to raise awareness of the problem in a variety of venues and start speaking out about the troubling statistics regarding adolescent depression and lack of mental health care that is actually available. Educating the right people on the problem and identifying the need for the intervention is the first step in making a change. The education occurred at any opportunity, but primarily focused at the implementation site and the university. At the implementation site the leadership was very approving of this project. The only

barrier that the DNP student had to overcome at the site was the absence from the site between internship and project implementation, a period of about two years. During this time, having a presence would have been helpful to facilitate more of a relationship with the staff to start building trust.

The DNP role of a scholar was demonstrated by identifying a gap in knowledge and addressed through the extensive literature review and data analysis. The correlating essentials are called clinical scholarship and use of analytical methods for evidence-based practice and use of technology. This essential was highlighted by creating a poster about the dissertation project. The results of this project can be further disseminated through a scholarly presentation, a poster, and publication so that it can be shared with other members of the profession. Melnyk will also be used as a resource and will receive appropriate credit if the results of this dissertation project are published.

The roles of innovator and educator correlate with the essential inter-professional collaboration. This was best demonstrated by implementing and testing the COPE program in a setting that it has not yet been used. This created new information and more was learned about the feasibility and effectiveness of this program in another setting. This program could also be utilized by other mental health professionals after proper training. Another innovative idea for the use of the COPE program would be to use it in a more pro-active manner by offering the program before the adolescents show signs of any depression and thus in turn dealing with population health.

The essential for clinical prevention and population health was best demonstrated by focusing on the participants' age and mental health diagnosis. Adolescents are a unique subgroup of the population. Interventions and treatment are unique to their developing minds and bodies.

People who suffer from mental health problems are sometimes considered a vulnerable population. The curriculum of the COPE program is developmentally based and provides an evidenced based treatment option for teens suffering from a mental health disorder. The COPE program could be used as more of a preventative measure, along with its use to treat known depression. Ideally, depression is treated as soon as it is identified to help prevent future recurrences and subsequent co-morbidities. With a broader implementation of the project, future disease and comorbidities could be prevented.

Finally, the role of advanced nursing practice was demonstrated by a thorough assessment of the project. This included designing, implementing, and evaluating the evidence-based practice intervention at this new site. Using the PARIHS model facilitated translating an evidenced-based innovation using advanced nursing practice skills. The results from this implementation are new evidence for the success of the COPE program. By sharing the results of this project, the COPE program will be further assessed for its ease and effectiveness. The role of advanced nursing practice was also evident in the opportunities it created to empower nurses to take part in a project like this. During the implementation of this project the nursing staff was key. Discussions between the staff and the DNP student blossomed into how the nurses felt empowered to start projects that make them feel more involved in the treatment plan for the patients. It would be wonderful to see the nursing staff develop an innovative project.

Summary and Conclusions

The purpose of this dissertation project was to implement the COPE program in one-on-one sessions in an inpatient adolescent mental health hospital. This project tested the acceptability, effectiveness, and feasibility of the COPE program in this setting. Two main evaluation tools were utilized, the BDI-II and the PBS. These instruments were administered at

the start of the intervention and then again at the completion. Evaluations were also obtained from the participants and the staff. Statistically significant results were yielded comparing the BDI-II pre-COPE and post-COPE, thus showing improved depression symptoms. The results from the PBS were also statistically significant in showing improved health beliefs pre-COPE to post-COPE.

Overall, both the participants and staff had positive feedback regarding the implementation and helpfulness of this program. These evaluations helped answer the questions regarding acceptability and feasibility. Further projects like this could explore long term follow-up on how the participants are using or have used the skills that were taught to them in the COPE program. Another approach might be to proactively teach skills learned in the COPE program to help adolescents in preventing depression from occurring. A more specific adolescent depression scoring tool would also be recommended for future projects. For this dissertation, the DNP student was able to assess the problem, identify best practice, and implement an intervention with measurable outcomes. The first step toward sustainability of this project in this setting has begun with the identification of the effectiveness, acceptability, and feasibility of the COPE intervention.

APPENDIX A

Letter of Permission to Use COPE

Hi Lindsey,

I am delighted to give you permission to implement and evaluate my COPE program in an inpatient psychiatric unit in your DNP project.

I would greatly appreciate it if you can provide me with an abstract of your proposed work, including number of subjects that will participate in your project and the measures that you will assess pre- and post- COPE along with the timeline for your project.

I am happy to provide consultation to you as you conduct your DNP project.

Best wishes!

Warm and well regards,

Bern

Bernadette Mazurek Melnyk, PhD, RN, CPNP/PMHNP, FNAP, FAAN

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<http://millionhearts.hhs.gov/index.html>

APPENDIX B

Participant Information Tool

Participant Information

Note: All information obtained is confidential.

Directions: Please fill in the blank, or check the number of the item that best answers the question.

1. Today's Date:
2. Your age in years: _____
3. Gender:
 Male
 Female
4. Please check your ethnic background:
 White, not of Hispanic origin
 Black, not of Hispanic origin
 American Indian/Alaskan Native
 Asian/Pacific Islander
 Hispanic
 Multiracial
 Other
5. Whom do you live with? _____
6. Have you ever been diagnosed with a mental health problem?
 Yes
 No

If you answered yes to the previous question, what mental health problems have you experienced (select all that apply)?

- ADD/ADHD
- Anxiety disorder
- Bipolar
- Depression
- Eating disorder
- Post-traumatic stress disorder (PTSD)
- Other (please specify):

8. Are there any other things that you can think of that prevent you from having a healthy lifestyle?
___ Yes
___ No
9. **If you answered yes to the previous question, please describe what other things prevent you from having a healthy lifestyle:**
10. Check if any of the following events have happened to your family in the **past 12 months**:
- ___ Parent had marital separation
 - ___ Parent divorced
 - ___ Change in relationship with parent's live-in partner (break-up, moved apart, etc.)
 - ___ Birth of a sibling
 - ___ Your parent began working outside the home
 - ___ Your parent had a change in work hours (+/- 10 hours per week)
 - ___ Other adult household member began working outside the home
 - ___ Change in other adult household member's work hours
 - ___ Death of an immediate family member
 - ___ Death of a family pet
 - ___ Hospitalization or newly diagnosed significant illness of an immediate family member
 - ___ Moved to a new location
 - ___ Had a family member in jail or prison
11. Are there any activities that you used to be involved in that you no longer participate in (i.e sports, clubs, or organizations)? Please describe...
12. What kind of grades do you get in school?
- ___ Mostly A's
 - ___ Mostly B's
 - ___ Mostly C's
 - ___ Mostly D's
 - ___ Failing

13. How many hours a day do you sleep? _____. From ____ (when) to ____ (when) do you usually sleep?

This is a _____ (choose one answer from below) amount for me...

normal

less than normal

more than normal

14. Has your relationship with your family changed recently?

Yes

No

15. If yes please describe how your relationship has changed...

16. Has your relationship with your friends changed recently?

Yes

No

17. If yes please describe how your relationship has changed...

APPENDIX C

Personal Belief Scale

How do you view living a healthy lifestyle?

Please fill in the circle for your response. (*Mark one answer for each item.*)

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
I am sure that I will do what is best to lead a healthy lifestyle.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I believe that exercise and being active will help me to feel better about myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I know how to deal with things in a healthy way that bother me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I believe that I can reach the goals that I set for myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am sure that I can handle my problems well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I believe that I can be more active.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am sure that I will do what is best to keep myself healthy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can deal with pressure from other people in positive ways.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I know what to do when things bother or upset me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I believe that my family and friends will help me to reach my goals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am sure that I will feel better about myself if I exercise regularly.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am able to talk to my family and friends about things that bother or upset me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

APPENDIX D

Evaluation of COPE Program (Participant)

Please respond to the following questions to help Lindsey Jelsma BSN, RN, DNP Student improve the COPE course.

Overall, did you find the 7 COPE sessions helpful?

- Yes
- No

Please rate the helpfulness of the following COPE sessions.

0= Not at all helpful

1= A little helpful

2= Somewhat helpful

3= Moderately helpful

4= Very helpful

(Session 1) Thinking, Feeling and Behaving: What is the Connection?	0	1	2	3	4
(Session 2) Self-Esteem and Positive Thinking/Self-Talk	0	1	2	3	4
(Session 3) Stress and Coping	0	1	2	3	4
(Session 4) Problem Solving and Setting Goals	0	1	2	3	4
(Session 5) Dealing with your Emotions in Healthy Ways through Positive Thinking and Effective Communication	0	1	2	3	4
(Session 6) Coping with Stressful Situations	0	1	2	3	4
(Session 7) Pulling it all Together for a Healthy YOU!	0	1	2	3	4

If you found the COPE module sessions helpful, how were they helpful to you?

If you did NOT find the COPE module sessions helpful, how were they NOT helpful?

What new skills did you learn through the COPE sessions? (please check all that apply)

- Positive thinking
- The ABC's (antecedent, belief, consequence)
- Positive self-talk
- Staying in the present moment
- Goal setting
- Monitoring my emotions
- Seeing the cup "half full"
- Changing unhealthy habits
- Coping positively with stress
- Seeking help when I need it
- Setting goals
- Using the 4-step approach to problem solving
- Being thankful
- Practicing mental imagery
- Regulating my emotions
- Effectively communicating
- Practicing self-control
- Planning for how to respond to negative events
- Other (please specify):_____

Which of the skills learned in the COPE program are you currently using?(please check all that apply)

- Positive thinking
- The ABC's (antecedent, belief, consequence)
- Positive self-talk
- Staying in the present moment
- Goal setting
- Monitoring my emotions
- Seeing the cup "half full"
- Changing unhealthy habits
- Coping positively with stress
- Seeking help when I need it
- Setting goals
- Using the 4-step approach to problem solving
- Being thankful
- Practicing mental imagery
- Regulating my emotions
- Effectively communicating
- Practicing self-control
- Planning for how to respond to negative events
- Other (please specify):_____

Do you know friends who would benefit from the COPE program?

- Yes
- No

Would you recommend the COPE program to other students?

- Yes
- No

What other information should be included in the COPE sessions?

APPENDIX E

Script for Talking With Teens and Parents about the COPE Program

You are being asked to be a part of a program called COPE because you struggle with depression. The doctor referred you to this program because of your depression or mood disorder. Depression is a common problem that many teenagers face.

I and the rest of the staff here at Forest View are trained in caring for people with depression. We all understand the importance of treating mental health problems and can offer you a variety of treatments while you are here.

Everyone's experience with depression is unique. For some people, they may feel sad or down or as though they have nothing to look forward to. Others might describe a crabby mood. Others will lose interest in things that were once fun to them (for example: you may have loved to go the mall with your friends, and now it doesn't sound like fun anymore). Still others will have a hard time paying attention, a hard time sleeping or staying awake. Others will have changes in their appetite, or symptoms, like stomach aches that are very real but do not have a physical cause. You may also have low energy or feel that you are worth nothing.

It is hard to say what causes depression. We know it runs in families or is genetic, so if one or more of your family members has depression or anxiety, you are at risk. We also know females and those who are poor are more likely to have depression. People who are Hispanic or African American have more depression. The brains of people with depression may process information differently too. Some people refer to this as a "chemical imbalance". Last, people with depression may have a false view of the world, themselves and the future. This causes people to think about themselves, their work, and the future in a negative way. This is called the cognitive theory of depression.

The good news is that there are a lot of things that can be done to help teens who are depressed. These can be put into two groups. The first group is medication. Medications work with the chemicals in our brains to help improve depression. Your medical care team will decide if this is something that may help you and then discuss this with you.

The second option is counseling or therapy. You may have heard this referred to as "Going to counseling" or "Seeing a therapist." The most studied therapy for teen depression is Cognitive Behavioral Therapy or CBT. This therapy changes the way we think about what happens in our daily lives. This is also available to you.

As a treatment option, I am offering you the chance to be a part of a project through Grand Valley State University. This project has a student pediatric nurse practitioner, me, work with you through a CBT course while you are inpatient. This has worked well for teens with depression in other settings. This would involve working through a workbook daily, each session meets for about 30 minutes. There are seven lessons to work through. These sessions include lessons on how to identify negative thoughts, feelings or behaviors that may cause depression

symptoms in you. There is some brief homework that you would need to complete in the evenings. Because this is a study, this option involves no cost, but there is also no financial reward. If the COPE program sounds interesting to you I can provide you with more information. During this study, if at some point you/your child needs more care than I can provide, I will discuss my concerns with the other medical team caring for you/your child.

No matter which treatment you choose the providers at Forest View and I want to help you to become the healthiest you can be.

APPENDIX F

Script for Recruitment

There is a program being offered called Creating Opportunities for Personal Empowerment, or COPE. It has been used previously with depressed adolescents in schools, outpatient settings, and in primary care offices. This program would be delivered to you during your regularly scheduled day. This program is free to those teens that meet the criteria and decide to participate.

The program utilizes a workbook to deliver therapy. This workbook describes and teaches you ways to deal with stress. It teaches different coping skills in order for you to handle different situations better. There are seven sessions and each session lasts approximately 30 minutes.

The program is delivered by a doctor of nursing practice student. If this is something that you are interested in I can contact this student and she will meet with you and describe the program in more detail.

APPENDIX G

COPE Curriculum Content

By: Dr. Bernadette Melnyk, 2007

1. Session 1: Thinking, Feeling, and Behaving: What is the connection?
2. Session 2: Self-esteem and Positive Thinking/Self-Talk
3. Session 3: Stress and Coping
4. Session 4: Problem Solving & Setting Goals
5. Session 5: Dealing with Your Emotions in Health Ways through Positive Thinking and Effective Communication
6. Session 6: Coping with Stressful Situations

- Session 7: Putting It All Together for a Healthy YOU!

APPENDIX H

Permission to Contact

I agree to have my parent or guardian contacted regarding my desire to participate in this project.

Your name (please print): _____

Your signature: _____

Date: _____

APPENDIX I

Script for Phone Consent

Hello, my name is Lindsey Jelsma and I am calling you from Forest View Hospital in regards to an opportunity that your child has to be a part of a project. I am a Doctor of Nursing Practice Student from Grand Valley State University. I am working with some of the adolescents here at Forest View by using a workbook that teaches them coping skills to help them deal with their thoughts and feelings. This workbook has been used previously with other adolescents and has been studied and shown to be effective in helping adolescents deal with their depression.

This workbook is delivered in seven, 30-minute sessions. Participation in this project will not change the other care that will be delivered to your child. The workbook is called Creating Opportunities for Personal Empowerment or COPE. The session content includes: analyzing how thinking, feeling, and behaving is connected; self-esteem; stress and coping; problem solving and goal setting; and healthy ways to deal with emotions. During these sessions the adolescents will be given the chance to reflect on what they are learning and try to apply it to their lives. Homework is assigned after the session. This homework will be completed in the evenings during journal time that the patients have each night. This homework is then reviewed at the beginning of the next session.

Confidentiality will be maintained and any information collected on your child will be de-identified. The identifying information will be kept in a safe and locked office at the hospital.

As part of the project some general demographic information will be collected. The adolescents will also take a few evaluations before the workbook is started and then again upon completion of all seven sessions.

If you are interested in this opportunity for your child I will go ahead and read the consent form in its entirety, answer any questions you may have, and then have you talk to one other licensed provider because we are obtaining consent over the phone. Permission from your child will also be obtained using an informed assent process.

***READ INFORMED CONSENT DOCUMENT**

APPENDIX J

COPE Parent/Guardian Consent

Creating Opportunities for Personal Empowerment

Introduction:

This form gives you information about your teen being a part of the COPE (Creating Opportunities for Personal Empowerment) program. This form also records that you agree to allow your teen to be a part of this project.

Project Leader:

Lindsey Jelsma, BSN, RN, and Doctor of Nursing Practice Student will be the leader for this project. As a student at Grand Valley State University, I will be supervised by Andrea Bostrom, PhD, RN, PMHCNS-BC.

Program Description:

The purpose of this project is to evaluate how acceptable, feasible, and effective the Creating Opportunities for Personal Empowerment (COPE) program is in the one-on-one sessions in an inpatient setting with hospitalized adolescents who are depressed. If your teen is part of this project, your teen will have seven COPE program sessions over the course of their inpatient stay. The COPE program uses a manual to teach the teen skills to help with thoughts and feelings. After each session the teen will have the chance to practice these skills. The content of the COPE program will be given to your teen during 7 sessions, each lasting about 30 minutes.

As part of the project, your teen will be asked to fill out some surveys on teen beliefs and moods (for example: Depression) before the COPE sessions begin. The scores and answers on these surveys will be a part of the project, but will not have your teen's name on them. Your teen's surveys will be coded so that the leader can see if the scores change as a result of the COPE program. We expect it will take about 45 minutes each time your teen fills out the surveys. Some of the questions may be hard for your teen to answer. If this happens your teen is free to leave the answer blank. Your teen will be asked to fill out the same surveys again after he or she completes the COPE sessions.

The total amount of time it will take for your teen to take part in this project is roughly 5 hours and 30 minutes. Forty-five minutes to complete surveys at the start of the project. There are seven 30-minute sessions to complete the program. Then 45 minutes to complete the surveys at the end.

Who can or cannot be a part of the project?

In order for your teen to be a part of COPE he or she must be inpatient at this hospital. He or she must also be able to read and write English, and understand the content of the program.

Risks:

The surveys do not ask your teen about child abuse or neglect. As a nurse, by Michigan law, I must report any suspected or actual child abuse or neglect should that become evident during a COPE session.

When a new therapy is started, depression symptoms could get worse. Your teen will be watched closely for this.

It is also possible that your personal information could be accidentally released. Every effort will be made to avoid this. A copy of this form will be given to you and the original will be kept in a locked drawer at Forest View Hospital. Paper copies of completed tools, any other de-identified papers, and the encrypted thumb drive that will be used to store computer information will be stored in a locked cabinet in Kirkhof College of Nursing at Grand Valley State University for at least six years.

Benefits:

When a new therapy is started it is also likely that fewer depression symptoms will be seen. This program has been used by other teens in other places and has been shown to improve their symptoms of depression.

New Information:

You will be contacted if there is new information that might change your decision about your teen being a part of the COPE program.

Privacy:

Your teen's record will be kept as private as the law requires. The results of this study may be published as a whole, but your teen's name will not be used. As per the policy at Forest View Hospital, you can access your child's medical record per request.

You will be asked to sign release of information forms which allow me to read your teen's chart for project purposes only. The chart will be accessed to verify that your teen has a diagnosis of depression, are between the ages of 12-18, have no active psychosis, and have no history or current diagnosis of an eating disorder.

To comply with laws or for reasons related to this program, I, or my supervisor may share a copy of this consent form or records that identify you only with the Grand Valley State University Human Research Review Committee.

Choosing to Quit the Program:

Your teen's involvement in this project is voluntary. Your teen does not have to take part. If you choose not to have your teen take part in this program, or you want your teen to quit the program at any time, there will be no penalty. It will not affect your teen's care in this facility and he or she will still be a patient here. If your teen does not finish the program, the surveys completed at the start of the program will be kept in the project files as a way to look at the differences between those teens who complete and those teens who do not complete the program.

Costs and payments:

There will be no payment for participation in the project. There are no costs to you. Insurance will not be billed.

Payment for injury:

Having your teen in the COPE program does not give up your legal rights. However, if hardship results from this study, neither Grand Valley State University nor the doctor of nursing practice student/supervisor are able to give you any money, insurance coverage, or free medical care.

Informed Consent:

By signing this form, you are saying: 1) that you have read this form or have had it read to you, and 2) that you understand this form, the study, and the risks and benefits. The leader will be happy to answer any questions you have about the COPE program or this study. Lindsey Jelsma can be reached at jelsmal@mail.gvsu.edu or at work at 616-267-0079

This research protocol has been approved by the Human Research Review Committee at Grand Valley State University. File No. 14-134-H Expiration: April 14, 2015. If you have questions about your rights, or if you feel your teen has been placed at risk, you can contact the chair of the Human Research Review Committee, through Grand Valley State University at 616-331-3197.

Please read, fill out, and sign these pages if you are agreeing to have your teen take part in the COPE program and project.

Parental Permission

I have read (or have had read to me) the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I give permission for my teenager to be a part of in the COPE program/project. (A copy of this form will be given to you for your records).

Your teenager's first and last name (please print): _____

Your name (please print): _____

Your signature: _____

Date: _____

If consent was obtained over the phone, two licensed providers must sign below indicating that the consent was read aloud and the parent/legal guardian has agreed to let their teen participate in the COPE program and all questions have been answered.

Witness: _____

Witness: _____

Date: _____

If you have any questions about this study or wish to learn about the results of this study as a whole you may contact the project leader as follows:

Name: Lindsey Jelsma

Work Phone: (616) 267-0079

Email: jelsmal@mail.gvsu.edu

APPENDIX K

COPE Participant Assent

Creating Opportunities for Personal Empowerment

Introduction:

This form gives you information about being a part of the COPE (Creating Opportunities for Personal Empowerment) program. This form also records that you agree to be a part of this project.

Project Leader:

Lindsey Jelsma, BSN, RN, and a Doctor of Nursing Practice Student will be the leader for this project. As a student at Grand Valley State University, she will be supervised by Andrea Bostrom, PhD, RN, PMHCNS-BC.

Program Description:

The purpose of this project is to evaluate how acceptable, feasible, and effective the Creating Opportunities for Personal Empowerment (COPE) program is in the one-on-one sessions in an inpatient setting with hospitalized adolescents who are depressed. If you are part of this project, you will have seven COPE program visits over the course of your inpatient treatment. The COPE program uses a manual to teach you skills to help with thoughts and feelings. After each session you will have the chance to practice these skills. The content of the COPE program will be given to you during each of your 7 sessions, each lasting about 30 minutes.

As part of the project, you will be asked to fill out some surveys on beliefs and moods (for example: Depression) before the COPE sessions begin. The scores and answers on these surveys will be a part of the project, but will not have your name on them. Your surveys will be coded so that the leader can see if the scores change as a result of the COPE program. We expect it will take about 45 minutes each time you fill out the surveys. Some of the questions may be hard to answer. If this happens you are free to leave an answer blank. You will be asked to fill out the same surveys again after you complete the COPE sessions.

The total amount of time it will take for you to take part in this project is roughly 5 hours and 30 minutes. Forty-five minutes to complete surveys at the start of the project. There are seven 30-minute sessions to complete the program. Then 45 minutes to complete the surveys at the end.

Who can or cannot be a part of the project?

To be a part of the COPE study, you must be inpatient at this hospital. You must also be able to read and write English, and understand the content of the program.

Risks:

The surveys do not directly ask you about child abuse or neglect. As a nurse, by Michigan law, I must report any suspected or actual child abuse or neglect should that become evident during a COPE session.

When a new therapy is started, depression symptoms could get worse. You will be watched closely for this.

It is also possible that your personal information could be accidentally released. Every effort will be made to avoid this. A copy of this form will be given to you and the original will be kept in a locked drawer at Forest View Hospital. Paper copies of completed tools, any other de-identified papers, and the encrypted thumb drive that will be used to store computer information will be stored in a locked cabinet in Kirkhof College of Nursing at Grand Valley State University for at least six years.

Benefits:

When a new therapy is started it is also likely that fewer depression symptoms will be seen. This program has been used by other teens in other places and has been shown to improve their symptoms of depression.

New Information:

You will be contacted if there is new information that might change your decision about being a part of the COPE program.

Privacy:

Your record will be kept as private as the law requires. The results of this project may be published as a whole, but your name will not be used.

You will be asked to sign release of information forms which allow me to read your chart for project purposes only. The chart will be accessed to verify that you have a diagnosis of depression, are between the ages of 12-18, have no active psychosis, and have no history or current diagnosis of an eating disorder.

To comply with laws or for reasons related to this program, I, or my supervisor may share a copy of this consent form or records that identify you only with the Grand Valley State University Human Research Review Committee.

Choosing to Quit the Program:

If you choose not to take part in, or you want to quit the program at any time, there will be no penalty. It will not affect your care in this facility and you will still be a patient here. The surveys you filled out at the beginning of the program will be kept in the study files.

Costs and payments:

There will be no payment for participation in the project. There are no costs to you. Insurance will not be billed.

Payment for injury:

Being in the COPE program does not give up your legal rights. However, if hardship results from this study, neither Grand Valley State University nor the doctor of nursing practice student/supervisor are able to give you any money, insurance coverage, or free medical care.

Voluntary Assent:

By signing this form, you are saying: 1) that you have read this form or have had it read to you, and 2) that you understand this form, the study, and the risks and benefits. The investigator will be happy to answer any questions you have about the COPE program or this study. Lindsey Jelsma can be reached at jelsmal@mail.gvsu.edu or at work at (616) 267-0079

This research protocol has been approved by the Human Research Review Committee at Grand Valley State University. File No. 14-134-H Expiration: April 14, 2015. If you have questions about your rights, or if you feel you have been placed at risk, you can contact the chair of the Human Research Review Committee, through Grand Valley State University at 616-331-3197.

Please read, fill out, and sign these pages if you are agreeing to take part in the COPE program and project.

Permission:

I have read (or have had read to me) the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I give permission to be a part of in the COPE program/project. (A copy of this form will be given to you for your records).

Your name (please print): _____

Your signature: _____

Date: _____

If you have any questions about this study or you wish to learn the results of this study as a whole you may contact the project leader as follows:

Name: Lindsey Jelsma
Email: jelsmal@mail.gvsu.edu

Work Phone: (616) 267-0079

APPENDIX L

Staff Evaluation Tool

1. I had a chance to look over and review the COPE program?
 - Yes
 - No

2. What contents of the COPE workbook appeared easy to use?

3. What feedback did you hear from the patients regarding the COPE program?

4. How well does using a workbook with specific homework as a method of delivering therapy works in this setting?

5. What do you think is a realistic amount of time to deliver an intervention?
 - 0-15 minutes
 - 15-30 minutes
 - 30-45 minutes
 - 45-60 minutes
 - Greater than 60 minutes

How do you think the patients benefited from the COPE program?

APPENDIX M

COPE Staff Consent

Creating Opportunities for Personal Empowerment

Introduction:

This form gives you information about being part of the COPE (Creating Opportunities for Personal Empowerment) program and dissertation project.

Project Investigator:

Lindsey Jelsma, BSN, RN, and Doctor of Nursing Practice Student will be the investigator for this project. As a student at Grand Valley State University, I will be supervised by Andrea Bostrom, PhD, RN, PMHCNS-BC.

Program Description:

The purpose of this project is to evaluate the acceptability, feasibility, and effectiveness of implementing the Creating Opportunities for Personal Empowerment (COPE) program in the one-on-one sessions in an inpatient setting with hospitalized adolescents who are depressed. You will be a part of the recruitment for the seven COPE program sessions over the course of the participants inpatient stay. The COPE program uses a manual to teach the teen skills to help with thoughts and feelings. After each session the teen will have the chance to practice these skills.

As part of the project, you will be asked to fill out an evaluation form at the end of this project. The evaluation will be used to assess for feasibility and acceptability of the COPE program. The responses on these surveys will be a part of the project, but will not have your name on them. We expect it will take about 10 minutes to complete the evaluation.

Privacy:

The results of this project may be published as a whole, but your name will not be used.

To comply with laws or for reasons related to this program, I, or my supervisor may share a copy of this consent form or records that identify you only with the Grand Valley State University Human Research Review Committee.

It is also possible that your personal information could be accidentally released. Every effort will be made to avoid this. A copy of this form will be given to you and the original will be kept in a locked drawer at Forest View Hospital. Paper copies of completed tools, any other de-identified papers, and the encrypted thumb drive that will be used to store computer information will be stored in a locked cabinet in the Kirkhof College of Nursing at Grand Valley State University for at least six years.

Voluntary Consent:

By signing this form, you are saying: 1) that you have read this form and 2) that you understand this form and the study. The investigator will be happy to answer any questions you have about the COPE program or this project.

This research protocol has been approved by the Human Research Review Committee at Grand Valley State University. File No. 14-134-H Expiration: April 14, 2015. If you have questions about your rights you can contact the chair of the Human Research Review Committee, through Grand Valley State University at 616-331-3197.

Please read, fill out, and sign these pages if you are agreeing to take part in the COPE program and project.

I have read (or have had read to me) the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I give permission to be a part of in the COPE program/project. (A copy of this form will be given to you for your records).

Your name (please print): _____

Your signature: _____

Date: _____

If you have any questions about this study or you wish to learn about the results of this study you may contact the lead project investigator as follows:

Name: Lindsey Jelsma

Work Phone: (616) 267-0079

Email: jelsmal@mail.gvsu.edu

APPENDIX N

Approval from Grand Valley State University Human Research Review Committee



DATE: April 14, 2014

TO: Lindsey Jelsma, DNP

FROM: Grand Valley State University Human Research Review Committee

STUDY TITLE: [523149-2] Use of the COPE Intervention for Depressed Adolescents

REFERENCE #: 14-134-H

SUBMISSION TYPE: Revision

ACTION: APPROVED WITH

CONDITIONS APPROVAL DATE: April 14, 2014

APPROVAL EXPIRATION: April 14, 2015

REVIEW TYPE: Expedited Review

Thank you for your submission of materials for this research study. The Human Research Review Committee has approved your research plan application as compliant with all applicable sections of the federal regulations, Michigan law, GVSU policies and HRRC procedures. All research must be conducted in accordance with this approved submission.

Please insert the following sentence into your information/consent documents as appropriate. All project materials produced for participants or the public must contain this information.

This research protocol has been approved by the Human Research Review Committee at Grand Valley State University. File No. 14-134-H Expiration: April 14, 2015.

Please remember that informed consent is a process beginning with a description of the study and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the study via a dialogue between the researcher and research participant. *Federal regulations require that each participant receive a copy of the signed consent document.*

The following information and indicated revisions are required in order to maintain current approval with the HRRC. Failure to submit within 30 days, unless otherwise noted, constitutes non-compliance with HRRC procedures and may result in a suspension of approval.

1. **The first paragraph in Document 7, *Script for Obtaining Phone Consent* is inaccurate. The legal entity is Forest View Psychiatric Hospital or Forest View Hospital NOT Forest View Mental Hospital. Please revise in the consent form script, the consent form itself, and any other written information to be provided to participants.**
2. **Private health information (PHI) is being obtained from the chart and HIPAA requires all PHI records - including signed consent forms - be kept for a minimum of 6 years after completion of the study. Please revise the consent form to include this information. FYI, consent forms may be scanned and retained digitally and the paper copies destroyed after scanning.**
3. **The HRRC presumes that you intend to meet the requirements for the HIPAA authorization by embedding the informational requirements into the consent form. To do that, the specific PHI to be accessed in the medical chart must be explicitly identified in the consent form.**

Based on the inclusion criteria required, the HRRC infers that the following information will be accessed and should therefore be noted in the consent and assent form: Diagnosis of depression; Aged 12-18; No active psychosis; No history or current diagnosis of eating disorder.

Advisory Comments Not Affecting Approvability

1. **Your statement, “Appropriate non-parametric statistics (such as the Wilcoxin Matched-Pairs Signed Rank test) will be used on individual item scores (ordinal data)...” The HRRC advises that If individual variables are ordinal, merely by adding them together does not make them continuous.**
2. **The revised Application addresses effectiveness. The HRRC advises that without a control group, either concurrent or historical, effectiveness cannot be ascertained with this study design. Therefore, reference to effectiveness should be removed from all explanatory and consent documents.**
3. **It is unclear how feasibility will be determined. What criteria and cut-off decision points will be used to determine that this intervention was feasible or not feasible? The “helpfulness” questions in the Participant Evaluation may help reflect upon acceptability, but do not address feasibility.**

This approval is based on the HRRC determination that no greater than minimal risk is posed to research participants. This study has received expedited review, 45 CFR 46.110 category 5 and 6, based on the [Office of Human Research Protections 1998 Guidance on Expedited Review Categories](#).

Please note the following in order to comply with federal regulations and HRRC policy:

1. Any change to previously approved materials must be approved by this office prior to initiation. Please use the *Change in Approved Protocol* form for this submission. This includes, but is not limited to, changes in key personnel, study location, participant selection process, etc. See *HRRC policy 1010, Modifications to approved protocols*.
2. All UNANTICIPATED PROBLEMS and SERIOUS ADVERSE EVENTS to participants or other parties affected by the research must be reported to this office within 7 days of the event occurrence, using the UP/SAE Report form. If the adverse event includes a fatality, hospitalization, or security breach of sensitive information immediately notify the Human Research Review Committee Chair, Dr. Paul J. Reitemeier, 331-3417 AND Human Research Protections Administrator, Mr. Jon Jellema, in the Office of the Provost, 331-2400. See *HRRC policy 1020, Unanticipated problems and adverse events*.

3. All instances of non-compliance or complaints regarding this study must be reported to this office in a timely manner. There are no specific forms for this report type.
See HRRC policy 1030, Research non-compliance.
4. All required research records must be securely retained in either paper or electronic format for a minimum of 3 years following the closure of the approved study. This includes original or digitized copies of signed consent documents. Research studies subject to the privacy protections under HIPAA are required to maintain selected research records for a period of at least 6 years after the close of the study.
5. **At least 60 days prior to current approval expiration**, please submit a Continuing Review form:
 - Protocols that are active and open for enrollment require both the Primary Investigator and Authorizing Official to electronically sign the Continuing Review submission in IRBNet.
 - Protocols that are active for data analysis or long term follow-up ONLY require the Principal Investigator's signature but do not need to be further authorized.
 - A copy of the informed consent/assent form currently in use in the study must accompany the submission unless the study has been closed to enrollment, and active only for data analysis, for more than 1 year.

If you have any questions, please contact the Research Protections Program, Monday through Thursday, at (616) 331-3197 or rpp@gvsu.edu. The office observes all university holidays, and does not process applications during exam week or between academic terms. Please include your study title and reference number in all correspondence with our office.

APPENDIX O

Approval from Grand Valley State University Human Research Review Committee

Change in Protocol



DATE: April 24, 2014

TO: Lindsey Jelsma, DNP
FROM: Grand Valley State University Human Research Review Committee
STUDY TITLE: [523149-3] Use of the COPE Intervention for Depressed
Adolescents REFERENCE #: 14-134-H
SUBMISSION TYPE: Amendment/Modification

ACTION: APPROVE

D EFFECTIVE DATE: April 24,
2014

REVIEW TYPE: CHANGE IN PROTOCOL

Thank you for your submission of materials for this research study. **Your request to modify the consent forms and other documents has been APPROVED as described. You may implement the changes to your study as described.**

Your project retains its original expiration date of April 14, 2015. Please include a brief summary of these approved modifications in your continuing review application, which should be submitted at least 60 days prior to approval expiration.

If you have any questions, please contact the Research Protections Program, Monday through Thursday, at (616) 331-3197 or rpp@gvsu.edu. The office observes all university holidays, and does not process applications during exam week or between academic terms. Please include your study title and reference number in all correspondence with our office.

APPENDIX P



Letter of Approval from Immersion Site

September 30, 2013

RE: Internship for DNP project

Lindsey Jelsema,

We have reviewed your materials for the COPE internship project and have determined that this program would be suitable for our inpatient population. We understand that your goal is to teach the COPE program to 22-25 teens hospitalized with depression, anxiety, and mild mood disorders. We understand that you will be presenting the materials in a one-on-one session for 7 sessions.

Our expectation is that these one-on-one sessions will not interfere with regularly scheduled programs and groups that are a required part of the hospital treatment. Throughout the course of your internship, I will be the liaison not only between the hospital and your school program but between you and the treatment teams. If you should have any questions about this letter or have any changes to your proposed program, please contact me directly.

For our planning purposes, when you have been given permission by your IRB to begin the program, we will need 2 weeks notice in order to schedule a brief orientation to the facility. Given the length of time and exposure to children and adolescents, we do require a background check and fingerprinting for students prior to beginning. The results are usually received within 10 days. For more details, please contact me directly at 954-3130.

Sincerely,

Kristin Mecklenburg, MA-LLP

Director of Clinical Services

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