MANAGEMENT OF DEPRESSION IN THE ELDERLY: A SCOPING STUDY

by

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Abstract

Background
Depression affects more than 6.5 million Americans age 65 or older. Nonpharmacological treatments may be effective within this patient population.

Objective(s)
This paper examines the evidence related to 22 nonpharmacological treatments for depression in elderly patients.

Design
A scoping study of the literature was performed, using the framework created by Arksey and O’Malley (2005). Search databases included CINAHL, ProQuest, Cochrane Libraries, Academic Search Premier, PsycINFO, PsycARTICLES, SocIndex, Ovid, PubMed, and Science Direct.

Results
There were 158 articles deemed appropriate for this study. The evidence supports the use of cognitive therapy, life review, and problem-solving therapy. Although exercise is represented by 34% of the evidence found, the results were mixed and inconclusive regarding its effectiveness.

Conclusions
Results of this study lend support for the use of cognitive therapy, life review, and problem-solving therapy. However, gaps exist in the literature providing insight for recommendations for further research.

Keywords: depression, elderly, nonpharmacological, scoping study
Introduction

Depression affects more than 6.5 million Americans, age 65 or older (National Alliance on Mental Illness [NAMI], 2009). Researchers have predicted that by the year 2030 the number of individuals, age 65 or older, with mental health disorders, including depression, will increase to 15 million as the baby boomer generation ages (Jeste et al., 1999). Consequences of depression, in the elderly, include an increased risk for medical illnesses, cognitive decline, and suicide and nonsuicide mortality (NAMI, 2009). In addition, depression negatively affects the individual’s quality of life and functional status, as well as increases health care costs (Ell, 2006).

As more elderly patients present the need for treatment of depression, it is recommended that health care providers research mental disorders, such as depression, and formulate conceptualizations regarding treatment modalities in order to improve patient health outcomes (Jeste et al., 1999). The purpose of this project was to review the evidence available, regarding nonpharmacological treatments for depression, in order to make general recommendations for practice and future research. Care providers will be able to use the results from this study when developing treatment plans for older adult clients with depression.

Background

Researchers have conducted numerous studies examining depression in elderly clients, including its causes, diagnosis, and treatment. According to Hall and Reynolds (2014), depression creates a medical burden to patients as they are less likely to have adequate control over comorbidities such as cardiovascular disease and diabetes. Additional consequences of depression, in the elderly, include an increased risk for medical illnesses, loss of functional ability, cognitive decline, decreased quality of life, and both nonsuicide and suicide mortality (Ell, 2006; NAMI, 2009). In 2006, the suicide rate within the general population was 11.16 per
100,000, while the suicide rate for people age 65 and over was 14.22 of every 100,000. For men over the age of 85, this number increases to 49.8 per 100,000 (American Psychological Association [APA], n.d.). In addition to the physical complications of depression, depression also increases health care costs (Ell, 2006). Depressed elderly people have twice as many doctor’s visits compared to non-depressed elderly, longer length of hospital stays, and are twice as likely to be on five or more medications (Hall & Reynolds, 2014). While medication therapy is commonly used to treat depression, antidepressants are often improperly utilized. Research shows that nearly 60% of elderly clients with depression experience one or more prescribing problems including medication interactions or adverse effects (Castillo, Begley, Ryan-Haddad, Sorrentino, & Twum-Fening, 2013). The use of nonpharmacological treatments has been shown to be effective in the treatment of elderly patients with depression, both as an independent treatment modality and in combination with medication (Unutzer et al., 2002).

**Methods**

The methodology used for this project was a scoping review of the literature, developed by Arksey and O’Malley (2005). This methodology allows the researcher to review a vast amount of evidence from various sources, in order to survey the existing literature regarding the topic of interest. A scoping study does not fully evaluate the quality of research to determine the best evidence; but, rather, maps the literature in order to answer the research question and identify gaps in the literature.

**Ethical Issues**

This study was submitted for review to the Institutional Review Board (IRB) at Capella University. Because the study did not meet the federal definition of human subject research, it
was deemed exempt from IRB review and oversight. There are no conflicts of interest to disclose for this project.

**Data Sources**

The literature search for this study was comprehensive. Searches of electronic databases, including CINAHL, ProQuest, Cochrane Libraries, Academic Search Premier, PsycINFO, PsycARTICLES, SocIndex, Ovid, PubMed, and Science Direct, were completed. The database search included, but was not limited to, search limiters for year, age group, and MeSH terms. Keywords used included depression and elderly, aged, and older adult. The researcher reviewed 22 interventions, in total. Interventions included acupuncture, art therapy, cognitive therapy, including cognitive behavioral therapy (CBT), commitment and acceptance therapy, dialectical behavioral therapy (DBT), electroconvulsive therapy (ECT), exercise and yoga, guided imagery, hypnotherapy, interpersonal therapy, life review and reminiscence, light therapy, massage therapy, meditation, music therapy, problem-solving therapy, psychodynamic therapy, psychoeducation, religion and/or spirituality, self-help and bibliotherapy, support groups, and transcranial magnetic stimulation (TMS). All search strategies, including the dates the searches were completed, the search terms used, and the number of results, both found and kept for further review, were recorded and logged into database research logs.

In addition to the electronic database searches, professional organizations, including the American Psychological Association, the American Association for Geriatric Psychiatry, the American Psychiatry Association, the National Alliance on Mental Illness, the Journal of the American Medical Association, and Evidence-Based Mental Health (BMJ), were also searched for relevant literature. Finally, to help ensure an exhaustive search of the literature, a hand search of all included article’s reference lists was also completed.
**Study Selection**

Studies were selected for inclusion if they were empirical research, published between 2004 and 2015. Other inclusion criteria included a patient population over the age of 65, or a mean age over age 65, and a focus on nonpharmacological treatment methods for depression. Studies not written in English were excluded. If a full text article was not available via the electronic source, Interlibrary Loan services were utilized to obtain the article. All studies found in the initial search were assigned an article number and were identified using both the article number and full APA citation. This data was stored in an Excel database and the intervention type, location of the article, and final inclusion or exclusion decision were charted. All references were exported to RefWorks.

**Data Extraction and Analysis**

Data was extracted from all included articles and was stored and organized using Excel spreadsheets. Data charted included the intervention type, a description of the intervention, the sample size and mean age, the research methodology, the level of evidence, and the general outcomes of each study. For this scoping study, level of evidence was determined utilizing the Johns Hopkins Nursing definitions that define level I evidence as experimental, including RCTs and systematic reviews, level II evidence as quasi-experimental, level III evidence as non-experimental, level IV evidence as opinion based, and level V evidence as non-research, including literature reviews or case reports (Institute for Johns Hopkins Nursing, 2013).

Both a numerical and thematic analysis were completed using this data. The numerical analysis identified the number of articles found, their year of publication, and the overall nature, or level, of the research included, per intervention. The thematic analysis utilized the extracted data to generalize the evidence of effectiveness for each intervention and to identify gaps in the
evidence base. Article numbers were used to identify the articles in the numerical and thematic analysis.

**Results**

The search strategies described above yielded 1,192 articles that were reviewed for inclusion or exclusion. Of these articles, 158 met the inclusion criteria. Of the included articles, 24 were located during a hand search of the literature, one was located during the search of professional organizations, and all others were located during the search of electronic databases.

**Intervention Type**

Figure 1 illustrates the number of articles found per intervention type. Of the 158 articles, 54 were related to exercise, 34 were related to life review, and 25 were related to cognitive therapy. No articles were found regarding hypnotherapy interventions. Ninety-six articles were considered level I research. Figures 2 and 3 demonstrate the distribution of articles by level of evidence and intervention type. However, only the level of evidence was included in the data analysis; there was no analysis of the quality of the research, as per the scoping study guidelines. Finally, figure 4 demonstrates the number of articles included per calendar year. While the research is relatively equally distributed, it is important to note that no articles have been published, after 2010, regarding acupuncture, hypnotherapy, massage therapy, or psychodynamic therapy.

**Evidence of Effectiveness and Gaps in Evidence**

The following information will provide a brief review of the numerical and thematic characteristics for each of the 22 interventions that were included in the scoping study. Gaps in the research will also be identified.
**Acupuncture.** Only one article was found regarding the use of acupuncture for depression in older adult clients. While this study demonstrated an improvement in depression scores after the use of 12 weeks of acupuncture, the sample size was limited to 13 participants (Williams & Graham, 2006). Therefore, there is a need for further research, especially randomized controlled studies with larger sample sizes, to determine the effectiveness of the intervention.

**Art therapy.** The researcher found five studies examining the effectiveness of art therapy for elderly patients with depression. Of these studies, two demonstrated a significant improvement in depression, as determined by the study authors (McCaffrey, Hanson, & McCaffrey, 2010; McCaffrey, Liehr, Gregersen, & Nishioka, 2011). Three additional articles demonstrated a positive impact on patient’s depressive symptoms (Kim, 2010; McCaffrey, 2007; Ravid-Horesh, 2004). Art therapy sessions most commonly lasted 45 minutes and included four to twelve sessions. Garden therapy was also used as a treatment modality. While this evidence provided some support for the use of art therapy, there is a need for further research, especially randomized controlled studies, to determine the effectiveness of the intervention.

**Cognitive therapy.** The researcher found 25 articles, including 17 level I articles, examining cognitive therapy and cognitive behavioral therapy, including meta-analyses. Randomized control trials (RCTs) found had sample sizes that ranged from 20 to 204 participants. Outcome measures utilized within the studies were varied and included the use of the Beck Depression Inventory (BDI), Geriatric Depression Scale (GDS), Hamilton Rating Scale for Depression (HRSD), and the Hopkins Symptom Checklist (HSCL). In a RCT with 204 participants, Serfaty et al. (2009) demonstrated that CBT was effective in the treatment of depression, over the participants’ usual treatment and a talk therapy control. Results showed an
improvement of 0.4 points per therapy session on the BDI. Similarly, Scogin, Moss, Harris, and Presnell (2014) demonstrated significantly lower depression scores in elderly patients receiving CBT, compared to the support group control, in a 134 participant RCT. Overall, the evidence found shows support for the effectiveness of cognitive therapy in the treatment of depression in elderly clients and sufficient evidence is available to support the use of CBT in this patient population.

Commitment and acceptance therapy. The researcher found two articles examining the use of commitment and acceptance therapy in the treatment of elderly patients with depression. Both studies utilized 12 sessions of therapy and measured depression via the BDI (Karlin et al., 2013; Petkus & Wetherell, 2013). While none of the evidence was level I evidence, it did lend support for the effectiveness of commitment and acceptance therapy. However, there is a need for further research, especially randomized controlled studies with larger sample sizes, to determine the effectiveness of the intervention.

Dialectical behavioral therapy. The researcher found three articles examining the use of dialectical behavioral therapy in elderly clients with depression. Out of this evidence, one meta-analysis was found that concluded that DBT is effective, and is as effective as cognitive therapies or psychodynamic therapies (Samad, Brealey, & Gilbody, 2011). Other evidence concluded that DBT was probably effective, but was based on only a small evidence base (Mackin & Areán, 2005; Zalaquett & Stens, 2006). Therefore, there is a need for further research, especially randomized controlled studies with larger sample sizes, to determine the effectiveness of the intervention, within this patient population.

Electroconvulsive therapy. The researcher found five articles examining the use of electroconvulsive therapy in elderly clients with depression. In a systematic review, Van Schaik
et al. (2012) concluded that ECT was as effective as medication in the treatment of depression. Other evidence also supported the use of ECT (Buhl et al., 2007; Burke, Shannon, & Beveridge, 2007; Hausner, Damian, & Sartorius, 2011; Popeo, 2009). However, there is a need for further evidence, especially randomized controlled trials with large sample sizes, to determine the effectiveness of the intervention.

**Exercise.** The researcher found 54 articles, representing 34% of the total evidence, related to exercise as a treatment for depression in elderly patients. Within these studies, exercise sessions averaged 30 to 60 minutes, with various methods used for measuring depression levels, including the BDI, HRDS, GDS, and Center for Epidemiologic Studies Depression Scale (CES-D). Various exercises were reviewed, including walking, strength training, Wii games, aerobic activities, tai chi, qigong, dance, flexibility, and yoga. Of the total number of articles, 27 were level I evidence, with 10 systematic reviews and/or meta-analyses and 18 RCTs, three of which included sample sizes greater than 100. In a RCT with 193 participants, Kerse et al. (2010) found that physical activity improved GDS scores in patients, but that the improvement was not statistically significant between the physical activity intervention and the social visit control group in relation to quality of life or mood. In contrast, a systematic review by Windle, Hughes, Linck, Russell, and Woods (2010) concluded that exercise, particularly two weekly, 45-minute sessions of light to moderate intensity exercise, is effective. An additional systematic review by Mura and Carta (2013) concluded that while a majority of the evidence demonstrated a reduction of depression symptoms after exercise interventions, other studies demonstrated non-significant improvements, signifying the inconclusive nature of the available evidence. Therefore, while evidence does exist to support the use of exercise as a treatment method for elderly patients with depression, more research is needed, including replicated systematic reviews, to better
understand and determine its effectiveness. In addition, research comparing various types of exercise should be completed to determine any differences in exercise types.

**Guided imagery.** Only two articles were found related to guided imagery. Of these articles, one was a RCT of 54 participants that concluded that guided imagery did not significantly reduce depression symptoms (Sharpe, Williams, Granner, & Hussey, 2007). However, in a quasi-experimental study, a therapeutic effect was demonstrated, when utilized as part of a garden therapy intervention (McCaffrey, 2007). More research is needed, especially randomized controlled studies with large sample sizes, to determine the effectiveness of this intervention.

**Hypnotherapy.** No articles were found related to hypnotherapy. Therefore, no conclusions can be drawn. More research is needed regarding the use of hypnotherapy in elderly clients with depression.

**Interpersonal therapy.** The researcher found seven articles related to interpersonal therapy. Of these articles, three were deemed level I evidence (Dombrovski et al., 2007; Mackin & Areán, 2005; Van Schaik et al., 2006). However, the effectiveness of interpersonal therapy was inconclusive (Zalaquett & Stens, 2006). While the case studies showed support for interpersonal therapy (Bjørkløf & Hagberg-Karlsen, 2007; Post, Miller, & Schulberg, 2008; Raue & Areán, 2015), a RCT with 116 participants found that interpersonal therapy had no effect on maintaining treatment improvements (Dombrovski et al., 2007). Similarly, a study with 142 participants demonstrated that interpersonal therapy was only more effective than participants’ usual care (Van Schaik et al., 2006). Therefore, the effectiveness of interpersonal therapy is inconclusive and more research is needed, particularly RCTs.
Life review. The researcher found 34 articles, representing 21.5% of the total evidence found, related to the use of life review or reminiscence for depression in elderly clients, including 25 level I articles. Pinquart and Forstmeier (2012) demonstrated, in a replicated meta-analysis, that reminiscence therapy affected numerous patient outcome measures, with statistically significant improvements seen for depression symptoms. In a 114 participant RCT by Choy and Lou (2015), a statistically significant difference in depression scores was found between a group reminiscence intervention and a wait-list control group. Numerous other RCTs also demonstrated statistically significant support for the use of life review, with three RCTs containing sample sizes larger than 100. In addition, two systematic reviews and a meta-analysis were found that demonstrated the effectiveness of life review. Based on this evidence, there is sufficient support for the use of life review and reminiscence therapies for elderly clients with depression.

Light therapy. The researcher found four articles regarding the use of light therapy. In these studies, the light therapy lasted from 50 to 60 minutes daily, most days per week. Two RCTs, with 60 and 89 participants, demonstrated significant improvements in depression symptoms with little to no adverse effects (Lieverse et al., 2011; Tsai, Wong, Juang, & Tsai, 2004). However, a third RCT demonstrated no improvement between bright green light and bright red placebo light (Loving, Kripke, Knickerbocker, & Grandner, 2005). Therefore, more research is needed, specifically randomized controlled studies with large sample sizes, to confirm the effectiveness of light therapy in the treatment of depression in elderly patients.

Massage therapy. Only one article was found regarding massage therapy as a treatment modality for elderly patients with depression. In this study, including 54 participants, the authors found a significant improvement in depression scores (Sharpe et al., 2007); however, more
research, including larger randomized controlled studies, is needed to determine its effectiveness as a treatment modality.

**Meditation.** Meditation was only reviewed in one study. While a marginal reduction in depression scores was demonstrated within this quasi-experimental study, patients were not clinically depressed at the start of the study (Yu, Woo, Chan, & Sze, 2014). Therefore, more research examining meditation as a treatment modality for elderly patients with depression is needed.

**Music therapy.** The researcher found six articles regarding music therapy in elderly clients with depression. A systematic review concluded that music therapy reduced depression symptoms, particularly related to mood (Maratos, Gold, Wang, & Crawford, 2008). Two RCTs also demonstrated a significant reduction in depressive symptoms; however, there is a need for further research on music therapy, to determine its effectiveness, as sample sizes were limited to 47 and 63 participants (Chan, Chan, Mok, & Tse, 2009; Myskja & Nord, 2008). Therefore, randomized controlled studies, with larger sample sizes, and replicated systematic reviews are needed.

**Problem-solving therapy.** The researcher found seven articles regarding problem-solving therapy. Of these articles, six were level I articles and all demonstrated consistent support for the use of problem-solving therapy in the treatment of depression in older adult clients. For example, a RCT by Areán et al. (2010) demonstrated that patients completing problem-solving therapy had a greater reduction in depression symptoms and a higher remission rate than those receiving supportive therapy. Of the 221 participants, 45.6% of patients receiving problem-solving therapy achieved remission, as compared to 27.8% of the control group. Within other studies included, two studies had sample sizes greater than 100. Overall, there is sufficient
evidence to support the use of problem-solving therapy for elderly patients with depression. Continued research should occur and systematic reviews should be replicated.

**Psychodynamic therapy.** The researcher found two articles regarding psychodynamic therapy. These authors found that psychodynamic therapy has a medium effect size (Pinquart, Duberstein, & Lyness, 2007; Wilson, Mottram, & Vassilas, 2008). Therefore, the evidence, regarding its significance, is inconclusive. More research is needed, especially randomized controlled studies with large sample sizes, to determine its effectiveness.

**Psychoeducation.** Psychoeducation was represented in three articles. Out of these studies, a significant reduction in depressive symptoms was demonstrated when psychoeducation was used with CBT or psychotherapy (Lazzari, Egan, & Rees, 2011; Ward & Brown, 2015). However, as a standalone intervention, it was found that psychoeducation has a medium effect size (Pinquart et al., 2007). Therefore, more research is needed, especially randomized controlled studies with large sample sizes, to determine its effectiveness as a standalone intervention for depression in elderly patients. In addition, more research is needed to define psychoeducation and its use in coordination with other treatment modalities.

**Religion/Spirituality.** The researcher identified nine articles related to religion and/or spirituality as a treatment modality for depression in elderly patients. All of the evidence found was level III evidence, but it all demonstrated a positive impact on depressive symptoms. More research is needed, especially randomized controlled studies, to determine the extent of improvement in depression symptoms and the overall effectiveness of religion and spirituality as a treatment modality. In addition, more research is needed in regards to the elements of religion, i.e. church attendance, prayer, social activities, etc., that may be effective.
**Self-help and bibliotherapy.** The researcher identified four articles regarding self-help and/or bibliotherapy. Moss, Scogin, Napoli, and Presnell (2012) demonstrated decreased depression scores after four weeks of behavioral activation bibliotherapy, in one RCT with 26 participants. Additional RCTs and longitudinal studies demonstrated support for bibliotherapy as a means to maintain patient improvement (Floyd et al., 2006; Zauszniewski, Eggenschwiler, Roberts, & Morris, 2006). However, researchers who conducted a RCT, with 170 participants, demonstrated no significant difference between the participants’ usual care and CBT-based bibliotherapy groups (Joling et al., 2011). More research is needed to define bibliotherapy and to determine in which context it is most effective. Randomized controlled studies with large samples sizes are needed to determine the effectiveness of bibliotherapy and self-help on lowering depression levels in older adults.

**Support groups.** The researcher found three articles examining support group therapy as a treatment for depression in elderly clients. Several types of support group therapy were administered, ranging from monthly peer sessions to weekly 60 minute sessions, in a group format. Ho (2007) demonstrated a decrease in GDS scores; however, other evidence, including a literature review, concluded that the evidence for support groups was incomplete (Zalaquett & Stens, 2006). Researchers found, in a RCT featuring 76 participants, that although improvements in depression scores were noted, the decrease was not statistically significant (Wang, Lin, & Hsieh, 2011). Overall, there is a need for further research on group therapy and its structure, to determine its effectiveness.

**Transcranial magnetic stimulation.** The researcher found three articles regarding transcranial magnetic stimulation (TMS). The transcranial magnetic sessions averaged five to seven sessions, over two to three weeks. All three articles demonstrated support for TMS,
including the ability to achieve remission in patients with no adverse effects (Abraham et al., 2007; Januel et al., 2004; Sayar, Ozten, Tan, & Tarhan, 2013). In order to support the overall effectiveness of the intervention, more research is necessary, including randomized controlled studies.

**Discussion**

Of the 22 nonpharmacological interventions reviewed, only cognitive therapy or CBT, life review or reminiscence, and problem-solving therapy demonstrated effectiveness in the treatment of depression in elderly clients. Cognitive therapy was reviewed in 25 articles with various research methodologies being utilized over the entire 10-year span included in the scoping review. From this data, it can be generalized that cognitive therapy is effective. Life review or reminiscence therapy was similarly covered in the literature and was included in 34 articles of various research types. While problem-solving therapy was only discussed in seven articles, these articles exhibited high levels of evidence that demonstrated support for its effectiveness in elderly patients with depression. Although exercise was covered in 54 articles included in the study, results regarding its effectiveness were inconclusive and mixed. More research is needed to support its effectiveness, as well as to determine which exercise modalities might be most effective.

Other interventions examined within this scoping study, had insufficient data to make generalized recommendations for practice. More research regarding these treatment methods, in regards to elderly patients with depression, is necessary. Specifically, well-designed randomized controlled studies are needed. In addition, it may be necessary to complete studies in which nonpharmacological methods are compared these methods, to determine which is most effective to aid care providers in planning and organizing their client care.
Limitations

This scoping study aimed to map the research that is available regarding various nonpharmacological treatment methods for depression in elderly clients. It sought to demonstrate the quantity and characteristics of the evidence that is available, in order to summarize findings and identify gaps in the research. Due to this methodology, this study does not address the quality of evidence found. In addition, it does not synthesize evidence to place weight on the effectiveness of interventions; therefore, only general recommendations for practice can be made.

Conclusion

Health care providers may use nonpharmacological interventions to treat depression in elderly patients, as these interventions have demonstrated effectiveness, while having few adverse effects on the patient (APA, n.d.). The results of this scoping study demonstrated that cognitive therapies, life review, and problem-solving therapy are effective in the treatment of depression in elderly patients. Recommendations for further research can be made, especially examining other treatment modalities with randomized controlled studies. It is the author’s intention that the presented information be used by practitioners, researchers, and policy makers to make decisions, regarding care of patients with depression, and to continue further research in the field.
References


doi:10.1017/S071498081300007X


Pereira, D. S., de Queiroz, B. Z., Miranda, A. S., Rocha, N. P., Felício, D. C., Mateo, E. C., ... Pereira, L.S. (2013). Effects of physical exercise on plasma levels of brain
derived neurotrophic factor and depressive symptoms in elderly women: A randomized clinical trial. *Archives of Physical Medicine and Rehabilitation, 94*(8), 1443-1450. doi:10.1016/j.apmr.2013.03.029


doi:10.1016/j.ctim.2014.05.012


Figure 1: Included Evidence by Intervention Type

Figure 2: Included Evidence by Level of Evidence
Figure 3: Level of Evidence by Intervention Type

Figure 4: Number of Articles Included by Calendar Year
APPENDIX A. STATEMENT OF ORIGINAL WORK

Academic Honesty Policy

Capella University’s Academic Honesty Policy (3.01.01) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person’s ideas or works.

The following standards for original work and definition of plagiarism are discussed in the Policy:

Learners are expected to be the sole authors of their work and to acknowledge the authorship of others’ work through proper citation and reference. Use of another person’s ideas, including another learner’s, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)

Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else’s ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

Capella University’s Research Misconduct Policy (3.03.06) holds learners accountable for research integrity. What constitutes research misconduct is discussed in the Policy:

Research misconduct includes but is not limited to falsification, fabrication, plagiarism, misappropriation, or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, conducting, or reviewing research, or in reporting research results. (p. 1)

Learners failing to abide by these policies are subject to consequences, including but not limited to dismissal or revocation of the degree.
Statement of Original Work and Signature

I have read, understood, and abided by Capella University’s Academic Honesty Policy (3.01.01) and Research Misconduct Policy (3.03.06), including the Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the APA Publication Manual.

Learner name and date
Aleesa A. Kittrell 2/3/2016 (electronically signed)

Mentor name and school
