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PRIMARY CARE PROVIDER ATTITUDES TOWARDS ADOPTION OF EVIDENCE BASED PRACTICE: INDICATORS OF ACCEPTANCE TOWARDS BIBLIOTHERAPY

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PRIMARY CARE PROVIDER ATTITUDES TOWARDS ADOPTION OF EVIDENCE BASED PRACTICE: INDICATORS OF ACCEPTANCE TOWARDS BIBLIOTHERAPY

By

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ABSTRACT

PRIMARY CARE PROVIDER ATTITUDES TOWARDS ADOPTION OF EVIDENCE BASED PRACTICE: INDICATORS OF ACCEPTANCE TOWARDS BIBLIOTHERAPY

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The rising prevalence of depression is straining the skeletal mental health systems in rural communities, resulting in a majority of patients receiving management for their depression solely by their primary care providers. However, providers need to be empowered with evidence-based resources to provide adequate care beyond pharmacotherapy exclusively. Bibliotherapy, or the prescription of books for the treatment of disease, is readily used by psychologists but less incorporated into the traditional medical model of patient care. This small pilot study provided primary care providers in a rural area complimentary copies of the self-help text *Feeling Good* (Burns, 2009) to incorporate into their care of mild to moderately depressed patients as they saw fit. Texts were provided with brief education. This scholarly project evaluated the self-reported prescribing practices and utilized the Evidence-based Practice Attitude Scale (EBPAS) tool developed by Gregory Aarons. There was no correlation found in EBPAS pre intervention scores and use of bibliotherapy, or the use of bibliotherapy and post intervention EBPAS scores. Sex, age range, years in practice, educational background, and number of depressed patients/month have the largest effect on EBPAS scores and bibliotherapy use. Findings were limited due to small sample size. Future studies with a larger sample size can yield more robust results of statistical significance that can better elucidate how provider attitudes influence the adoption of bibliotherapy.

DEDICATION

This scholarly project is dedicated to my parents, Nick and Cathy Dennis. They have modeled a tireless work ethic for the entirety of my life, which I strive to match. They have also demonstrated outstanding resilience when faced with the unexpected events life can bring, which I often reminded myself of when I experienced personal difficulties during this program. My success in completing this degree is just as much theirs. I will forever be grateful for their confidence in me.

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Chapter One

Depression has been identified by the World Health Organization (2017) as the third leading cause of global disease burden; it is projected to be the leading cause by 2020. Quickly becoming the most common mental health disorder, depression is affecting nearly one in 10 adults each year (Pardini et al., 2014). Common estimates suggest that around 90% of all those with mental health problems only receive treatment in primary care (Brewster, Sen, & Cox, 2012). These estimates bolster the need for alternative treatment options and training for advanced practice nurses. The need for creative and effective treatment modalities coupled with the limited amount of mental health resources found in many rural areas, has pushed researchers to study non-pharmacological treatment options, including bibliotherapy.

Though rural residents do not have a statistically higher incidence of depression, they are considered especially vulnerable to depression (Brossart et al., 2013). Rural residents are more likely to have a chronic health condition, report poor health, lack health insurance, and live in poverty (Stamm, 2003). Gamm, Stone and Pittman (2003) estimate that one third of rural counties lack any mental health professionals, with even fewer offering bilingual services. Thus, services that exist in such areas are regularly described "as disjointed and lacking in consistency" (Brossart et al., 2013, p. 252). The need for this population to travel greater distances for appropriate mental health services leads to reduced outpatient visit rates and an increased probability of hospitalization (Brossart et al., 2013). Those suffering from depression often rely on their primary care providers for management of their condition.

Traditional depression treatment often involves the prescription of psychotropic medications, which can be both dangerous and expensive. Side effects range from sexual dysfunction to fatigue and sleepiness, even increased acts of self-harm (Naylor et al., 2010). Evidence suggests that for some, sexual dysfunction may be a long-term and irreversible side effect after discontinuation of antidepressants (Csoka, Csoka, Bahrick, & Mehtonen, 2008). Studies have linked the use of antidepressants to an increased risk of obesity, diabetes, and stroke (Patten et al., 2009). Side effects and deaths increase when antidepressants are prescribed to patients on other medications (Naylor, 2008). Acts of deliberate self-harm have also been consistently associated with antidepressants and have led to FDA warnings (Naylor, 2008). Most alarming is the possibility that antidepressant medications may cause irreversible biochemical changes that can predispose some patients to chronic depression (Naylor, 2008). These symptoms coupled with unimproved or worsening symptomology are related to poor adherence to antidepressant medication regimens in the primary care setting (Naylor, 2008).

Consideration of these risks and compliance issues highlights the need for exploration of alternative approaches that can be delivered in rural primary care settings. Primary care physicians and advanced practice nurses are increasingly challenged with the management of depressed individuals and frequently called upon to do so with minimal resources (Brewster et al., 2012). Affording providers with increased mental health resources in the primary care setting can lead to increased provider satisfaction and patient access (Vickers et al., 2013). Moreover, specialty care access for more complex patients would be enhanced if patients with lower severity mental health problems could

have their care managed in the primary care setting (Pomerantz, Cole, Watts, & Weeks, 2008).

With the national push towards managed care, financial costs are readily considered as a component of a treatment's efficacy. Cost-Benefit analyses have demonstrated that cognitive-behavioral interventions are at least as cost-effective as antidepressant prescriptions (Antonuccio, Thomas, & Danton, 1997). Additionally, integration of psychological treatment interventions into primary care settings can result in the reduction of overall medical expenditures (Pallak, Cummings, Dörken, & Henke, 1993). However; it is understandably impractical for providers in a primary care setting to provide psychotherapy for depression (Naylor et al., 2010). This impracticality is where the use of bibliotherapy stands to improve patient care. For just $6.00, a copy of *Feeling Good: The New Mood Therapy* by Dr. David Burns (2009, hereafter referred to as *Feeling Good*) can be purchased. Following prescription from a provider, the text can facilitate patient insight into their depression and effectively manage their condition. Prior research has concluded that physicians possess positive attitudes regarding writing non-pharmacological or "green prescriptions" for behavior change, e.g. exercise, and that patients benefit from such prescriptions (Swinburn, Walter, Arroll, Tilyard, & Russell, 1998).

Perhaps best defined by researchers Moldovan, Cobeanu, and David (2013), "… bibliotherapy refers to self-managed interventions that are based on validated and specific written materials and are generally facilitated by a healthcare professional" (p. 483). However, its use has not been well established with primary care providers and is more traditional utilized by psychologists (Floyd, 2003). Though the use of bibliotherapy for

the treatment of mental disorders can be dated back to the early 1800s, most primary care providers have not heard of bibliotherapy, and, therefore, have not considered prescribing it (Levin & Gildea, 2013). Whereas "a sizable majority of psychologists utilize some form of bibliotherapy, with experienced practitioners using bibliotherapy more frequently than their less seasoned colleagues." (Dysart-Gale, 2008, p. 35) Bibliotherapy prescriptions from primary care providers can provide instant, cost-conscious, noninvasive treatment without the threat of stigmatization that may accompany seeking more formal mental health treatment (Gregory, Schwer Canning, Lee, & Wise, 2004).

A multitude of books have been identified as beneficial for mental health disorders. One such text, *Feeling Good* (Burns, 2009), is regularly utilized for the bibliotherapeutic treatment of depression (Pardini et al., 2014). This work guides readers through an independent form of cognitive behavioral therapy (CBT). CBT traditionally provides instruction and encouragement to the patient, in order to promote psychosocial strength, coping, and problem solving skills (Songprakun & McCann, 2012). Burns walks readers through a 10-part program which entails the following components:

> …self-assessment for depression, anxiety, and relationship satisfaction; didactic instruction on the core principle that you "feel the way you think" and, furthermore, that bad feelings often arise from distorted thinking; exercises on identifying and disputing distorted thinking; instruction and practice on additional techniques such as cost-benefit analysis and examining the evidence; practice with more advanced cognitive techniques including the acceptance paradox; practice in identifying and modifying self-defeating beliefs; cost-benefit analysis of beliefs about self-esteem; identification and correction of perfectionism;

> analysis of procrastination and prescriptive help with it; and ongoing practice with all of the above ingredients. (Gregory et al., 2004, p. 275)

Since the initial publication of *Feeling Good* in 1980, numerous studies have been conducted featuring this self-help manual. In contrast to traditional pharmacological options, the use of bibliotherapy poses no risk of side effects to patients.

The growing body of bibliotherapy research lends significant credibility to its prescriptive use by both psychologists and physicians. Naylor et al. (2010) demonstrated that a behavioral prescription for *Feeling Good* (Burns, 2009) was as effective as standard care (which commonly involved antidepressant medication and/or referral to psychotherapy) to decrease measures of depression and dysfunctional attitude. This data is supported by the most recent meta-analyses of cognitive bibliotherapy for depression which yielded a positive effect size of 0.77 from 20 outcome studies (Gregory et al., 2004). Despite the positive research supporting its use, bibliotherapy is simply not being used by primary care providers in the United States.

It is apparent that facilitating bibliotherapy into practice is worthwhile (Brewster et al., 2012). Utilizing evidence-based practice to create policy does not need defending, but its natural progression from research into reality needs to be catalyzed. Advanced practice nurses, physician offices, and community health centers need a plan to address the growing mental health needs of patients that has proven to be efficient, and bibliotherapy may be just that. However, facilitation of evidence-based practices (EBPs), including bibliotherapy, may be limited or facilitated by provider attitudes toward the adoption of new treatments, interventions and practices (Aarons et al., 2010). The aim of this DNP scholarly project is to evaluate the self-reported prescribing practices and

Evidence-based Practice Attitude Scale (EBPAS) scores before and after providing free access to the text *Feeling Good* (Burns, 2009) and written explanation of bibliotherapy to a group of primary care providers managing the care of mild to moderately depressed individuals in a rural area. EBPAS was created in accordance with Ajzen's theory of planned behavior which posits that attitudes (a person's positive or negative evaluation of performing the behavior), subjective norms (a person's perception of the social pressures put on them to perform or not perform the behavior) and perceived behavioral control (a person's confidence in their ability to perform a behavior, often referred to as self-efficacy) influence one another; and together shape a person's intentions and behavior (Ajzen, 1991). EBPAS scores were evaluated for a correlation to a change in prescribing practices. Additionally, post EBPAS scores were evaluated for change to see if an opportunity to utilize bibliotherapy influenced future attitudes towards the adoption EBPs entirely. For this DNP Scholarly Project, there were four research questions:

1. Do EBPAS scores predict adoption of bibliotherapy (BT)?
2. What provider characteristics influence EBPAS scores?
3. What provider characteristics associate with bibliotherapy use?
4. Does opportunity to participate in an evidence based scheme (bibliotherapy) influence EBPAS scores?

Chapter Two

Depression

According to the World Health Organization (WHO, 2017), more than 300 million people worldwide are affected by depression in varying intensities. Symptomology of depression varies greatly, but often includes fatigue, hopelessness, and unease (Songprakun & McCann, 2012). Major depression holds a recurrence rate estimated at 80%-90%, with each recurrent episode carrying a 10-15% risk of chronicity (McKendree-Smith, Floyd, & Scogin, 2003). Depression is projected by the WHO (2017) to become the leading cause of global disease burden by 2020. Often considered a serious health condition when long-lasting or severe in intensity; at its worst, depression can result in suicide. Presently, over 800,000 suicides occur yearly (WHO, 2017). In addition to the tremendous cost of human life, cost-of-illness research has concluded that depression is associated with a massive economic burden – tens of millions of dollars in the U.S. alone each year (Wang, Simon, & Kessler, 2003).

This burden is largely attributed to lack of work productivity secondary to the psychosomatic and physical manifestations of depression. The existing body of literature on the subject indicates that depression is strongly correlated with numerous economic burdens related to impaired work performance (Wang et al., 2003). The underuse of standard depression treatments compounded by additional treatments lacking quality review is further associated with the economic toll. Unfortunately, enhancing outreach and implementation of quality depression programming has not been widespread due to numerous barriers at the level of primary care providers, insurance, and healthcare systems (Wang et al., 2003).

Traditional treatment approaches for depression in primary care involve pharmacotherapy as a first-line intervention. However, with psychotropic medication come a number of risks and side-effects. Selective serotonin reuptake inhibitors (SSRIs) are often the medication of choice for a patient presenting with depressive symptom with side effects including: agitation, sleep disruptions, and sexual dysfunction (Naylor et al., 2010). It is possible that sexual dysfunction may be a long-term irreversible side effect for some patients, even after discontinuing a SSRI (Bahrick & Harris, 2009). A wide-array of undesirable cognitive and physical symptoms have also been reported by people who responded positively to antidepressant treatment, including apathy, inattentiveness, forgetfulness, word-finding difficulties, mental slowing, sleepiness, sedation, and even impaired driving ability (Naylor et al., 2010). Even discontinuation of antidepressants can result in substantial withdrawal symptoms for many patients and there exists a possibility of irreversible biochemical changes that predispose patients to chronic depression despite discontinuation (Fava, 2002). Lastly, (Fournier et al., 2010) found in their recent meta-analysis that antidepressants did *not* show clinically significant improvements over placebo treatment, except for severely depressed patients, who comprise less than one third of patients for whom such medication is actually prescribed. Though risks exist in initiation of pharmacological management of depression, the larger issue is the lack of mental health experts available to treat patients in our country.

Alarmingly, one third of rural counties in the United States lack *any* health professionals who can address mental health issues (Brossart et al., 2013). Thusly, a majority of patients, around 90% of all those with mental health problems only receive treatment in primary care (Brewster et al., 2012). Rural residents are characterized as a

particularly vulnerable population to depression due to confounding characteristics, such as: poverty, chronic disease, lack of health insurance, poor health, isolating effects of neighborhood stability, decreased social support due to younger cohorts migrating to urban areas, and an overly segmented and thinning network of mental health services (Brossart et al., 2013; Scogin, Moss, Harris, & Presnell, 2014). Mention of antidepressants in primary care progress notes occurs in over 7% of *all* visits in outpatient settings (Naylor et al., 2010). The burden of managing depression is increasingly being shouldered by primary care providers, some of whom practice in rural counties that lack any kind of specialty mental health services to consult or refer patients for treatment (Brossart et al., 2013).

It has been established that expanding integrated mental health services can result in improved staff and provider satisfaction in the primary care setting (Vickers et al., 2013). Non-pharmacological interventions need to be explored given the poor adherence to antidepressant medication often found in primary care settings due to side effects, lack of improvement or even worsening of symptoms (Naylor et al., 2010). Primary care is an obvious target for increased use of bibliotherapy given that approximately half of all cases of depression are ultimately managed by general health practitioners (Moore, 1997). Collectively, these insights underscore the need to investigate and diminish barriers to proven efficacious therapies in the management of depression.

Bibliotherapy

Books have long been believed to help human needs, an epigraph on the library of Alexandria from around 300 BC reads ‘Medicine for The Mind’ (Jack & Ronan, 2008). Bibliotherapy, or the prescription of books for the treatment of disease or as a means of

healing, can be dated back to the "moral therapy" movement in the early 1800s that sought to provide more enlightened asylum care for those suffering from psychiatric disorders (Levin & Gildea, 2013). By the early 1900s, bibliotherapy was most commonly managed under the care of hospital librarians who instructed patients to read specific materials (McKnight, 2014). Though poetry and fiction are still used in many models; bibliotherapy today is often used as a means to present cognitive behavioral therapy to patients (Levin & Gildea, 2013; McKnight, 2014).

Cognitive behavior therapy (CBT) is a structured therapeutic approach that lends itself to the bibliotherapy format (McKenna, Hevey, & Martin, 2010). The foundation of CBT is that one's depressed moods and thoughts are perpetuated by maladaptive thinking and that revision of these thought patterns is necessitated to gain improvements in mood (Floyd, Scogin, McKendree-Smith, Floyd, & Rokke, 2004). Structured activities provided in bibliotherapeutic texts can be assigned as "homework" for the patient to promote mastery of information and ultimately use of modified patterns of thought (McKenna et al., 2010). It is impractical for providers in primary care to deliver psychotherapy, but a behavioral prescription for an empirically supported text to deliver components of cognitive-behavior interventions is indeed reasonable (Naylor et al., 2010).

Several government agencies have implemented models based on components of bibliotherapy. In 2004, the US National Library of Medicine (NLM) encouraged the use of preprinted pads and a toolkit promoting their program (McKnight, 2014). This referred patients to MedlinePlus in an effort to direct patients toward quality healthcare resources. Launched in 2013, the United Kingdom has adopted a nationwide

bibliotherapy program, known as “Books on Prescription” which connects patients to the existing library infrastructure and encourages general practitioners to prescribe from a list of specific self-help books to bolster treatment for a variety of mental health disorders (McKnight, 2014). A similar model of library-based self-help bibliotherapy was successfully integrated within a family practice setting in a rural community in Canada with success (Tukhareli, 2014). The National Institute for Health and Clinical Excellence (NICE) first included bibliotherapy in their stepped care model in 2004 (Tukhareli, 2014). Stepped care models in medicine are created to encourage providers to begin with the least expensive/invasive intervention possible and move upward in cost/invasiveness if needed to achieve therapeutic goals. In regards to mental health, stepped-care can ensure those with common mental-health problems, like mild depression, do not burden treatment options like psychotherapy when an intermediate option like supported self-management may be sufficient (Tukhareli, 2014). The United States Department of Veterans Affairs (2015) has also acknowledged the efficacy of bibliotherapy by establishing a research panel and publishing a guide for clinicians and patients which outlines text and internet recommendations for a number of diseases including: anger, insomnia, substance abuse, schizophrenia, PTSD, trauma, depression, anxiety, and bipolar disorder.

Considering the robust governmental backings, it is perhaps unsurprising to hear that bibliotherapy for the treatment of depression in primary care has been found to compare favorably to pharmacological management. Over the past three decades several dozen empirical single studies and meta-analyses have been conducted on the value of cognitive bibliotherapy for the treatment of depression (Gregory et al., 2004).

Songprakun and McCann (2012) completed a randomized controlled trial with 54 outpatients in Thailand. Participants were assigned to an intervention group consistent of a self-help manual in addition to standard care, and a control group that solely received standard care. Statistically significant differences in favor of the intervention group were seen in levels of psychological distress, tiredness, hopelessness, and restlessness and the significant differences persisted or were furthered at the one month follow-up. Songprakun and McCann (2012) work affirms the benefits of bibliotherapy in people with moderate depression if incorporated as an adjunct to standard care and treatment.

In a 2010 study conducted by Naylor et al. (2010) 38 patients were seen by six trained family physicians and were randomized to receive usual care or behavioral prescription. Both treatment groups demonstrated statistically significant improvements in depression symptoms and increases in quality of life (Naylor et al., 2010). The book used in this study was *Feeling Good* by Dr. David Burns (2009). A similar study with the same text was conducted by Moldovan, Cobeanu, and David (2013) in which 96 mildly depressed young adults were placed in immediate treatment with bibliotherapy, delayed treatment, placebo, and no treatment groups. It was found that automatic thoughts, dysfunctional attitudes and irrational beliefs showed clinically significant improvement in the cognitive bibliotherapy group and were maintained at three-month follow-up evaluation (Moldovan et al., 2013). In one of the more historical studies it was found that *Feeling Good* was effective treatment for most (66%) of participants, and for those who did not improve it was still benign (Scogin, Jamison, & Gochneaur, 1989). Furthermore, treatment gains for mild to moderately depressed individuals were maintained at their six-month and two-year follow-ups (Scogin et al., 1989).

Multiple other studies on bibliotherapy allow for meta-analyses to be conducted which combine diverse studies quantitatively by effect sizes. Febbraro and Clum (1998) completed a meta-analysis of 13 studies that found that self-regulatory treatment was significantly better than no treatment at all and often more effective when administered on an individual basis. Generally effect sizes around 0.20 are considered small, 0.50 are viewed as moderate, and in the area of 0.80 are considered large (Gregory et al., 2004). Gould and Clum (1993) conducted the first meta-analysis of self-administered treatments and reported an effect size of 0.74. for three depression bibliotherapy studies. In the first meta-analysis of bibliotherapy specifically for depression conducted by Cuijpers (1997), six studies (three of which were in the Gould and Clum meta-analysis) yielded a large mean effect size of 0.82 (with a 95% confidence interval of 0.50-1.15). In another, more impressive meta-analysis of 17 similarly structured studies completed by Gregory et al. (2004), bibliotherapy for depression demonstrated a large effect size of 0.77 (with a 95% confidence interval of 0.61-0.94).

One of the most significant appeals of bibliotherapy is the lack of side effects noted with this treatment option. Additionally, bibliotherapy lends itself to application by providers in rural areas, for patients that wish to avoid the stigma of seeking mental health treatment, and in instances to bridge care for those that are on waiting lists for psychotherapy (Gregory et al., 2004). In one study by Rapee, Abbott, and Lyneham (2006) bibliotherapy eliminated the need for therapy 12 weeks later amongst 20% of patients on a waiting list for psychotherapeutic treatment of anxiety disorders. Bibliotherapy is also inexpensive, noninvasive, associated with high patient acceptability, has low relapse rates, high adherence rates, and no rebound effects when treatment ends

(McKenna et al., 2010). Moreover, bibliotherapy has provided a means for patient empowerment, increasing patient responsibility in treatments and ultimately control over their depression by developing insight and awareness into their negative thoughts and emotions (Floyd et al., 2004). Providing a self-help book is received as an endorsement by the patient and directly communicates a professional's confidence in the efficacy of the text. Portrayal of hope has been identified as a primary factor for improvement in psychotherapy (McKendree-Smith et al., 2003).

This being said, bibliotherapy requires a level of attention and motivation that are often lacking in seriously depressed individuals, isolating this treatment approach to those suffering from depression in a lesser severity (Gregory et al., 2004). Additionally, the literacy level of some regularly recommended texts has been found to be too high (Chamberlain, Heaps, & Robert, 2008). Participants in bibliotherapeutic schemes with lower education levels have shown higher discontinuation rates (McKendree-Smith et al., 2003). Significant suicidal intent should be considered exclusionary for management with bibliotherapy solely, as these patients require closer monitoring. Such disadvantages and exclusions must be discussed with the patient in addition to the potential advantages of this treatment modality. The entirety of this patient conversation necessitates a certain finesse to ensure that bibliotherapy is presented as a viable treatment option and to guarantee that they do not feel slighted from a more superior form of treatment (i.e. medication or psychotherapy) (Chamberlain et al., 2008; McKenna et al., 2010).

Feeling Good (Burns, 2009) is the book utilized in this project to provide bibliotherapy to primary care patients suffering from mild to moderate depression.

Feeling Good (Burns, 2009) has a sixth grade reading level and in previous studies has been rated as 'highly interesting' by participants (Scogin et al., 1989). Frequently cited in other bibliotherapy research, this publication was written by a psychiatrist using the foundations of cognitive behavioral therapy to create a 10-part program. This book includes elements on self-assessment for depression, instruction on how to "feel the way you think", and aides in identification of distorted thinking and associated bad feelings that arise from it by a variety of exercises, cost-benefit analysis of self-esteem beliefs and modification of self-defeating beliefs. The handbook provides repeated practice after didactic instruction on these concepts through various worksheets and exercises that can be easily completed by a motivated patient in increments. When utilized in primary care, bibliotherapy can provide practitioners with feedback from the recipients themselves in terms of monitoring progress (McKenna et al., 2010).

Evidence Based Practice Attitudes

One of the five core-competencies identified by the Institute of Medicine's (2003) report regarding health professional education was *evidence-based practice*. A complex concept, evidence-based practice (EBP) is considered a problem solving approach to health care needs. EBP comprises both the best scientific evidence available in published research and experiential evidence contributed by provider-patient relationships (Pugh, 2012). Initiatives to incorporate EBP into all realms of medicine share the desired commonalities to improve efficacy and efficiency. EBP ensures health care providers use factual data "to promote optimal outcomes or equivalent care at lower cost or in less time and to promote patient satisfaction and higher health-related quality of life" (Pugh, 2012, p. 5).

The process of translation of evidence *into* practice is historically slow, it has been estimated that it can take as long as 17 years for new research to become incorporated into clinical practice (Balus & Boren as cite in Dearholt & Dang, 2014). Facilitation of evidence based practice is a problem that nurses are uniquely poised to handle as the largest group of health professionals in our country and frequent leaders on the interdisciplinary care team. Consideration of health care provider attitudes is one critical component in the identification of barriers that may be maintaining distance between evidence and clinical practice (Aarons, 2004). For any evidence-based scheme to be effectively disseminated and implemented into a community, an analysis of provider attitudes toward a specific concept, EBP practice in general, and details of current practice is needed. The Evidence-Based Practice Attitudes Scale (EBPAS) was initially created to evaluate mental health provider attitudes toward the adoption of EBP in the community setting (Aarons, 2004). McKenna et al. (2010) found that though the majority of general practitioners expressed enthusiasm towards bibliotherapy, the extent to which it was implemented varied widely; the aim of this project is to identify the role of provider attitudes in this trend.

Theoretical framework: Ajzen's theory of planned behavior

Ajzen's theory of planned behavior looks to predict and explain human behavior in specific contexts (Ajzen, 1991). The instrument utilized in this scholarly project, EBPAS, was created in accordance with Ajzen's theory of planned behavior. This theory posits that attitudes, subjective norms, and perceived behavioral control influence one another; and together shape a person's intentions and ultimately becomes a predictor of their behavior.

The first component in Ajzen's model is attitudes, specifically a person's *attitude toward the behavior.* This refers to the degree of how favorable or unfavorable the person evaluates the behavior in question. Application of this component of the theory in this study hypothesized that a positive evaluation of the provider's attitude toward bibliotherapy initially would influence their behavior or use of bibliotherapy in the study.

The second antecedent in Ajzen's model is subjective norms, which refers to the person's *perceived social pressure to perform the behavior.* Application of this component of the theory in this scholarly project was completed by questions on the EBPAS tool, including: How likely are you to adopt a therapy if it was required by your supervisor? Or your state?

The third component influencing intention in Ajzen's theory is *perceived behavioral control*, which refers to the perceived ease or difficulty in completing the behavior and is thought to be formed from both past experiences and consideration of future difficulties in performing said behavior. Perceived behavior control is "concerned with judgments of how well one can execute courses of action required to deal with prospective situation" (Ajzen, 1991, p. 183). In this scholarly project, this was explored through the questions: How likely would you be to use this therapy if it was intuitively appealing? Or if you had adequate training on how to implement said therapy?

Ajzen proposed that, generally, the more favorable the attitudes, subjective norms, and perceived behavioral control, the stronger an individual's intention to engage in the behavior in question. Ultimately, intention is expressed by whether or not one performs the behavior. Even then, a given behavior may not be performed because of deterrent factors such as the perceived availability of requisite opportunities and resources

(Egeland, Ruud, Ogden, Lindstrøm, & Heiervang, 2016). Minimization of such factors was attempted in this project by providing complimentary copies of the bibliotherapy text for use by primary care providers with suggestive guidelines for implementation that underscored provider expertise as most important.

The EBPAS assesses four dimensions that were created to parallel Ajzen's theory: the intuitive appeal of EBPs, the likelihood of adopting an EBP given the requirements to do so, openness to new practices, and perceived divergence between research-based interventions and current practice. The higher the score, the more positive the attitude toward EBPs, except for the divergence scale, which is scored in reverse (Egeland et al., 2016). EBPAS scores were evaluated for a correlation to a change in bibliotherapy prescribing practices. Additionally, post-intervention EBPAS scores were analyzed to see if an opportunity to utilize bibliotherapy influenced future attitudes towards the adoption EBPs entirely.

Chapter Three

Purpose and Sample

Adult depression is increasing at alarming rates and the growing numbers are straining many rural communities' available mental health services (Brossart et al., 2013). This trend has resulted in the majority of depressed patients seeking management solely from their primary care providers (PCPs) (Brossart et al., 2013). Bibliotherapy, or the prescription of specific texts for illness, has been repeatedly proven as effective as standardized treatments of medication and psychotherapy for the management of mild to moderate depression (Gregory et al., 2004; Naylor et al., 2010). Though regularly utilized by counselors and psychologists, most primary care providers are unaware of this evidence-based practice. This scholarly project was designed to help facilitate the use of bibliotherapy for the treatment of mild to moderate depression into practice. It evaluated how primary care provider attitudes towards evidence based practice in general influenced adoption of a specific EBP scheme, bibliotherapy; and inversely how opportunity to adopt bibliotherapy influenced general attitudes towards EBP. Within this project, patients stood to benefit from the consideration of bibliotherapy in their treatment for depression. Beyond this project, the improved understanding of provider attitudes toward EBP may enhance patient outcomes.

Criteria to be included in the study consisted of participants 18 years of age or older, an active primary care provider of any level, and practicing within 60 miles of the primary research site. A total of 72 primary care providers meet this inclusion criteria. A sample size calculator was used with a confidence level of 95% with a 5% margin of error. A minimum sample size goal of 61 for convenience sampling was determined for

this project. Participants were recruited through fliers, emails, and in-person office explanations of research. Less than ten providers comprised the final sample size.

Project Approval

Institutional Review Board (IRB) approval was obtained from researcher's university in March of 2017 (See Appendix A). Evidence-based Practice Attitude Scale (EBPAS) is an established reliable and valid tool developed by National Institute of Health researcher, Dr. Gregory Aarons, which was used with his permission (See Appendix B). Permission for use of this tool was obtained prior to IRB approval. Additional IRB approvals were attained from respective governing bodies of various primary care providers (See Appendix C).

Design and Measures

The research design employed for this scholarly project was a quasi-experimental, mixed methods with embedded design and a simple interrupted time series (Terry, 2015). The survey directly utilized EBPAS Likert type questions with additional, project specific qualitative questions. Further, associated demographic data was anonymously collected. Demographic data gathered included the following components: (a) age, (b) gender, (c) years of practice, (d) educational background, (e) and type of practice (profit vs nonprofit). Additionally, (a) estimated number of depressed patients seen monthly, (b) if they utilized bibliotherapy, (c) at what frequency they utilized bibliotherapy, and (d) an open-ended question on their current understanding of bibliotherapy. The post intervention survey included additional bibliotherapy-specific qualitative questions regarding how effective they found it, if they will continue to use it, and any positive or negative patient input.

Instrument

The majority of quantitative data for this research was derived from the Evidence-based Practice Attitude Scale (EBPAS) which has been tested to evaluate mental health and social service provider attitudes toward adopting evidence-based practices (Aarons et al., 2010). Questions were in a Likert format with options ranging from "not at all" to "to a very great extent". Scores on the EBPAS derive from 4 subscales (i.e., Appeal, Requirements, Openness, and Divergence) as well as the total scale (See Appendices D and E). The Aarons (2004) and Aarons et al. (2007) studies concluded good internal consistency and reliability, respectively, for the total score (Cronbach's $\alpha = 0.77$ and $\alpha = 0.79$). EBPAS subscale scores, excluding divergence, range $\alpha = 0.78$ to $\alpha = 0.93$, with somewhat lower reliability estimates for divergence ($\alpha = 0.59$ and $\alpha = 0.66$) (Aarons et al., 2010). EBPAS was transferred unchanged to an online survey format utilizing Qualtrics. Additional demographic questions and bibliotherapy specific open-ended queries were added to the preliminary and post intervention survey, respectively. Six descriptive variables were investigated through survey distribution in an attempt to elucidate correlation in EBPAS scores to provider characteristics. Those variables were: age range, sex, years in practice, educational background, organization type, and number of depressed patients per month.

Informed Consent, Risks and Benefits

The attached consent form was reviewed and obtained prior to administration of the bibliotherapy educational handout, viewing of the prescribing scenario video, and collection of any data. Potential participants were informed that they were not required to complete the entire process and could choose to drop out of the process at any time.

Return of the completed survey indicated willingness to participate in the study. The informed consent document was kept separate from collected data in order to maintain anonymity.

This research posed minimal risks to the primary subjects. No individual identifiers were used in anyway. Participation of a subset of providers in a practice where others were against the use of bibliotherapy may worsen collegiality and create discomfort for research participants. Demographic items such as educational attainment or subjects' email addresses that can be considered potentially harmful socially, if data were to be made public in a breach of the Qualtrics server or the primary investigators email, computer or office. There was no risk in the prescription of *Feeling Good* (Burns, 2009). However, mismanagement of depressed individuals posed serious risks, including death. Strict guidelines for incorporation of this text were not provided nor suggested; provider expertise were underscored to hold precedent in this study. The educational handout highlighted the populations best served by this intervention; and excluded severely depressed individuals from primary management with bibliotherapy.

Procedures

Upon obtaining facility permissions and signature of consent form (See Appendix F), the student investigator dispensed the bibliotherapy handout and a varying number of copies of the text *Feeling Good* (Burns, 2009*).* Then a private email link was sent to participants to complete the online survey and view the modeled prescribing scenario video (See Appendix G). The modeled prescribing scenario was provided to demonstrate how to incorporate the suggestion of bibliotherapy with a patient in a way that was not perceived as dismissive. Several researchers have cited the importance of a confident

approach to enhance the viability of alternative treatments in patients' minds (McKenna, Hevey, & Martin, 2010). If a provider gives a self-help book and communicates confidence in its efficacy, "it is likely to engender hope, and hope has been hypothesized as a primary factor for improvement in psychotherapy." (McKendree-Smith et al., 2003, p. 282)

An opportunity for questions regarding the study was provided at this time. The providers were encouraged to incorporate the text at their discretion with depressed patients over a span of three months. Communication between the researcher and the subjects occurred in person when given the texts, two weeks following implementation via email or phone, and during the implementation phase via monthly phone calls. Post-intervention data collection was obtained through an additional email link sent three months after signature of consent. Preliminary and post-intervention self-reported prescribing practices were analyzed in relation to EBPAS to evaluate the predictive value of scores on the adoption of bibliotherapy. Additionally, demographic information including type of provider training (MD, PA, NP, etc) and length of years practicing was compared to adoption rates. Opportunities for qualitative responses were also given (See Appendices D and E). Data collection occurred during the months of June, July, August, September, October, November, and December 2017.

Data Analysis

R programming language software was used to analyze data collected via Qualtrics by a hired statistician. Descriptive statistics were reviewed. Further, paired t-tests were utilized to compare mean EBPAS scores pre and post intervention. Additionally, various regression analyses were considered to identify links between

demographic data and adoption of bibliotherapy. Recurring themes and patterns were noted by the student investigator when examining qualitative questions. Frequency of similar responses were noted by the student investigator in a private spreadsheet. Preliminary and post intervention surveys were paired anonymously through the Qualtrics server. All research materials and associated documents will be kept in a locked filing cabinet for the next seven years and then destroyed.

Chapter Four

Project Summary

The aim of this scholarly project was to evaluate the self-reported prescribing practices and Evidence-based Practice Attitude Scale scores (EBPAS) before and after providing free access to the text *Feeling Good* (Burns, 2009) and written explanation of bibliotherapy to a group of primary care providers managing the care of mild to moderately depressed individuals in a rural area. EBPAS was created in accordance with Ajzen's theory of planned behavior (Ajzen, 1991). For this scholarly project, there were four research questions:

1. Do EBPAS scores predict adoption of bibliotherapy (BT)?
2. What provider characteristics influence EBPAS scores?
3. What provider characteristics associate with bibliotherapy use?
4. Does opportunity to participate in an evidence based scheme (bibliotherapy) influence EBPAS scores?

All analyses and plots were created using the R programming language.

Data Analysis

The data for this analysis came from a convenience sample of initially eleven primary care providers from the area in and around a Midwest city, but was reduced to less than 10 due to subjects dropping out of the study. There were two main response variables: total EBPAS score and whether or not a provider used bibliotherapy at either pre or post intervention. Along with pre or post intervention, there were six descriptive variables that were considered, with three others eliminated because of a fair number of non-answers for those questions. Those variables were: age range, sex, years in practice, educational background, organization type, and number of depressed patients per month.

Initially, t-tests and regression models were planned to compare mean EBPAS scores pre and post intervention and to identify links between demographic data and adoption of bibliotherapy. However, for both differences in mean EBPAS scores pre and post intervention and EBPAS scores for bibliotherapy (BT) users or non-users, minimal group mean differences were found, $p = -0.11$ and $p = 0.33$ respectively, seen in Tables 1 and 2 below.

Table1

Mean EBPAS Scores and Subscores by Bibliotherapy Use

	Use Bibliotherapy	Don't Use Bibt.	Diff: (Use-Not)
Total EBPAS	34.89	34.78	-0.11
Requirements	4.00	5.67	1.67
Appeal	10.44	10.78	0.33
Openness	9.33	7.56	-1.78
Divergence (Rev. Scored)	11.11	10.78	-0.33

Note Bibt stands for bibliotherapy. Divergence component is reversed scored.

Table 2

Mean EBPAS Scores and Subscores by Survey Session

	Preliminary Survey	Post Survey	Diff: (Prelim-Post)
Total EBPAS	34.67	35.00	0.33
Requirements	5.11	4.56	-0.56
Appeal	10.56	10.67	0.11
Openness	8.11	8.78	0.67
Divergence (Rev. Scored)	10.89	11.00	0.11

Note Divergence component is reversed scored.

In looking at the boxplots of total EBPAS scores and subscores for BT usage and survey session (preliminary or post), there were only small differences in the distributions

and medians of the subscores. For this reason, one can say that there is no differences between pre and post intervention and that EBPAS is not a predictor of BT adoption with out running any statistical tests. Since it is visually obvious that there are no differences, then there is no reason to run a statistical test and risk making an error saying there is a difference when there really is not. Because of the homogeneity and the small sample size then, it was ill-advised to test means or run regression models. Specifically for the regression models, too small of a sample size will violate the assumptions of the model, meaning and inferences made from the model are suspect. In this case, it was better to explore the data in-depth than rely on a model built on too small of a sample size.

Additionally, looking at the association between EBPAS score and bibliotherapy utilization would require a more complex model (i.e. a generalized linear mixed model) as the data provided binary responses (use of BT or not) and one would need to take into account the repeated measurements on the providers. With few observations, this would have many issues with assumptions and the actual fitting of the model; the observations exceed the number of degrees of freedom to fit the model. In lieu of building models, the focus of the analysis was on comparing demographic trends in EBPAS scores and in the proportions of BT usage in the demographic groups. To investigate demographic trends, the analysis focused on exploratory data analysis (EDA) through data visualizations and summary tables. An extensive EDA found that most demographic variables were not strongly associated with differences in proportions of bibliotherapy usage.

Results

Subsequent to a small sample, n of 10 or less and university regulations, results have been presented in percentages rather than exact values to prevent potential

identification of study participants. In the plot EBPAS Scores by Provider and Survey Session the providers as a whole seemed to have more similar EBPAS scores after the study than before the study. Most of the subscores do not seem to differ across BT use and pre and post intervention. EBPAS scores differ the most by age range, sex, educational background, and depressed patients per month. More providers used BT after the study than before (33% of providers said they used it regularly before the study, 66% after the study). The proportion of survey responses that use BT is greater in the highest age range (45-54) than in the lowest age range (25-34) and can be seen in Figure 1. A larger proportion of females use BT than male use BT (Figure 2). Providers who work at a for-profit organization have a much greater proportion of providers who use BT than non-profits (Figure 3). The proportions of BT usage did not differ much across years of practice, education background, and depressed patients per month.

The research questions are addressed succinctly below:

1. Does EBPAS predict adoption of bibliotherapy? No, there was a very small difference (*p=-0.11*, use BT - not use BT) in mean EBPAS scores for survey responses for primary care providers that used bibliotherapy compared to those who did not use BT. Because of the tiny difference in means, no statistical test was conducted. This also means the researcher cannot say definitively that EBPAS scores do not predict adoption of bibliotherapy either.

2. What provider characteristics influence EBPAS? From these data, it seems that sex, age range, years in practice, educational background, and depressed patients/month have the largest effect on EBPAS scores.

3. What provider characteristics associate with bibliotherapy use? Similar demographics to those that influence EBPAS seem to impact BT usage. There is not enough evidence to draw a direct connection between EBPAS and BT usage based on these data.

4. Does opportunity to participate in an EB scheme (bibliotherapy) influence EBPAS scores? This was answered by the differences in mean EBPAS scores for the pre and post intervention surveys and there was little difference in the group means (*p=0.33*, post-pre).

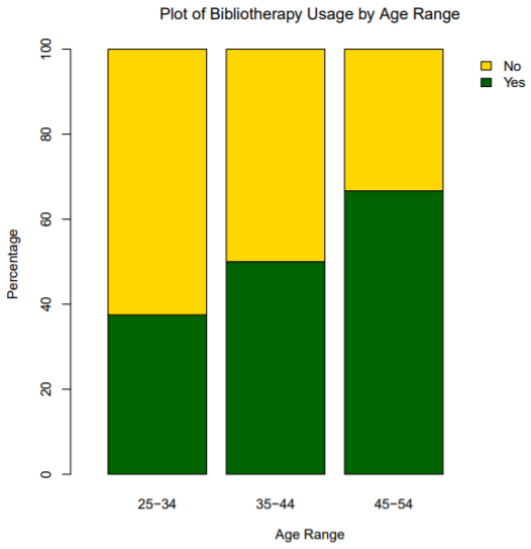

Figure 1. Bibliotherapy Usage by Age Range

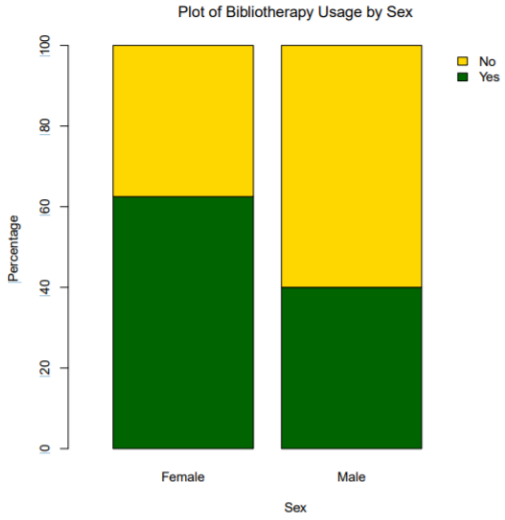

Figure 2. Bibliotherapy Usage by Gender

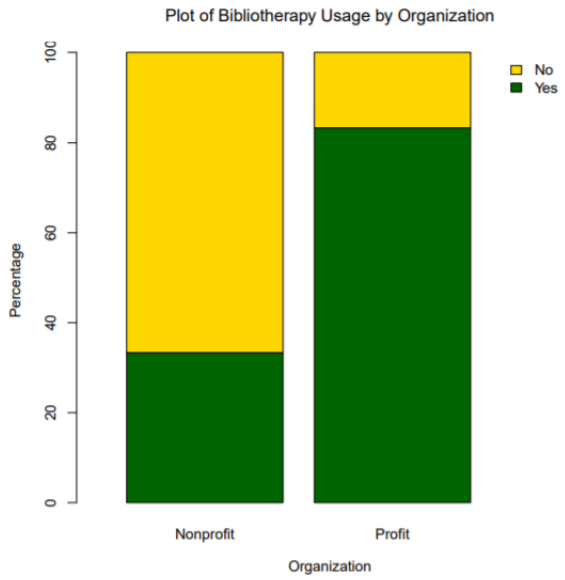

Figure 3. Bibliotherapy Usage by Organization

Strengths and Limitations

The most obvious limitation of this project is the limited sample size. Copies of the texts were provided from a mini-grant with limited funding. Interest by providers to participate in this scholarly project exceeded the available resources of the researcher. Because convenience sampling was utilized, one is unable to allow the extension of inferences beyond the sample in this pilot study. Additionally, due to the study structure and lack of random assignment of the treatment amongst a traditional experimental and control group; one cannot say that the intervention caused any changes in EBPAS scores, but rather that there is an association. Correlative conclusions are not provided as comparisons of two quantitative relevant variables was not found. However, small group sizes (one or two providers per group) can make it seem like there might be differences when a larger, more representative sample might show no difference.

Though the findings are indeed limited due to the aforementioned limitations, any contribution to the understanding of provider attitudes towards evidence based practice, specifically bibliotherapy, can be incorporated into an implementation scheme to diversify interventions used by rural primary care providers in the management of depressed patients. Additionally, providers unfamiliar with this treatment modality were exposed to the concept of bibliotherapy and several reported favorable results in their patients; thusly, encouraging use of *Feeling Good* (Burns, 2009) in the management of appropriate future patients and facilitating the application of evidence based mental health care in a high-need rural area. A summary of both the favorable and negative qualitative responses from patients can be seen in Figure 4. Intent and explanation as to whether study participants planned to continue to use bibliotherapy are provided in Figure 5.

What positive statements did patients express regarding bibliotherapy?
If a patient is religious, they appreciate their provider supporting this.
Patients reported that reading the book was relaxing.
Liked some of the exercises
They felt it helped them understand their anxiety & depression.
"I really appreciated the book. I tried some of the exercises and they seemed helpful. It was nice to do it on my own timeline."
Knowing more about personal medical problems is helpful.
What negative statements did patients express regarding bibliotherapy?
None.
None
Don't have time to read
None.
"This is a really big book--do I need this much help?!"
Time consuming.

Figure 4 Qualitative Responses: Patient Statements

Will you continue to utilize bibliotherapy in your future practice? Why or why not?
Yes. I think it is a great asset.
Yes, after receiving the education provided by Shannon, I plan to use bibliotherapy in my current and future practice.
Yes, depending on the patient's needs and reception of treatment
Difficult to say. Patients seemed reluctant to receive this type of therapy. Only was able to give one book out. May not be of value for our visits, but could be utilized in other avenues as when people attend counseling or other therapy.
No. Not familiar with it
Yes - I find it a valuable tool to integrate into my practice.
Yes, helpful!
Yes selectively
Most patients presenting for depression in my practice are to a severity where meds are indicated and counseling is beneficial. Giving them another task, amongst the several other I initiate, didn't seem prudent in the patients I've seen since the initiation of this exercise.

Figure 5 Qualitative Responses: Provider Statements

Future Studies

Future studies could yield results that are more robust by utilizing random sampling and recruiting for a larger sample size. The small convenience sample in this pilot study did not allow for the extension of inferences beyond these specific providers. Future studies may provide insight into trends in adoption of bibliotherapy and in EBPAS scores based on the differences in providers, that could then be used to tailor educational tools for certain types of providers which would subsequently enhance the likelihood of adoption of bibliotherapy in the treatment of depression by primary care providers.

Recommendations and Conclusions

A rich evidence base exists to support the incorporation of bibliotherapy into primary care providers' management of mild to moderately depressed patients. This project aimed to identify the role provider attitudes and characteristics had on the implementation of this treatment modality, in the hopes to identify barriers to its use. Due to limited sample size there were no findings of statistical significance; however, this

pilot study can contribute to the creation of future studies and highlighted some interesting demographic trends. Most importantly, as gleaned from the qualitative responses, a number of depressed individuals in our area reported benefit from reading *Feeling Good* (Burns, 2009)and some providers plan to continue to incorporate bibliotherapy into their future practice. Upon conclusion of this scholarly project, it was found that multiple family practices plan to continue use of prescribed reading. One privately run family practice has incorporated a bibliotherapy guide in their resource binder, which is referenced by nurses and doctors and distributed to patients for behavioral health services. This guide is given in addition to a list of counselors in the area and may prove particularly beneficial for patients that are wait-listed or limited in options for therapy due to insurance coverage. Another family practice retained the remaining copies of the text and in addition to expressing their intent to continue to prescribe it when appropriate, this office has now discussed creating a more expansive bibliotherapy program comprised of a lending library of texts within their own office to address a multitude of disorders. The adoption of this incredibly safe, effective, low-cost, and evidence-based intervention, in even the smallest scale, has the potential to impact depressed individuals positively in our area for years to come.

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Appendix A

Institutional Review Board Approval

Memorandum

TO: Shannon Scott
Nursing Department

CC: Anne Stein
Nursing Department

DATE: March 2, 2017

FROM: Rob Winn, Ph.D.
Interim Dean of Arts and Sciences/IRB Administrator

SUBJECT: IRB Proposal HS17-828
IRB Approval Dates: 3/2/2017 - 3/2/2018
Proposed Project Dates: 2/1/2017 - 8/31/2017
"Primary care provider attitudes towards adoption of evidence based practice: Indicators of acceptance towards bibliotherapy?"

The Institutional Review Board (IRB) has reviewed your proposal and has given it final approval. To maintain permission from the Federal government to use human subjects in research, certain reporting processes are required.

A. You must include the statement "Approved by IRB: Project # HS17-828" on all research materials you distribute, as well as on any correspondence concerning this project.

B. If a subject suffers an injury during research, or if there is an incident of non-compliance with IRB policies and procedures, you must take immediate action to assist the subject and notify the IRB chair (dereande@nmu.edu) and NMU's IRB administrator (rwinn@nmu.edu) within 48 hours. Additionally, you must complete an Unanticipated Problem or Adverse Event Form for Research Involving Human Subjects

C. Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding. Informed consent must continue throughout the project via a dialogue between the researcher and research participant.

D. If you find that modifications of methods or procedures are necessary, you must submit a Project Modification Form for Research Involving Human Subjects before collecting data.

E. If you complete your project within 12 months from the date of your approval notification, you must submit a Project Completion Form for Research Involving Human Subjects. If you do not complete your project within 12 months from the date of your approval notification, you must submit a Project Renewal Form for Research Involving Human Subjects. You may apply for a one-year project renewal up to four times.

Appendix B

Email correspondence with Gregory Aaron

Dear Shannon,

This email provides permission to use the EBPAS in your research. I have attached files with the EBPAS, scoring instructions, and US National norms. What you are proposing falls under "dissemination research" since you are focusing on providing information (in the form of a book) to providers. However, it sounds as though you may be doing more than just providing the text. There is a fairly well-developed literature showing that providing educational materials or training alone is not an optimal strategy for behavior change. This is under the broader rubric of dissemination and implementation research. You may already be familiar with this research area - and I have found the NIH guidance to be helpful as a starting point in framing these issues.
http://grants.nih.gov/grants/guide/pa-files/PAR-16-238.html

Best of luck with your research.
Greg Aarons

Gregory A. Aarons, PhD
Professor of Psychiatry | Director: Child and Adolescent Services Research Center
University of California, San Diego | 9500 Gilman Dr. (0812) | La Jolla, CA 92093-0812
+1 858-966-7703 x3550 |
+http://psychiatry.ucsd.edu/About/faculty/Pages/gregory-aarons.aspx

-----Original Message-----
From: Shannon Dennis [mailto:sdennis@nmu.edu]
Sent: Monday, July 18, 2016 9:37 AM
To: Aarons, Gregory <gaarons@ucsd.edu>
Subject: EBPAS Use

Hello Dr. Aarons:

I am a DNP student in the early stages of developing my scholarly project. I am interested in utilizing your EBPAS tool (if given your consent) in my research. I have received a small grant to distribute 65 copies of the evidence-based text, "Feeling Good", to primary care providers managing the treatment of mild to moderately depressed patients. From my review of literature, bibliotherapy has been proven effective but its use has continued to be overlooked by primary care providers. I would like to see if access to and education about the text is sufficient to elicit change and attitudes towards EBP . I am interested in evaluating their pre and post EBPAS in addition to their self-reported prescribing practices. I'd be happy to keep you updated on the progress of my humble project. My faculty chair and I would eventually like to publish.

Thank you for your time and consideration.

Appendix C

Bellin IRB Approval

Bellin Health IRB — Protocol Exemption Notification

To: Shannon Scott
From: Mary Sallenbach, IRB Coordinator
Subject: Protocol #61
Date: 08/01/2017

The protocol **61. Primary care provider attitudes towards adoption of evidence based practice: Indicators of acceptance towards bibliotherapy?** has been verified by the Institutional Review Board as **Exempt** according to 45CFR46.101(b)(2): Anonymous Surveys - No Risk on 08/01/2017.

Please note that changes to your protocol may affect its exempt status. Please contact me directly to discuss any changes you may contemplate.

Thanks,

Appendix D

Preliminary Survey

Q How old are you?

- ❍ Under 18
- ❍ 18 - 24
- ❍ 25 - 34
- ❍ 35 - 44
- ❍ 45 - 54
- ❍ 55 - 64
- ❍ 65 - 74
- ❍ 75 - 84
- ❍ 85 or older

Q Please specify:

- ❍ Male
- ❍ Female

Q How many years have you been in practice?

- ❍ 0-5 years
- ❍ 5-10 years
- ❍ 10-20 years
- ❍ 20-30 years
- ❍ 30-40 years
- ❍ 40 plus years

Q What is your educational background?

- ❍ MD
- ❍ PA
- ❍ NP
- ❍ DO

Q What kind of organization do you work for?

- ❍ Profit
- ❍ Nonprofit

QHow many patients do you estimate that you see with any depressive disorder monthly?

- ❍ 0-10 patients
- ❍ 10-20 patients
- ❍ 20-30 patients
- ❍ 30-40 patients
- ❍ 40 plus patients

Q What is your current understanding of bibliotherapy?

Q Do you currently use bibliotherapy in your practice?

- ❍ Yes
- ❍ No

Condition: No Is Selected. Skip To: Evidence-Based Practice Attitude Sc....

Q How frequently do you utilize this therapy?

- ❍ 0-1 times a month
- ❍ 2-4 times a month
- ❍ 5-10 times a month
- ❍ daily

Evidence-Based Practice Attitude Scale EBPAS Gregory A. Aarons, Ph.D

The following questions ask about your feelings regarding using new types of therapy, interventions, or treatments. Manualized therapy refers to any intervention that has specific guidelines and/or components that are outlined in a manual and/or that are to be followed in a structured/predetermined way.

Q1 I like to use new types of therapy/interventions to help my clients

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q2 I am willing to try new types of therapy/interventions even if I have to follow a treatment manual

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q3 I know better than academic researchers how to care for my clients

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q4 I am willing to use new and different types of therapy/interventions developed by researchers

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q5 Research based treatments/interventions are not clinically useful

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q6 Clinical experience is more important than using manualized therapy/treatment

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q7 I would not use manualized therapy/interventions

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q8 I would try a new therapy/intervention even if it were very different from what I am used to doing

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

For questions 9-15: If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:

Q9 it was intuitively appealing?

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q10 it “made sense” to you?

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q11 it was required by your supervisor?

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q12 it was required by your agency?

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q13 it was required by your state?

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q14 it was being used by colleagues who were happy with it?

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q15 you felt you had enough training to use it correctly?

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Appendix E

Post Intervention Survey

Q Do you currently use bibliotherapy in your practice?

- ❍ Yes
- ❍ No

Condition: No Is Selected. Skip To: How effective did you think bibliot....

Q How frequently do you utilize this therapy?

- ❍ 0-1 times a month
- ❍ 2-4 times a month
- ❍ 5-10 times a month
- ❍ daily

Q How effective did you think bibliotherapy was for your patients that you prescribed it?

Q Will you continue to utilize bibliotherapy in your future practice? Why or why not?

Q What positive statements did patients express regarding therapy?

Q What negative statements did patients express regarding therapy?

Evidence-Based Practice Attitude Scale EBPAS Gregory A. Aarons, Ph.D

The following questions ask about your feelings regarding using new types of therapy, interventions, or treatments. Manualized therapy refers to any intervention that has specific guidelines and/or components that are outlined in a manual and/or that are to be followed in a structured/predetermined way.

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- ❍ To a great extent
- ❍ To a very great extent

Q2 I am willing to try new types of therapy/interventions even if I have to follow a treatment manual

- ❍ Not at all
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- ❍ Not at all
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- ❍ To a very great extent

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- ❍ To a great extent
- ❍ To a very great extent

Q5 Research based treatments/interventions are not clinically useful

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- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q6 Clinical experience is more important than using manualized therapy/treatmentNot at all

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- To a moderate extent
- To a great extent
- To a very great extent

Q7 I would not use manualized therapy/interventions

- Not at all
- To a slight extent
- To a moderate extent
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- To a very great extent

Q8 I would try a new therapy/intervention even if it were very different from what I am used to doing

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- To a very great extent

For questions 9-15: If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:

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Q10 it “made sense” to you?

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- ❍ To a very great extent

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- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q13 it was required by your state?

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q14 it was being used by colleagues who were happy with it?

- ❍ Not at all
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- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Q15 you felt you had enough training to use it correctly?

- ❍ Not at all
- ❍ To a slight extent
- ❍ To a moderate extent
- ❍ To a great extent
- ❍ To a very great extent

Appendix F

Informed Consent

Northern Michigan University
Informed Consent
Evidence Based Practice and Bibliotherapy

You are being asked to participate in a research study. Before you give your consent to volunteer, it is important that you read the following information to be sure you understand what you will be asked to do.

Investigators

Shannon Scott RN, BSN
Doctoral of Nursing Practice Student
Northern Michigan University
1401 Presque Isle Ave
Marquette, MI 49855
sdennis@nmu.edu
(906) 250-2638

Advisor: Anne Stein, PhD, FNP-BC, COHN-S
Assistant Professor School of Nursing
anstein@nmu.edu
(906) 227-1540

Purpose of the Research

This research study is designed to help facilitate the use of bibliotherapy for the treatment of mild to moderate depression into practice. It will evaluate how primary care provider attitudes towards evidence based practice in general influence adoption of a specific EBP scheme, bibliotherapy; and inversely how opportunity to adopt bibliotherapy will influence general attitudes towards EBP. The data from this research will be used to create a Scholarly Project which will allow me to complete my doctorate.

Procedures

If you volunteer to participate in this study, you will be asked to:

- Complete a survey which will be emailed to you
- Read the informational handout provided
- Watch the very brief video (link of which will be emailed) of a modeled prescribing scenario
- At minimum, review the text index and exercise pages to familiarize yourself with text
- Incorporate the prescription of *Feeling Good* as you see fit in the management of mild to moderately depressed patients
- Complete another survey which will be emailed to you three months later

Your participation will take approximately one hour to complete.

Potential Risks or Discomforts

This research poses minimal risks to the primary subjects. No individual identifiers will be used in anyway. Stigma towards the incorporation of bibliotherapy into your prescribing practices may create discomfort for you. Demographic items such as educational attainment or email addresses can be considered potentially harmful if data were to be made public. There is *no* risk in the prescription of *Feeling Good.* However, mismanagement of depressed individuals poses serious risks, including death. Bibliotherapy is not appropriate as a primary treatment for severely depressed individuals.

Potential Benefits of the Research

Participants in this study stand to gain an increased understanding of the efficacy of bibliotherapy and may begin to consider adapting their prescribing practices to incorporate appropriate texts for a variety of conditions. Evaluating efficacy of this minimal-interaction introduction to bibliotherapy will provide insight into how best to facilitate bibliotherapy into primary care practice. Utilization of bibliotherapy posits a cost-effective and proven solution to overwhelmed mental health services in rural areas; it also stands to serve a subset of depressed individuals' avoidant of traditional behavioral therapy secondary to the perceived social stigma around seeking treatment. Moreover, identification of how provider attitudes influence the adoption of EBP will create insight into the delay of incorporation of research into practice.

Confidentiality and Data Storage

Data will be collected via Qualtrics online surveys emailed to participants. Results will be anonymized. No individual identifiers will be used in anyway. Results will be stored on the primary investigator's password required university laptop and backed up on an exclusive jump drive; both of which are stored in a locked office on campus. Upon graduation the data will be removed from the laptop and stored on the jump drive for the remaining required 5 years in a locked filing cabinet in the primary investigators home. Faculty chair, Anne Stein will have access to data to assist in statistical analyses until project completion.

Participation and Withdrawal

Your participation in this research study is voluntary. You may refuse to participate or stop participation at any time without penalty. To stop simply contact the primary investigatory and you will be unsubscribed from the email surveys and arrangements for copies of the texts to be reallocated to other providers will be made.

Questions about the Research

If you have any questions about the research, you may contact: sdennis@nmu.edu or 906 250-2638

This research project has been reviewed and approved by the Institutional Review Board for the Protection of Human Subjects at the Northern Michigan University

I have read the information provided above. I understand that by returning signing this form I am agreeing to participate in this research study.

Printed Name:_____

Signature: _____ Date _____

KEEP THIS INFORMED CONSENT COVER LETTER FOR YOUR RECORDS.

Appendix G

Modeled Prescribing Scenario Dialogue

Provider: Hey there

Patient: Hi

Provider: I've been looking over some of the paperwork, Sally, that you filled out with the nurse. From what I can score here, we put you in what we call the mildly depressed range. That gives us a handful of options for treatment. We can do medication, therapy, or a combination of the two. How does that sound to you?

Patient: Okay but I have already been seeing someone through work. Through the EAP program. I don't really think that the talking is helping that much.

Provider: No?

What I can do is start you on a low dose antidepressant. We like to start with Prozac, 10mg. It is a medication you take daily. I would have you return in 3 to 4 weeks for reevaluation. The unfortunate thing with antidepressant medication is that it takes anywhere between 4-12 weeks before you see an effect from it. Sometimes we have to try a few before we find the one that works for you.

Patient: That seems like a long time to wait to feel better

Provider: I understand that, there are some other options. Especially if you don't like talk therapy in person. Any chance you enjoy reading?

Patient: Yeah

Provider: Okay, there is a book written by Dr. David Burns, he is a clinical psychiatrist, its based on the principles used in counseling. So if you have ever heard of cognitive behavioral therapy, or CBT, it's the same idea. It has been out since the 70s, its actually been well researched and proven to be as effective as medication treatment in mild to moderate depression. With your scores, I'd still like to start you on a medication in the interim. But this book will help you work on some of those thoughts that are causing the feelings you are having

Patient: Sure, that sounds good.

Provider: I have a copy here, you can keep this one. I'm going to call that prescription into the pharmacy for you. Do you have any questions for me?

Patient: This looks like a really long book, is there a certain speed I should be reading this at?

Provider: You know, 20-40 pages a day would be a really good goal. It is okay to take it in pieces. There is a lot of content and information to digest. There is a handful of

activites that you will actually be doing on different pieces of paper. But if you read 20-40 a day I would think you'd see some effect by the time I see you again.

Patient: sounds good

Provider: I'm going to have make an appointment when you check out at the front desk for around 3 to 4 weeks from now.

Patient: About a month, okay!

Provider: we will see if the medication is working for you and how you are liking the book. We will talk about it then. Also if you are feeling any worse between now and then, I'd like you to call and we will get you in sooner, okay?

Patient: okay

Provider: I hope you feel better soon.