Professional Communications and Writing Guide - PSL

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Scholars' professional communications—their writings, their presentations, and their discussions with colleagues and other professionals—reflect the quality of their thought and the strength of their arguments. This *Professional Communications and Writing Guide* has been prepared to offer guidance and support to learners and faculty at Capella University who want to enhance the quality of their professional communications and, in particular, their writing.

The *Professional Communications and Writing Guide* primarily focuses on scholarly writing in the courses (course papers, unit postings, and critiques and responses to learner–colleagues). However, the advice, examples, and guidelines can be applied to all forms of scholarly writing, both in the graduate programs and later in professional life. The key objective of this guide is to articulate a common set of expectations for learners and faculty at Capella University.

The three sections of this guide follow the usual progression in professional writing in our courses.

- Section 1 – Course Posting Guidelines and Examples: offers tips and examples of high-quality initial courseroom postings and of responses to learner–colleagues.

- Section 2 – Course Paper Template and Guidelines: provides information and advice about formatting, style, and content in a scholarly paper.

- Section 3 – Course Paper Sample: shows a sample paper, with many of the common issues and expectations highlighted.

We anticipate expanding the guide periodically to include sections on other kinds of professional communications, such as the preparation of formal or informal reports, scholarly and professional presentations (such as lectures), preparation of papers for publication, and discussions with colleagues.

The faculty of Capella University welcomes feedback and suggestions about this guide. Please direct them to Randy.Johnson@capella.edu or Stone.Shiflet@capella.edu.

Section 1 – Course Posting Guidelines and Examples

This section presents guidelines and advice for writing successful postings in the Capella University courseroom. This section is designed to articulate clear expectations for the quality of the postings made to answer the discussion questions and to respond to peers in the courseroom. The expectations outlined later in Section 3 should be applied to all forms of courseroom writing, including discussions and assignments. Obviously, e-mail communications are somewhat more private and can be more informal, but the basic standards of professional etiquette should always be followed. You should always try to be as professional as possible in all forms of communication within the courseroom.

This section has two main parts. Part 1 offers guidelines, advice, and an example for successful responses to the discussion questions. Part 1 is further divided into three steps and then followed by a reference list. After that, Part 2 discusses tips for successful responses to course peers. Part 2 also has six suggested examples of good (and not so good) replies to peers and a reference list.

Part 1: How to Answer Discussion Questions

Step 1: Understand what the question requires. Read the discussion questions carefully. Note that most discussion questions will have both a content issue and a level of critical analysis issue. Instructors will evaluate both issues: how well the response addresses the content issue(s) and its level of critical analysis.

Content issues require discussion of relevant research and theory—which are presented in required readings for the unit but can also be found in related research identified by the learner—that addresses the content of the question. Opinion (defined as assertions based on personal experience without research support) is not acceptable as the only basis for a response, but opinions may be stated as such. Appropriate and relevant research and theory must be cited in the explication of the content issue.

Analyze the question to ensure that you have identified all the required content issues. Many questions have more than one; answering only one, when there is more than one, weakens your answer. If the question requires more than one content issue, it is acceptable—indeed, it is a best practice—to separate the issues and treat them individually, using appropriate section headings.

Course discussion questions often (though not always) ask for more than one level of critical thinking. Typically, your discussion of the research and theory related to the content issue demonstrates your comprehension and understanding—the lowest level of critical thinking in Bloom's taxonomy (Bloom & Krathwohl, 1956). Many questions go on to require some *analysis* (Bloom's mid-level critical thinking). Sometimes, this mid-level analysis is followed by a request for a *synthesis,* an *evaluation,* or an *application* (Bloom's high-level critical thinking).

The key verbs, indicating the level of analysis, should be clear. For instance, *describe, summarize,* or *compare* and *contrast* are common words asking for low-level (comprehension and understanding) critical thinking. At the mid-level, words such as *analyze* or *develop* are common. At the highest level, you will find words such as *synthesize, integrate,* or *evaluate.*

When these specific words are not found, look for synonyms or instructions that *imply* the level of critical thinking. For example, if the question asks, "What are three types of qualitative analysis that might be used to study long-term employee reactions to organizational change?" then this is low-level, asking for a description and summary of the theories and research involved in that content area. Note that an answer that merely named three types without any discussion would fail because it provides no evidence of comprehension and knowledge competence. If the question goes on to say, "Design an employee training program using elements from all three approaches," it is asking for *analysis* and *synthesis* (in order to combine elements [synthesis], one must first break down the three approaches into component parts [analysis]) and *application* (high-level), which entails using the synthesis to create a new use or application. Words such as *design*, *create*, and *use* indicate a request for application, a higher level of analysis.

Step 2: Turn your literature review into a draft answer. After you have completed your study of the literature related to the discussion question topic and are prepared to write your answer, create an outline. If you do not ordinarily write from an outline, it is highly recommended that you do develop the habit, because it will prove to be a very important skill in the capstone projects including comprehensive examinations or integrative projects.

There should be three main parts to your answer, which should always begin by repeating the question:

- An introduction, in which you **restate the question** to be answered and briefly **introduce your response**—one paragraph. State succinctly your core answer to the question, for example, by outlining the main points you will make.

- The body of the answer, in which you **discuss your response in detail**—two to five paragraphs. These paragraphs elaborate and provide details, evidence, and logical support for the points outlined in the first paragraph.

- A conclusion, which provides a conclusion or summary—one paragraph. This paragraph should summarize your answer and include recommendations for your own further study.

Paragraphs should always be developed according to the MEAL Plan. One of the sentences (usually the first) should state the main idea for the paragraph. The other sentences should support the main idea by adding details, subpoints, or evidence. Make sure that you develop your position on each main point with analysis, and then link or include a transition to the next paragraph.

All the paragraphs in the body develop and elaborate on the full answer stated succinctly in the introduction. Hint: If you list the topic sentences of the paragraphs, the list should provide a logically flowing outline of a complete answer to the question. Each of the supporting paragraphs in the body should flow in a logical fashion from the introduction of your position, to a discussion of your position, and finally to a logical conclusion.

Make sure to use the appropriate citations to the sources you reviewed. Scholarly writing requires that all positions be supported by citations to the literature. Best practice is to cite additional sources beyond course texts and required articles (although those are also acceptable). Remember to post the full references in a reference list below the answer. You must use correct

APA sixth edition format and style in your citations and references, and best practice is to use APA style for text as well. (Although we encourage it, you do not have to use APA for responding to other learners.)

Avoid the practice of composing long paragraphs in which you string together a number of ideas from a source and then cite that source after the final sentence. This gives the impression that all the sentences except the last are your ideas, which of course they are not. Instead, use the main idea from the author you are citing as your topic sentence (giving the citation up front), and then build on that idea by adding your own analysis or the related ideas of other authors on the same topic (also citing those sources). (See the Signal Phrases appendix.)

If you discover that your paragraphs look like a string of citation parentheses on the page (that is, each sentence is a citation from another author—or worse, from the same author), you are not doing enough of your own thinking in that paragraph. Go back and revise using the MEAL Plan. You should of course cite each author, but you should also provide your own analysis, synthesis, evaluation, or application of the main ideas. Faculty are not interested merely in what our learners have read of authors—we are interested in what elements of those authors' ideas our learners have understood and integrated, analyzed, synthesized, applied, evaluated, and put to creative uses. The surest way to demonstrate that you understand an author's work is to do high-level critical thinking about it.

Step 3: Review and revise. Before you post your discussion answer, read it carefully to make sure that your presentation is reader-friendly and clearly expresses your response. Also, use spell-check and edit your answer for typographical, spelling, punctuation, grammar, usage, and other editorial errors. These errors detract from the overall evaluation.

Most faculty members prefer that you write in the third person, although some prefer first person as long as the writing is scholarly and formal. Check with your course instructor to be sure you understand his or her preferences. You will be required to write in the third person for final papers, the integrative project (master's programs), the comprehensive examination, and the dissertation (doctoral programs). Course postings can be useful practice.

With practice, you will learn to express your positions comfortably in the third person. Adopt the scholarly habit of thinking of your own ideas and work as being someone else's. This will help you to write in the third person more easily, and it will also help you practice the intellectual skill of considering what challenges, disagreements, or alternative approaches someone might make to your work.

For example, the previous paragraph can be rewritten in the third person without changing the meaning: "Learners writing in the third person learn with practice to express their positions comfortably. Putting one's analysis in the third person fosters the scholarly habit of thinking of one's own work as being someone else's. This in turn promotes ease in third-person writing and strengthens one's ability to consider what challenges, disagreements, or alternative approaches a reader might make to one's work."

Now, we will move on to a discussion of a sample discussion posting, the answer to a unit discussion.

Sample Discussion Question

Discuss the higher incidence and prevalence of eating disorders in women, compared with men, in the United States. Analyze possible explanations for the differences, and evaluate whether current diagnostic and conceptual practices help our understanding of male eating disorders.

Sample Answer

This posting will discuss the higher incidence and prevalence of eating disorder diagnoses in women (compared with men), to discover possible explanations for those differences and to discuss whether our current practices in diagnosis and treatment facilitate our understanding of male eating disorders.

Traditionally, the incidence of eating disorders is more prevalent in the female population versus the male population; however, in recent years, more men are seeking treatment for eating disorders. A majority of the research literature deals with eating disorders in the female population, and the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*) (American Psychiatric Association, 2000) diagnostic criteria for anorexia nervosa and bulimia nervosa are consistent with the female presentation of the disorders. Although more men are seeking treatment for eating disorders, women are still more likely to seek treatment and report past treatment experiences (Lewinsohn, Seeley, Moerk, & Striegel-Moore, 2002). There may be differences in the attitudes of men and women that conceal deeper similarities.

The disproportionate ratio of eating disorders diagnosed in females versus males in Western cultures may reflect the Western equation of thinness with female beauty. Grover, Keel, and Mitchell (2002) report females and males have different perspectives of normal weight. Normal weight females as compared to normal weight males are more likely to report the perception of feeling overweight; furthermore, regardless of actual weight status, males are more likely to report feeling normal. To compound the difference in the perception of weight, females are more likely to associate weight with self-esteem. In general, cultural beliefs appear to increase the likelihood of women developing eating disorders and in contrast, insulate men.

Nevertheless, the results of a 2001 survey by Jackson and Stanton suggest that more men are seeking treatment for weight-related problems. According to the data from their survey of 300 psychotherapists across the United States, the incidence of men seeking weight-related help in the United States appears to have increased 17 percent between 1997 and 2000. At the same time, therapists did not report an increase in the number of diagnoses of eating disorder by *DSM-IV-TR* (2000) criteria. In discussing these two points, Jackson and Stanton speculated that they may confirm Grover, Keel, and Mitchell's report (2002) about differing perspectives mentioned above. Men may be seeking help with their weight for different reasons and with different attitudes than women do.

Lewinsohn et al. (2002) identified a need to redefine the diagnostic criteria for eating disorders to better differentiate female and male symptoms. While cultural factors may influence the prevalence of eating disorders, failing to identify a more accurate male profile contributes to underdiagnosing eating disorders in men. For example, based on the sources cited thus far, one can surmise that men experiencing eating disorders may be more likely to participate in excessive exercise rather than binge-and-purge behavior or restricting intake alone. If this conjecture is true, understanding the primary factors that contribute to the development of eating disorders—which may be common to both genders—does not necessarily translate into an effective diagnostic system for identifying the problem. Focusing on eating disorders as primarily a female phenomenon and designing the diagnostic criteria based on female symptomology fails to accurately identify and assess the actual prevalence of eating disorders in the male population.

In conclusion, the differences in the incidence and prevalence of females and males seeking treatment for eating disorders may be explained by a mix of cultural factors, obscuring deeper diagnostic similarities. In any case, more accurate profiling of male presentations of eating disorders is essential to a full understanding of the differences. Better treatment of males with eating problems will depend on more accurate assessment, which is still not available. Further study of the male cultural attitudes toward weight and their changing impact on men's psychological well-being will be helpful.

References [for the sample posting]

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Grover, V. P., Keel, K. P., & Mitchell, J. P. (2002). Gender differences in implicit weight identity. *International Journal of Eating Disorders, 34*, 125–135.

Jackson, A. L., & Stanton, M. P. (2001). Male eating disorders, treatment-seeking, and diagnostic trends: A national therapist survey. *Journal of Epidemiological Psychology, 17*, 17–29.

Lewinsohn, P. M., Seeley, J. R., Moerk, K. C., & Striegel-Moore, R. H. (2002). Gender differences in eating disorder symptoms in young adults. *International Journal of Eating Disorders, 32*, 426–441. doi:10.1002/eat.10103

Discussion of the sample response. Notice that the answer to the discussion question started with a restatement of the question itself. This allows the reader to fully grasp what is about to be presented, as well as offering a baseline for evaluating the quality of the response. In

the discussion answer in the courseroom, this opening paragraph serves the same purpose as the introduction to a paper, outlining the main points to follow.

Then the answer proceeds to answer the question item by item, as outlined in the opening. Notice that the paragraphs each address a main point, supported by or stemming from (usually) a single source, which is always cited. Additional sources that add to that single main point also appear in some of the paragraphs. In each case, however, the paragraph keeps a single main point.

The author provides his or her own reflection on what he or she studied and integrated from the sources (see second to last paragraph). The author clearly states this as his or her own thoughts, showing how he or she has reflected and integrated the studied material.

Finally, a conclusion not only summarizes the main points of the answer but also provides a suggestion for some further literature review that readers might undertake to deepen understanding of the issue. This is a fine answer to the discussion question posed.

Having briefly examined a high-quality discussion posting, we turn our attention now to how to write great responses to the postings of learner–colleagues in the courseroom.

Part 2: Tips and Suggestions on How to Write Great Responses to Classmates' Discussion Answers

Suggestion 1: Give plenty of support and add value. Discussions in the courseroom can become very powerful learning experiences. Telling your colleagues when they have written exceptionally clear, useful, or articulate postings is a wonderful way to enhance the sense of the learning community that we strive for at Capella. That said, required responses that only contain cheerleading comments with no other value added are not sufficient to meet the requirement of critiquing another learner's post. Additional responses beyond the required critique of another learner's post are always welcome and encouraged, and these certainly can be short supportive appraisals. However, if the required critique posting is only supportive and praising—the good element, it fails to give evidence that the posting was read—the downside.

Such responses are unsatisfactory as critiques. For example, submitting "Nice post, Sally. I really learned a lot from you! This will help me in understanding our course material" would be insufficient as a required critique post, although it would be a gracious gesture as an additional reply to your colleague. This does not mean that praise is not acceptable—indeed, praising your colleague's work enhances the quality of your response.

Praise is important. Still, the principle to follow is that critiques ought to add value to your colleagues' original posts. To add value to your response, you must go beyond praise and support. Tell Sally what in her post was helpful, how it enhanced your learning, what issues it clarified, and details on how it clarified the discussion question for you—this specificity gives greater value to your response.

For example, a valuable response might begin with something like this: "Nice post, Sally. I really learned a lot from you. Your explanation of Ford's theory and especially how it applies to management theory was new to me and very clear." Then you can go on to deepen the discussion, which we will discuss in the next section.

Suggestion 2: Remember that this is a discussion on an assigned topic. Focus your response on the points made by the colleague to whom you are responding. In a face-to-face conversation, the respondent does not immediately change the subject to something he or she is more interested in, nor should that happen in courseroom replies. Instead, good communication skills suggest that the respondent could accurately play back what he or she had heard to be sure he or she understood and then could expand on those ideas, analyzing or commenting on them or raising a question that they brought to mind. Most importantly, the reply would stay on topic, and the topic is what the original post said about the discussion assignment, not a new idea.

Your response also should not jump immediately into your own take on the question, ignoring what your colleague said. Instead, give a sympathetic reading and summary of your colleague's post, to show that you have read and understand it, before you launch your own counterpoint or different interpretation.

The requirement to critique a colleague's answer fosters discussion of the *topic assigned for the discussion*. If the question asks for discussion of topics A, B, and C, keep your critique of or reply to your colleague focused on what your colleague wrote about topics A, B, or C. For example, in a course on research methods, a discussion question asks for an analysis of the sampling procedures used in a research article. When learners in that course make their critiques or responses to their colleagues, even when the original answer focuses properly on the sampling procedures, an occasional respondent will go off-topic to ask a question about, say, the article's conclusions. This is incorrect. Stick to the topic about which you were asked and about which your colleague wrote.

Your response should not stay with the original answer if the original answer does not address the discussion topic, however! In that case, a helpful critique might start with an appreciation of what the colleague did say, followed by a discussion of what the posting did not say, namely, the answer to the asked question. Here is where you can practice the art of providing difficult feedback in a graceful manner, something all professionals must master if they wish to prosper in their chosen fields.

To summarize, then, a high-quality response to a discussion answer would first summarize briefly the main idea or ideas communicated in the original posting, to ensure that those points were grasped. Then, the respondent could add his or her thoughts, always sticking to the topic raised by the discussion question for that unit. Here is an example of a response to the previous sample discussion posting. Remember the question: possible explanations for the difference in the occurrence of eating disorders in men and women, whether current diagnostic and conceptual practices help our understanding of male eating disorders, or both. Here is the example of a high-quality reply:

> Sally, I was interested in two of your points. You noted from one study that cultural and gender-specific perceptions of beauty ideals might account for some of the different prevalence of eating disorders between men and women. But you also pointed out from another study that men's eating problems might be under-diagnosed because our conceptualizations tend to be based on women's disorders.

In my own experience with young male athletes (I've been an assistant high school wrestling coach for 12 years), I think I see evidence of both ideas. Some of these young men are often obsessed with their weight (wrestlers are notorious for this, but other sports promote it, too), but they don't define this obsession as being a disorder. They tend to see it as getting an advantage in competition. I've observed many boys for whom making weight is every bit as huge a problem for them as losing weight is for the females with eating disorders (though of course, they don't seem to go to the same extreme, sometimes requiring hospitalization). But as you note in your first point, it is an ideal of male strength and athletic prowess they are aiming for, which seems to me similar to the myths of female beauty with a different content. I think that my observations concur with your reflections in your post.

It follows from your second point that if we redefined eating disorders in a way that included this obsession with ideal athletic weights, more young men would receive the diagnosis. From your perspective and the articles you studied, does this seem reasonable to you?

Sincerely, Joe

This example stays with and expands upon the main points of the original posting. The requirement for using citations and references is relaxed in the reply postings, and the language can be more informal, as befitting a real discussion. The key point is that the reply stays very close to the points of the original posting and to the substance of the assigned topic.

Note too that the last sentence invites further discussion. This is a key factor to the idea of discussion. The greatest learning occurs when people talk more deeply into a topic. This is the aspiration underlying the assignments in the discussion room.

Suggestion 3: When asking a question, give your own thoughts as background. Harry Stack Sullivan, an American pioneer psychiatrist who wanted to develop a method of dialogue with his clients, used to discourage his students from asking questions, by noting humorously that questions end with a hook (the question mark), and nobody likes getting hooked (L. Pilling, personal communication, 1973). This is why the so-called tennis-ball question is discouraged. Tennis-ball questions are brief hooks that give no information on which to base an answer and offer no personal investment by the questioner. Here is an example of the tennis-ball response: "Thank you for your post, Sally. Do you think that eating disorders are overdiagnosed in our country?"

What is Sally to make of such a question? The tennis-ball approach has two strikes against it. First, the respondent is not doing any work and gives no clues about what he or she is thinking. Although the question may be a good and honest one, there is no indication to Sally of what points in the original posting that it addresses, no context for how it flows from the original's ideas, and no description of what the respondent is thinking. If this were a face-to-face conversation, such a tactic would leave Sally very uncomfortable.

And that is the second problem with the tennis-ball approach: Receiving a tennis-ball response can feel a bit intimidating or even hostile, and genuine dialogue rarely comes of it. That was

Harry Sullivan's point: Safety for the one who is being questioned leads to genuine dialogue. The community of learning idea means we want to make our colleagues feel safe discussing things with us; this is a core value of professional communications.

Here is an example of a response that raises a new question without hooking Sally with the infamous tennis-ball question:

> Sally, I was interested in the second of your two main points, in which you talked about the idea that men's eating problems might be underdiagnosed because our diagnostic conceptualizations tend to be based on women's disorders. As I reflected on that, I think it certainly could be true, and when I read Joe's response to you, I can clearly see that there is some validity to the argument you made.
>
> But I have another question that is related to your point. The idea that male eating disorders are underdiagnosed for perhaps cultural reasons seems to me to make a couple of presuppositions or assumptions that trouble me. For one thing, aren't we assuming that the rate of female diagnosis of eating disorders accurately represents a real phenomenon? I don't have any research to support me here, but except for those women who actually approach death with their disorder, there seems to be a cultural norm to have an eating disorder for a few years in adolescence. Like Joe, I have been a high school teacher and counselor for 15 years, and I have seen the numbers of eating disorders climb in recent years without understanding why. Again, I don't mean to impugn the genuine horror of these disorders in some sufferers, I only mean to wonder if the high rate of diagnosis in young women may be partially a cultural artifact.
>
> That said, do you believe that it could be reasonably argued that eating disorders are perhaps overdiagnosed in the United States? I'm curious about your thoughts on the subject.
>
> Thanks, Sally, for an interesting discussion.
>
> -Naomi S.

In this example, the opening summary orients the conversation to the relevant points from the original, and Naomi's thinking and the anecdotal experience behind her question becomes quite clear in the second paragraph. The question that in the tennis-ball approach felt demanding, but now it makes sense and can be discussed in the context of research, theory, or experience.

Suggestion 4: Remember that "Participation in the Courseroom Discussion" is the standard. In the final analysis, the degree to which you interact with colleagues determines the true measure of participation, and the Capella model of learning at the graduate level is that participation is a key to learning. Obviously, someone who writes substantive messages to five other learners every unit is participating at a higher level than someone who posts a reply to only one colleague, assuming that both learners post substantive replies that make use of the suggestions above. Conversely, five cheerleading or tennis-ball replies are a lower level of quality participation than one high-quality reply.

Nevertheless, meeting the basic Capella requirement (one post in reply to a colleague's original posting for each discussion question assigned in the Discussion area) or the requirement stated in the individual course is all that needs to be done; it meets the requirement for "satisfactory" (grade B) performance. However, every learner should consider the following: Increased substance and frequency will improve the learning experience. The gold standard for a graduate education is not what score you receive. It is the depth and meaningfulness of your learning and the critical analysis of that learning. You can evaluate these only in yourself, and only active engagement in scholarly conversation with your colleagues will help you achieve it.

Suggestion 5: Take good care of the mechanics. Finally, successful learners check their typing, style, and grammar before leaving the courseroom. Faculty members emphasize this element of scholarship earlier in our programs, as early as in the first foundation courses (FirstCourse), because there are too many learners arriving at capstone projects (integrative projects in the master's programs or the comprehensive examinations in the doctoral programs) without mastering basic grammar, usage, and mechanical skills. So now is the time to learn and master those skills, basic to the craft of the scholar-practitioner.

Remember: Capella offers two very powerful resources for you to use both in the courseroom and at colloquia, and they are the Writing Feedback Tool (in the Capella Writing Center on the learner iGuide) and the Writing Program faculty, who are at every residency. If you have any uncertainties about writing and usage, editorial mechanics, the sixth edition of the APA manual, formatting, plagiarism, or anything else about writing, the faculty wants to take this opportunity to strongly recommend that you ask the Writing Program mentors for help. Contact Stone.Shiflet@capella.edu directly.

Section 1 References

American Psychological Association. (2010). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: Author.

Bloom, B., & Krathwohl, D. (Eds.). (1956). *Taxonomy of educational objectives: The classification of educational goal*s (Vol. 1). New York, NY: Longmans, Green.

Section 2 – Course Paper Template and Guidelines

This section provides a template for a standard course paper (end-of-term product). The sample paper, formatted in APA sixth edition style, is found in Section 3. Section 2 also offers a set of guidelines for constructing and organizing an acceptable paper into major units (introduction, main points or body, and conclusions) and then organizing these units into sections and subsections.

Graduate school and professional writing requires high-level critical analysis along with lower-level understanding and comprehension of the ideas, research, and theories used. This section offers some suggestions for strengthening critical writing, including its organization. Other resources on critical thinking and analysis should be consulted to deepen one's understanding of these issues.

Finally, a set of references to format and style issues in the sixth edition of the *Publication Manual of the American Psychological Association* are provided to address common errors. Learners should become familiar with Chapter 2, "Manuscript Structure and Content," on pages 21–59 of the APA manual. No single step will more immediately improve one's writing and scholarly presentation of ideas than becoming familiar with and correctly using these rules.

This section begins with a template of the title page.

Template: Title Page

Running head: [ALL UPPERCASE] 1

[The running head contains the keywords from the title. Starting on page 2, it is placed in the page header, which will repeat on each page.]

Title [in uppercase and lowercase letters; in the upper half of the page.]

First Name MI. Last Name

Capella University

Abstract

[in uppercase and lowercase letters; centered at the top of a new page]

The abstract must be double-spaced and in block format with no left indentation. The sixth edition of the APA manual stipulates that an abstract should not exceed 250 words. The abstract is not an introduction to the subject. It is a summary of every main point in the paper. The reader should have the gist of the entire paper by reading the abstract. The writing should be clear and vigorous and free of extraneous words. The APA manual (pp. 25–27) provides specific guidelines for the abstract. The abstract should cover three points: (a) the topic of the paper—including the question to be answered, thesis to be argued, or problem to be solved (this should be stated not introduced); (b) the main points of the exposition—including research methods used to answer a research question, the main points of the argument, or the key theories or premises of the argument; and (c) the conclusions drawn and recommendations made stemming from the analysis in the middle section. Each segment should be approximately one to three sentences long, unless a complex element requires more description, and the tone should be formal and in the active voice and third person. If sources are used, citations must be included and counted as words.

Table of Contents

[in uppercase and lowercase letters; centered at the top of a new page]

Guidelines for the Table of Contents

The entire table of contents must be double-spaced. To create the table of contents you may use the Index and Tables tool (in the Insert menu). This feature requires that you use headings consistently throughout the paper, which is also important to do from a formatting perspective. If you need assistance with headings, see pages 62–63 of the APA sixth edition. You can format headings in MS Word to comply with APA style, using the Style tool in the Format menu. We recommend using two or three levels of headings.

Guidelines for the Main Body of the Paper

- Your paper (unless it is for a special purpose, like a comprehensive examination style paper, an annotated bibliography, or an interview report) must do **one, and only one**, of the following:

    o it should **answer** a clearly stated **question**;

    o it should **argue** or defend a clearly-stated **thesis** (position) or counter-thesis, demonstrating why a particular position (thesis) should or should not be accepted; or

    o it should **pose** a problem and offer a **solution** to it.

- Clear organization is very important. Your topic should be focused and specific, and each of the main points that develop your argument or support it (that is, answer the question or argue the position you are taking) should have its own section. To clearly mark the organization, use **Level 1 headings** for the main sections of your text (see APA, 6th ed., pp. 62–63). Do not be afraid to use Level 2 and Level 3 headings for important subordinate points or subsections within a main section. Most course papers will not need more than three heading levels.

- The body of your paper must have the sections listed below, described in the pages that follow:

    o an introduction that follows the title of the paper;

    o discussion of the main points, each having its own Level 1 heading (you also can use Level 2 headings for subordinate points);

    o a conclusion, which starts with a Level 1 heading; and

    o a reference list.

- If you use **tables or figures**, follow APA sixth edition rules to format them (pp. 125–167). Place each table or figure inside your text as close to your mentioning it as possible.

- Rarely will a course paper need an **appendix** to present material that would distract the reader if included in the main body of the paper. See pages 38–40 of the sixth edition of the APA manual for guidance.

- Although **grammar, usage, and mechanics** ("G/U/M") are a local concern, they are still very important. All grammar, usage, spelling, and punctuation should conform to good English composition as codified by the sixth edition of the APA manual. Elaine Hacker's books and handbooks are also a handy and very helpful baseline for good grammar. Follow APA guidelines when you are uncertain of formatting, style, grammar, or usage.

[Note: Although these guidelines are single-spaced, your entire paper must be double-spaced.]

The Introduction to the Paper

[Use title of the paper in uppercase and lowercase letters and centered at the top of a new page.]

1. The introduction to the paper, which should not have "Introduction" as a heading, follows immediately below the title of the paper, which is typed in uppercase and lowercase letters and centered. (There is no heading labeled "Introduction" since it is assumed all papers begin with an introduction; see APA, 6th ed., p. 27.)

2. In a course paper, the introduction section should state the **question** to be answered, the **thesis** to be argued, or the **problem** to be solved. If the paper is a special purpose paper (e.g., an annotated bibliography or an interview report), the introduction should make the paper's purpose clear and identify the types of issues that will be addressed.

3. The introduction should provide a **brief background of the main issues** involved in the question, thesis, or problem. It should not provide a lengthy theoretical overview of the entire field of study. For example, if the question you are writing about is whether X is an effective method of leadership for Y project teams, it is not necessary to go into detail about the history of leadership or the origins of project management in the United States. Nor is it necessary to discuss in great detail the origin and development of the X leadership theory (or its relationship with any other form of leadership). An acceptable background passage would include a brief description of the problems that make the new leadership strategy necessary, sufficient information for the reader to understand what X leadership consists of and what the problems of Y project team applications look like, and a brief outline of why X might be useful in addressing the problems of Y. These points, while limited in scope, should be supported with citations to the relevant literature. In the introduction, these citations should be given succinctly; they will be more fully elaborated and critically evaluated in the main body of the paper (see below).

4. Next, the introduction should also state the **main points** that will be developed in the paper to answer the question, argue the thesis, or solve the problem. The logic of the argument should be apparent to the reader. In the case of a special paper (such as a report of an interview), the main themes that will be addressed should be stated. This requirement makes **outlining** your paper an important step, because creating an outline will assist you in ensuring that your paper indeed has main points and that those main points indeed are lined up logically. Make sure that the brief statement of the main points of your argument (in the introduction) follows the order in which the points are handled in the body of the paper.

5. The introduction should also briefly state the **conclusions** that the paper will reach, without going into detail about them. In the case of a special paper, there should be a clear statement of what you took away from the experience of preparing the paper.

6. Many writers write the introduction after the main body of the paper is finished.

7. Your theme in the introduction is "Tell them what you will tell them."

The Body of the Paper

[Level 1 heading; use words appropriate to your topic]

Organization of the Body of the Paper

[This is a Level 2 heading; use words appropriate to your topic.]

- The organization of the main body of the paper should follow the points stated in the introduction. The key is that the main points line up logically to support the objective of the paper. Again, an outline will prove helpful. In the case of special papers, the actual assignment may predetermine the outline.

- Keep your focus: Stick to the main points stated in the introduction. **Answer** the question, **argue** the thesis, or **solve** the problem. Do not introduce unrelated or tangential ideas in the main body of the paper. (See the next point.)

- Follow exactly the logic and outline you wrote in the introduction, if you wrote that first. If you will write your introduction last, Capella faculty highly recommend that you have and stick to an outline. If in working on the main body, you come across new information that changes your argument, be sure to revise the introduction to include the new points.

Literature Review Section

[This is also a Level 2 heading; use words appropriate to your topic.]

- In the main body, you will be describing, evaluating, and drawing conclusions from the literature that you reviewed for this paper and may have mentioned briefly in the introduction. You should present the literature review as follows:

- Describe the particulars of the studies (population, approach, methods, and findings) or the main points of the theories (key concepts and variables). Remember that your readers did not read the study, so they need to know what the study actually did and what it was designed to do.

- Evaluate the strength of the research you reviewed. (For example, a study that has a sample of five people is weak when it comes to generalization to an entire population. Its findings should be considered with caution, and you should state that in your analysis.) Other factors to evaluate include the correctness of the methods related to the research question, the appropriateness of the instruments, and the logic of the interpretation of the conclusions.

- Discuss the articles' conclusions in terms of how they support or challenge your own position, which is the focus of the paper.

Evaluation of the Literature

[This is also a Level 2 heading; use words appropriate to your topic.]

- **Critical thinking** is crucial in the main body of the paper. Do not just report studies; **evaluate** them (see the preceding point). Do not merely analyze or compare-and-contrast; these steps are important, but you do them when you report on the studies. Try to synthesize or integrate studies (bring disparate studies together to focus on the same issue) and always evaluate them. Are the studies you are presenting well designed and logically interpreted? Do they support your point? If they challenge your point, can you show why they fail to do so successfully?

- Critical thinking also requires that you give those who see things differently their due. Search for alternative hypotheses, opposing views, and differing explanations. Report these too, and analyze and evaluate their strengths. If the opposing views are stronger and more robust, be humble enough to adopt them or acknowledge them. If you do not adopt them in the end, explain why not.

Alternative Explanations and Approaches

[This is also a Level 2 heading; use words appropriate to your topic.]

- When you have adopted a position (based on your literature review and evaluation), mention alternative explanations, even if the original author(s) failed to do so. This shows high-level critical and creative thinking about the research you are relying on and about your own work.

- After you finish the main body of the paper, write a brief summary of your main points and a transitional sentence or paragraph looking ahead to the Conclusion section.

- Your theme in the main body of the paper is "Tell them what you have to tell them."

Conclusion

[Level 1 heading]

- In the conclusion section, you should once again summarize the main points. Your summary need not be more than one or two sentences, since you already provided one in the ending of the main body (see above). Most important: be sure to answer the question you raised for the paper in a very clear statement. For example, if your paper raised the question "What approaches to change management are most effective when midsize manufacturing companies are faced with requirements to downsize?" you should answer it clearly. Do not leave it to your readers to draw their own conclusions. Readers may disagree with your conclusions, but they should know what they are and how you came to them. Showing them the how is the job of the main body of the paper. Your theme in the conclusion is "Tell them what you told them."

- What do your conclusions mean? Offer your interpretation of the meaning of your conclusions about the thesis, your answer to the question, or your solution to the problem.

- Include a subsection evaluating the strengths and weaknesses (limitations) of your paper. Could it be organized in a better way? Might you have explored different literatures if you had had more time? If you had this paper to do over again, how would you improve it? In a term paper, this discussion need not be extensive, but give evidence that you have considered it. Critiquing your own work is excellent practice for your comprehensive exams, dissertation, or integrative project.

- What questions has this paper raised for you that go beyond its topic? Include a subsection about recommendations for future study that proposes questions that you think should be investigated further, related problems remaining to be solved, or elements of the thesis that were not argued fully. Again, this need not be extensive, but practice it in every paper you write.

- Finally, take your final position. Is there anything you want to say about the issues you have discussed in this paper? At the graduate level, it is appropriate to take a position, to state your own opinion based on the research you have done. Do it here. It is also acceptable to describe any takeaway messages you got from doing the project.

- Be sure to use third-person writing throughout the entire paper. Some authors try to make their writing more formal by using the word *we*, but this is inappropriate and misleading. Was there more than one person writing the paper and doing the literature review and evaluation? If there is only one name on the title page, there should not be *we* writing the paper!

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References

[in uppercase and lowercase letters; centered at the top of a new page]

American Psychological Association. (2010). *Publication manual of the American Psychological*

Association (6th ed.)*.* Washington, DC: Author.

The reference list must comply with Chapter 7 of APA sixth edition. Perfection is the standard. Here are some common reference list errors (per Capella University faculty experience):

- Incorrect capitalization of or failure to italicize titles of books and journals. Capitalize only the first word of book titles (and the first word after a colon), but capitalize all main words of a journal title.

- Incorrect capitalization of journal article titles. Capitalize only the first word (and the first word after a colon).

- Incorrect citation of Web-retrieved articles.

- Incorrect italicization of book and journal titles. Italicize book titles and titles of journals. Edition numbers (in parentheses), chapter titles, and article titles are not italicized.

- Incorrect use of ampersand (&) versus *and* when referencing multiple authors of a particular work. In reference lists, use ampersand before the last author listed.

- Incorrect use of commas and periods in citations and reference lists. (For in-text citations, a common error includes placing periods before rather than after the author-year citation in a sentence.)

- Too frequent use of secondary or tertiary sources (such as textbooks, summary articles, and reviews) rather than primary sources (original research or theory). Use primary sources at least 75 percent of the time.

- Unnecessary inclusion of the issue number after the volume number in a reference to a periodical. Include the issue number only if the pages are numbered in each issue starting at 1.

- Inclusion of in-text citations not referenced in the reference list.

- Inclusion of references that are not cited in the text.

Appendix

[in uppercase and lowercase letters; centered at the top of a new page]

Note: In a course term paper, an appendix is unlikely to be necessary. Use an appendix only if the paper refers to some document, instrument, data set, or other material that the reader should be able to see but that would distract if included in the main text.

APA Format and Style Issues

The pages cited below from the sixth edition of the APA manual do not represent every APA requirement. They are areas that represent errors commonly made in papers, as reported by faculty instructors across Capella.

- *Title page* (p. 229).

- *Abstract* (pp. 25–27)

- *Table of contents*—not usually required but may be at the instructor's preference. If using one, go to the Insert menu (MS Word) and use the Index and Tables tool or the Table of Contents tool. The inclusion of two heading levels is recommended.

- *Formatting and order of pages* (pp. 228–230).

- *Sample papers* (pp. 41–59). A sample paper is also included in this writing guide in Section 3, and your paper should look very similar to it. You may not utilize everything illustrated, but if you do, use the sample as a guide.

- *Headings*—appropriate use is very important (pp. 62–63).

- *Series*—knowledge of all types is very important (pp. 63–65).

- *Spelling* (p. 96).

- *Text citations*—brief notes that identify sources used in the text (pp. 169–192).

- *References* (pp. 193–224).

- *Quotations* (pp. 170–174).

- *Tables and figures*—if you use them (pp. 125–167).

- *Appendices*—if you use them (pp. 38–40).

Section 3 – Course Paper Sample

The sample paper was written for the School of Psychology; however, its basic precepts are applicable across the entire university.[1] To maintain consistency, instructors should require strict APA formatting; however, you should always ask instructors their preferences on the first day of class. Unless otherwise indicated, this paper adheres to the sixth edition of the *Publication Manual of the American Psychological Association*. (See the sample papers in the APA manual starting on page 41.)

Running head: LEARNED HELPLESSNESS AND PATIENT ADHERENCE[2]   1

Learned Helplessness and Patient Adherence in Medical Treatment[3]

Name of Learner

Capella University

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[1] **General guidelines include setting uniform 1-inch margins at the top, bottom, left, and right of each page and using a uniform typeface—preferably Times New Roman or Courier—and font size (usually 12-point) throughout the paper.**

[2] **The running head should contain the keywords from the title. The running head is also placed in the manuscript header, which repeats on each page, starting on page 2. All pages should be numbered.**

[3] **Center the title between the left and right margins and place it in the upper half of the page.**

Abstract

[4]Learned helplessness (LH) is a condition that can negatively impact patient adherence to medical treatment, which represents a significant factor in the cost-therapeutic-effectiveness index. LH represents an irrational self-attribution that results in a patient giving up. Through assessment, however, LH is readily identifiable, and once identified, LH responds to cognitive-behavioral interventions. Health care professionals can also initiate procedures to inhibit the development of LH in the medical setting. Effectively addressing LH in the medical setting, therefore, can significantly improve the cost-therapeutic-index for medical treatment.

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[4]**Abstracts should be left aligned, with no indentation. The preferred length of an abstract is 250 words or fewer. Do not confuse the abstract with an introduction to the subject. An abstract is a summary of every main point in the paper (APA, 6th ed., pp. 25–27).**

Table of Contents[5]

[5] The APA manual does not mention a table of contents, but if it is an instructor's preference, please consider the one below as a model. If including a table of contents, go to the Insert menu (in Microsoft Word) and select the Index and Tables tool or the Table of Contents tool.

[6] Indent the Level 2 headings in the table of contents.

Learned Helplessness and Patient Adherence in Medical Treatment[7]

A medical patient with chronic conditions can experience many failures in an attempt to control his or her condition. Repeated failures at exerting self-control measures can result in a patient's diminished perception of self-ability to influence the course of a chronic condition. As a result, a patient may develop negative self-appraisals. Negative self-attributions can surpass the impact of the medical condition on the patient's overall level of disability (Turk, 1996). Learned helplessness (LH)[8] develops when a patient perceives his or her condition as uncontrollable, feels no current self-control over outcomes, and negatively assesses future events (Peterson, Maier, & Seligman, 1993).

Medical professionals, according to McKean (1994), can use psychological testing to identify patients who are prone to develop or who currently experience a condition of LH. As noted by Henkel, Bussfeld, Möller, and Hegerl[9] (2002), LH is a reversible condition, and, as observed by both Faulkner (2001) and McKean, medical professionals can, most importantly, prevent the development of LH. The psychological impact of the patient's perception of self-control or a lack of self-control influences the effectiveness of pharmacological interventions and overall activity levels; therefore, intervention and prevention strategies can enhance patient adherence and treatment outcome (Turk, 1996).[10]

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[7] **Do not use "Introduction" as a heading. Instead, type the paper's title with title-case capitalization.**

[8] **Use acronyms for frequently used terms.**

[9] **For a work that has three, four, or five authors, list all authors the first time the work is cited.**

[10] **In the introduction, paragraphs often contain multiple points with multiple citations. In the body of the paper, paragraphs usually contain one citation or at most two citations supporting the main point of the paragraph.**

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Understanding LH[11]

LH Defined[12]

The theory of LH encompasses three areas. Contingency represents the patient's perception of a lack of control between his or her responses and the outcome of the condition. Cognitively, the patient personalizes his or her condition and presents a negative expectancy for outcome. Peterson et al.[13] (1993) argued that because personal responses fail to impact the condition and the patient anticipates continued personal failure, behaviorally the patient displays passive behavior as the result of noncontingency.

Faced with the perceived uncontrollable events of a chronic medical condition, a patient experiencing LH views his or her condition as uncontrollable and sees no alternatives to avoid or escape the negative effects of a progressive condition. [14]With no sense of self-control of current and future events, the patient experiences cognitive impairment, which, Gluck (1997) concluded, restricts learning adaptive behaviors. In a stimulus-response model, Terry (2003) observed that when a patient is faced with uncontrollable events, the patient learns there is no contingency between his or her response and the undesired outcome. Cognitive theory, as described by Henkel et al. (2002), defines helplessness as an unrealistic and negative appraisal of personal

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[11] This is a Level 1 heading.

[12] This is a Level 2 heading. Typically, two or three levels of headings are adequate for a course paper.

[13] Use *et al.* (not italicized) after a work with three or more authors has been cited once. Note that there is not a comma before *et al.* and that there is a period only after *al.*

[14] Use two spaces between sentences (APA, 6th ed., p. 88).

competence. Moreover, Seligman (1998) defined LH as quitting or giving up because no personal action will change the current situation.

LH as described in the stimulus-response model differs from LH in the cognitive model. In the stimulus-response model, the stimulus (the uncontrollable medical condition) results in a lack of response (LH). In a cognitive model, the activating event (the medical condition) does not result in a condition of LH. Instead, Ellis (1973) noted that the patient's belief about his or her medical condition results in LH. Consistent with a cognitive view of LH, a patient does not develop LH in response to a chronic medical condition; rather, a faulty belief system predisposes the patient to LH. Finally, as Henkel et al. (2002) added, patients may experience the uncontrollable onset of a chronic condition, but LH is the eventual result of the belief that they have no control over the future outcome of their condition.[15]

Attributions and LH

A patient who believes he or she cannot control a chronic medical condition, as noted by Barder, Slimmer, and LeSage (1994),[16] may begin to develop negative self-attributions of personal incompetence and to accept global attributions that no one can alter the condition. Furthermore, if the patient's negative attributions are stable and global, he or she is more likely to experience recurrent depressive episodes. According to Yee, Pierce, Ptacek, and Modzelesky (2003), a patient with tendencies to attribute the causation of multiple life events to a similar source is more susceptible to develop LH. Confronted with a chronic medical condition and

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[15] **All paragraphs should contain at least one citation to adequately support your positions.**

[16] **Make sure every work cited in text has a corresponding entry in the reference list. This one is missing from the reference list.**

failed attempts to improve his or her condition, the patient is more likely to develop global

attributions of failure and incompetence.

Seligman (1998) argued that global attributions represent a patient's habitual manner of

explaining why events occur in life. According to Seligman,[17] negative explanatory style or a

generally pessimistic outlook can inflate minor setbacks into significant personal defeats. As a

consequence, in Seligman's model of LH, the chronic medical condition is not the sole

precipitator of LH. The patient instead perceives the medical condition from a global, pessimistic

perspective. The chronic medical condition is but one of many uncontrollable life events, but the

impact of a chronic medical condition may serve as the final overwhelming event that results in

the patient giving up. Peterson et al. (1993) noted that the role of attributions in

the development of LH, therefore, represents the reformulated model of LH. In the reformulated

model, causal attributions interact with uncontrollable events that result in LH. Universal

helplessness and personal helplessness represent two perceptions of uncontrollability. Universal

helplessness thus occurs when the patient experiences a chronic condition that is terminal and

has no cure. All individuals who experience the disorder die, and no one can intervene to change

the course or outcome of the condition. Personal helplessness represents an event in which a

patient with a chronic condition does not improve in therapy, but other patients with the same

condition do improve. As a result, the patient becomes self-recriminating and develops a

diminished self-esteem. In universal helplessness, no one, including the patient, can alter the

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[17] **Once you have cited the date of a work in a paragraph, you do not have to repeat the date in that paragraph, unless the citation is entirely parenthetical (APA, 6th ed., p. 174).**

prognosis. Although helpless, the patient is not self-recriminating and does not experience a

diminished self-esteem.

In the reformulated theory of LH, the individual's beliefs or attributions, as argued by

Peterson et al. (1993), are more significant in the development of LH. For example, an extreme

experience can result in the development of LH, but LH is more likely to develop as the result of

an individual's expectancy of uncontrollability. A patient who expresses a lack of influence or

control in multiple life circumstances is therefore likely to apply his or her negative, global

attribution to the medical condition. As a consequence, as with all other areas in his or her life,

the patient views personal effort as futile because of the expected negative outcome, and, most

importantly, the patient's expectancy of outcome is now independent of his or her responses.

Not only is the current situation beyond his or her control, but the patient now anticipates that all

future situations are beyond such control. Again, as Seligman (1998) observed, LH is quitting or

giving up because no personal action will change the current situation or future situations.

According to Peterson et al. (1993), global and pessimistic expectancies represent causal

factors of LH; however, a patient's causative explanations are not necessarily causal factors. A

careful analysis of three[18] domains of the patient's causal explanations may indicate vulnerability

for LH. The patient attributes the uncontrollability of his or her current condition to personal

factors. As stated above, beliefs of personal uncontrollability indicate low self-esteem. The

patient's causal explanations are stable across time. As Peterson et al. pointed out, the failure of

past and current efforts to impact his or her condition is sufficient to negatively predict future

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[18] **Numbers one through nine are spelled out, except as noted in the APA manual (pp. 111–112).**

effort. The patient's causal explanations generalize across multiple life areas and are not specifically limited to his or her medical condition.

LH or Learned Dependency

Learned dependency resembles LH, but learned dependency is an outcome of a learning process. As argued by Baltes (1995), learned dependency represents a reliance of one individual upon others. Noncontingencies associated with LH impair the individual's ability to form associations between responses and outcomes; thus, negative expectancies of future conditions block learning (Peterson et al., 1993). In learned dependency, the individual may experience physical, social,[19] or economic loss, but in return, he or she may gain attention and social contact (Baltes, 1996). Baltes contended that LH is often inappropriately identified in the elderly population. While cases of LH are found in the elderly population, learned dependency often results in environments that utilize a medical model in which the patient's personal responsibilities are assumed by the caretaking environment.

Coping Style and LH[20]

Zhukov and Vinogradova (2002) hypothesized that a difference in genetically based coping styles may explain why some individuals develop LH and others do not. Using genetically bred rats, Zhukov and Vinogradova exposed an active, high avoidance group of rats and a passive, low avoidance group of rats to inescapable shock. Rats in the active coping style group attempted to escape the shock. If allowed to escape or even to incorrectly perceive

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[19] Use commas after each item in a series.

[20] When a heading at or near the bottom of a page is not followed by at least two lines of text, move the heading to the next page.

success through activity, the rats in the active coping style group did not develop LH. If the active coping style group was prevented from escaping or performing active behaviors to escape the shock, the rats developed LH. The rats in the passive coping style group made no effort to escape and did not develop LH. The researchers concluded that rats with active coping styles will develop LH if deprived of the opportunity to actively escape the shock. In contrast, rats with passive coping styles do not display escape behaviors and therefore cannot be deprived of the opportunity to escape.

Compared to the passive coping style rats, the active coping style rats had a higher mortality, more behavior problems, and a higher incidence of peptic ulcers. The need to exert escape behaviors was unnecessary for the passive coping style rats; however, if the active coping style rats had the illusion their behavior was even slightly successful, they did not develop LH. Active coping styles were characterized by sympathetic activity and passive coping styles by parasympathetic activities (Zhukov & Vinogradova, 2002).[21] Zhukov and Vinogradova identified the passive coping style as resistant to the development of LH.

A Limited Resource Model

Muraven and Baumeister (2000) proposed a self-regulation and limited resource model to explain the impact of severe and/or[22] prolonged stress. Self-control requires energy and energy can be depleted. Volition associated with an active coping style requires strength and energy, which are limited resources. All efforts of self-control draw upon the same reserves of strength

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[21] **Use an ampersand (&), not *and*, in a citation within parentheses.**

[22] **Avoid *and/or* constructions. They are awkward and invite misinterpretation. This phrase could be rewritten: "severe stress, prolonged stress, or both."**

and energy. Situations that require more self-control are subject to a more rapid depletion of resources and, ultimately, a breakdown in self-control. Acts of self-control thus diminish the available reserves of strength available for subsequent acts of self-control. If conditions are favorable, strength and energy reserves are not depleted, and with rest, the reserves are replenished.

Muraven and Baumeister (2000) observed that a limited resource model predicts that, confronted with a difficult task, the exertion of self-control diminishes reserves and decreases the potential for success in successive attempts. In the classic model of LH, if efforts of self-control have no impact on outcome, the individual learns a noncontingency between effort and outcome. In the limited resource model, the presence of stress requires multiple acts of self-control. Attention, vigilance, and other behaviors associated with sympathetic arousal require multiple acts of self-control. Each act of self-control draws upon the same sources of strength and energy. When faced with a significant stressor, the individual has less capacity to respond. In the limited resource model, an active coping style, as described by Zhukov and Vinogradova (2002), would require multiple simultaneous acts of self-control. A passive coping style requires less self-control and therefore consumes less strength and energy. In an attempt to explain the impact of overwhelming stress, Muraven and Baumeister (2000) proposed an exhaustion theory as opposed to LH.

General Adaptation Syndrome

The limited resource hypothesis of Muraven and Baumeister (2000) posited an exhaustion theory that correlates with Selye's (1984) general adaptation syndrome (GAS). GAS maintains that stress initiates an alarm reaction in organisms. The alarm reaction represents the

mobilization of the organism's resources to cope with the stressor. An organism is unable to sustain a prolonged alarm reaction. In order to prevent the depletion of resources and death, the organism must shift into an adaptive phase or a resistance phase. The alarm reaction represents a biological "all-out"[23] frontal attack. The resistance phase represents a siege strategy to conserve resources and wear down the stressor. Although an adaptive action to conserve resources, an extended resistance phase eventually depletes the organism's resources (the exhaustion phase). The exhaustion phase is similar to the end of the alarm phase. Resources are exhausted and the organism is unable to sustain action against the stressor. The alarm phase, resistance phase, and exhaustion phase represent a course consistent with evolution.

Selye (1984) explained that GAS represents two domains. The three phases of alarm, resistance, and exhaustion represent time. Adrenal, thymicolymphatic, and intestinal changes represent space. On exposure, the stress or stressors responsible for the development of LH initiate the alarm phase of GAS. If the power of the stressor is sufficient to result in LH, remaining in the alarm phase would quickly deplete resources and result in death. The adaptive strategy is to enter a phase of lower intensity but sustained action.

The stress response represents a physiological mechanism consisting of three components, as noted by Selye (1984). The first component is the direct impact of the stressor. The second component is the mobilization of resources for attack and defense. The third component is the inhibition of unnecessary responses to conserve resources. Reactions to stress consist of attack and retreat or "passive tolerance." The resistance phase represents the organisms

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[23] **Use double quotation marks to accentuate a word or phrase (APA, 6th ed., p. 91).**

attempt to cope with a prolonged stressor. Henkel et al. (2002) observed that the resistance

phase and LH are both characterized by increased adrenal activity.

LH and GAS

In LH, Selye (1984) argued that the overwhelming event or events would initiate the

alarm phase of GAS. In response, a sustained alarm action would quickly deplete resources and

result in exhaustion. In order to maintain a defense, heightened activity of the alarm phase shifts

into a resistance phase. Resistance represents a lower intensity reaction to stress that conserves

resources and, thus, sustains the defense against the stressor and inhibits the onset of exhaustion

and breakdown, the by-products of overwhelming stimulus.

Ellis (1973) maintained that the perceived overwhelming stimulus does not result in LH.

Instead, the individual's personal belief about himself or herself in relation to the overwhelming

stimulus results in LH. According to Gluck (1997), LH causes cognitive impairment that restricts

learning adaptive behaviors. Seligman (1998) defined LH as giving up as a result of the failure

of personal action to change current circumstances.

In LH, failure to change the situation leads to beliefs related to personal ineptness

(Peterson et al., 1993). In the GAS model, to prevent exhaustion and death, failure to change the

overwhelming stimulus would necessitate shifting from the alarm phase to the resistance phase

(Selye, 1984). Failure to change the current circumstances leads to the belief that all future

attempts at change are predictably futile (Peterson et al., 1993). Beliefs of personal ineptness

may represent adaptive behavior occurring in the resistance phase.

In the resistance phase, activity is decreased to maintain a prolonged defense that reduces

the draw upon personal energy and resources (Selye, 1984). Increased adrenal activity

characterizes LH and the resistance phase of GAS (Henkel et al., 2002; Selye, 1984). An

increase in adrenal activity indicates an increase in sympathetic nervous system activity and a

heightened state of physiological arousal, as noted by Tortora (1994). For an individual faced

with an actual or perceived overwhelming stimulus, Selye (1984) argued that a high level of

activity would rapidly deplete energy and resources, leading to a state of exhaustion, breakdown,

and death.

An individual experiencing LH is cognitively passive (Peterson et al., 1993) but maintains

physiological arousal indicative of resistance (Henkel et al., 2002). The resistance phase prolongs

defensive behavior, but eventually energy and resources are depleted and the individual enters the

exhaustion phase (Selye, 1984). Cognitive passivity may represent an adaptive response in the

resistance phase of GAS. Cognitively, passivity represents the individual's belief of

uncontrollability in response to the overwhelming circumstances (Ellis, 1973). The individual's

belief and not the event result in the emotional consequence of LH. The perception of failure and

adoption of passivity may represent an adaptive response to conserve energy and resources. In

the limited resource model, the presence of stress requires multiple acts of self-control (Muraven

& Baumeister, 2000). As noted by Zhukov and Vinogradova (2002), active coping necessitates

multiple simultaneous acts of self-control and increases the consumption of energy and resources.

The increased consumption of energy and resources associated with active coping would expedite

the transition from the resistance phase to the exhaustion phase. Adaptively, a passive style of

coping would consume less energy and resources and prolong the transition from resistance to

exhaustion.

Passive Volition

When an individual is confronted with an overwhelming stressor, his or her volition requires strength and energy, which deplete resources (Muraven & Baumeister, 2000). Volition represents active striving to control the process. In contrast, passive volition represents allowing the process to occur (Peper, 1979a). Zhukov and Vinogradova (2002) demonstrated how coping styles respond differently to uncontrollable stimuli. Individuals with active coping styles attempt to escape. Individuals with active coping styles do not develop LH as long as they believe their efforts obtain some success. The effort may have no actual impact on the stressor, but accurate or inaccurate, the belief of success prevents the development of LH. When confronted with failure, individuals with active coping styles are susceptible to LH.

An individual with a passive coping style is not motivated to escape and therefore makes no effort to escape an overwhelming stimulus, observed Zhukov and Vinogradova (2002). Active coping is associated with sympathetic arousal and passive coping with parasympathetic +arousal. Active coping compared to passive coping resulted in higher mortality, more behavior problems, and an increase in the incidence of peptic ulcers. Overall, an individual with a passive coping style appears resistant to LH.

Zhukov and Vinogradova's (2002)[24] experiment utilized genetically bred rats to produce active and passive coping styles. Developing a general passive coping style in humans may not be acceptable or necessary; however, humans can learn to cope via passive volition (Peper,

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[24] **In a new paragraph, repeat the year of a work that has already been cited.**

1979a). Active coping strives for a successful future outcome (Peper, 1979b).[25] Passive volition

maintains a focus on the present and an awareness of the process. Rather than striving to reach

the end, learning passive volition is becoming a part of the means that eventually reaches the

end.

Passive volition is a necessary process for learning the self-regulation of autonomic

functions (Peper, 1979b). Passive volition can be learned and therefore does not require a

generalized coping style, as demonstrated by Zhukov and Vinogradova (2002); however, their

research indicates that a passive coping style is resistant to LH. Passive volition represents a

learned coping strategy that, similar to a passive coping style, increases parasympathetic activity

and may serve to selectively prevent LH (Peper, 1979b).

Locus of Control and LH

Peterson et al. (1993) viewed both locus of control and causal attributions as cognitive

constructs that influence and explain individual behavior. Locus of control and causal attributions

relate to individual behavior and outcome and may influence individual motivation. Peterson et al.

defined locus of control as a belief in the type of reinforcement the individual experiences.

Reinforcement includes the rewards and punishments of the environment. In contrast, causal

attributions refer to the individual's appraisal of life events. Internal causation in LH refers to

how the individual explains the cause of the uncontrollable event.

Accepting an internal causation defines the circumstance as unique to the individual and

decreases self-esteem (Peterson et al., 1993). Accepting an external causation defines the

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[25] **When two or more works by the same author from the same year are cited, add a lowercase letter after the year to distinguish one work from the other: 1979a, 1979b.**

circumstance as a condition that could happen to all other people and therefore does not affect the individual's self-esteem. An internal locus of control indicates self-responsibility and independence (Grunfeld, Jahanshahi, Gresty, & Bronstein, 2003). An external locus of control indicates abdicating personal responsibility to others and dependence. An internal locus of control is associated with personal passivity and an external locus of control with personal activity. Within this description of causal beliefs and locus of control, individuals with an external locus of control and an internal causal belief view the rewards and punishments in life as something done to them and attach causation as unique to themselves. Individuals with an internal locus of control and an external causal belief view the rewards and punishments of life as something generated from within and attach causation as universal.

Locus of control and LH are not necessarily general in scope or constant in time (Grunfeld et al., 2003; Peterson et al., 1993). An uncontrollable event can alter an individual's locus of control. For example, when an individual with an internal locus of control experiences a serious accident resulting in a permanent injury and a chronic pain condition, the patient perceives his or her condition as, "Why did this happen to me and what did I do to deserve this?" The uncontrollable event is the accident. The accident results in a change in the individual's locus of control from internal to external ("What did I do to deserve this?"). The individual now views the life event as an external punishment applied to himself or herself. In addition, the individual internalizes the cause of his or her condition ("Why did this happen to me?"). The individual now assumes a personal causal belief. In reverse, Grunfeld et al. (2003) argued that the passage of time, a change in circumstance, or both can alter the individual's locus of control and causal belief, resulting in a waning of LH.

The Biological Aspects of LH

In animal studies, rats exposed to inescapable shock experienced a reduction in norepinephrine (NE) levels in the brain (Peterson et al., 1993). A depletion of NE, Peterson et al. and Tortora (1994) argued, can result in mood alterations and motor deficits. The administration of drugs to deplete or block NE resulted in a failure to learn escape behavior as seen in LH. Drugs administered to prevent the depletion of NE as a result of inescapable shock blocked the learning deficit observed in LH (Peterson et al., 1993).

Rats exposed to inescapable shock experienced lower levels of gamma-aminobutyric acid (GAMA) than rats that experienced escapable shock (Peterson et al., 1993). Lowered levels of GAMA resulted in anxiety (Peterson et al., 1993; Tortora, 1994). Similar to NE, drugs that deplete GAMA resulted in anxiety. Drugs administered to prevent the depletion of GAMA offset the presence of anxiety following inescapable shock, and while inescapable shock resulted in lower levels of GAMA, escapable shock did not. Henkel et al. (2002) reported deficits in serotonergic mechanisms in LH. Furthermore, uncontrollable stress appeared to increase the activity of the hypothalamo-pituitary-adrenal (HPA) system resulting in an increase in sympathetic activity (Henkel et al., 2002; Tortora, 1994).

Assessing LH

To appropriately assess the risk for developing LH, McKean (1994) emphasized the need to assess across the three domains of LH. Passivity, giving up, and procrastination are risk factors for LH in the behavioral domain. Low self-esteem, high levels of frustration, and a deficit in problem-solving skills are risk factors for LH in the cognitive domain. Dysphoria and a depressed mood following the occurrence of negative experiences are risk factors for LH in the

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affective domain. McKean (1994) concluded that preventing and treating LH require a global

assessment of LH to understand the interrelationships between the behavioral, cognitive, and

affective domains. McKean used four tests to assess the risk factors for LH. The Learned

Helplessness Scale is a 20-item scale to assess expectations of uncontrollability. The

Explanatory Style Questionnaire identifies explanatory styles regarding negative outcomes. The

Procrastination Assessment Scale for Students identifies tendencies to procrastinate on tasks

related to academic performance. The Beck Depression Inventory identifies depression and

specific emotional factors related to LH.

In a study to identify the role of LH in fibromyalgia,[26] Nicassio, Schuman, Radojevic,

and Weisman (1999) used a 2-hour psychosocial interview; administered the Pain Rating Index

of the McGill Questionnaire to measure the sensory, cognitive, and affective components of the

patient's response to pain;[27] administered the Fibromyalgia Impact and Assessment

Questionnaire to assess the impact of pain during the patient's previous week; and administered

the QWB Scale to assess the patient's level of disability as a result of pain over the previous

week.

Seligman (1998) focused on the individual's explanatory style following negative life

events. Seligman identified self-attributions as a reason that strict behavioral principles of

stimulus-response better represent animal behavior than human behavior. A continuous

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[26] **APA does not require capitalization of diagnostic terms unless they are proper nouns (for example, Alzheimer's disease, Huntington's chorea).**

[27] **Replace commas in a series with semicolons when there is interior punctuation within one or more of the clauses or phrases making up the series. Also, note that this series of clauses uses parallel constructions—that is, each item in the series has the same grammatical structure.**

reinforcement schedule in animal studies results in a rapid extinction of behavior following the withholding of the reward; in comparison, partial reinforcement sustains behavior much longer before extinction occurs. In contrast, a person who explains the withholding of reward negatively (for example, "they have decided not to give me any more rewards") will give up. A person who perceives the withholding of reward with a positive explanatory style (for example, "the equipment is broken") will view the absence of reward as temporary and expect the circumstances to change. Human behavior is not simply determined by a schedule of reinforcement in the environment. Humans attach attributions to explain why the environment schedules reinforcement in a particular manner.

[28]The assessment of attributions to identify the risks for developing LH or the presence of LH necessitates identifying an explanatory style (Seligman, 1998). The assessment of LH in real-world conditions includes assessing across three dimensions: permanence, personalization, and pervasiveness. Permanence represents giving up because of the belief that the results of bad events are enduring. In contrast, transience represents perseverance because of the belief that the results of bad events are temporary. Personalization represents giving up because the cause of bad events are internalized and characterized by a belief of self-blame. People who externalize the cause of negative events and believe good things result from life circumstances maintain a positive self-esteem. A positive self-esteem promotes a belief of generating positive outcomes. Pervasiveness represents an individual's propensity to catastrophize. Permanence concerns time and pervasiveness concerns space. A universal negative explanatory style represents a belief that

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[28] **Note that the first two sentences, which were constructed to convey a comparison, use parallel construction.**

failure in one situation results in failure in many or all situations. A feeling of helplessness can generalize across multiple life events or it can be localized and attributed to a specific event. Generalization contributes to LH and localization inhibits LH. Personalization controls feelings toward negative events. Permanence and pervasiveness control the responses to negative events. Permanence indicates the duration of LH, and pervasiveness indicates the depth of LH.

Assessing LH to improve patient adherence to treatment requires an effective and efficient assessment procedure. Measuring across the three domains of LH as suggested by McKean (1994) required four tests, and only three of the tests are appropriate for the medical setting. Nicassio et al. (1999) utilized three tests and a 2-hour[29] psychosocial interview to assess LH; furthermore, the tests are limited to use in a pain population. Seligman (1999) utilized a single instrument devised by Seligman and Teasdale[30] to assess the patient's attributional style.

Assessing across the three domains as prescribed by McKean (1994) represents an effective approach to assessing LH, but utilizing three tests in a medical setting is time consuming for the patient and the medical staff. Also, completing three tests may exceed the endurance capacity of many patients. Utilizing three tests to assess LH increases cost by requiring more materials and staff time to score and interpret the results. Nicassio et al. (1999) also used three tests that are appropriate for the medical setting, but their method of assessment represents similar problems with resources and cost found in McKean's approach. While

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[29] **When a number refers to time, a date, or an age, use a numeral (APA, 6th ed., p. 112).**

[30] **Reference is missing from the reference list.**

appropriate for a medical setting, the tests are limited to a pain population, and one test is limited to a population with fibromyalgia.

Seligman (1998) used one test to focus on three domains of the patient's attributional style to assess LH. He focused only on one of the three domains of LH but considered the cognitive domain as the most important of the three. He utilized a test with 48 questions. The patient selects one of two responses provided for each question. The test requires approximately 15 minutes to complete and a brief period for scoring and interpretation. Utilizing Seligman's method of assessment offers an efficient and cost-effective approach to identifying risk factors for LH or the presence of LH. If the test from Seligman and Teasdale results in a positive finding that identifies a patient's attributional style as consistent with LH, testing the other two domains as suggested by McKean (1994) may be warranted. Initially assessing the cognitive domain could improve the cost-effectiveness ratio for assessing LH in a general medical population across multiple medical settings.

Prevention and Intervention

Faulkner (2001) identified the need to assess hospital environments that treat older individuals for patient empowerment and disempowerment. Empowerment is a social process that promotes the individual's ability to service personal needs, to resolve personal problems, and to facilitate a feeling of self-control.[31] Empowering environments promote activity and renew an interest in life. In contrast, disempowering environments are controlled, do not encourage patient participation in the treatment process, increase dependency, and may

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[31] **Note the parallel structure in the preceding three items: "to service, to resolve, and to facilitate."**

 contribute to the development of LH. The regular assessment of hospital environments could

identify factors contributing to patient empowerment and disempowerment. Results of the

assessment process could then be used to adjust program environments to promote patient

empowerment. Henkel et al. (2002) stated that patients need to internalize a belief of self-

efficacy. In addition, patients need to feel a sense of personal control and personal influence

over their lives.

Individuals who successfully cope and manage difficult circumstances early in life

develop personal resilience. Resilience improves an individual's ability to cope with future

negative events (Overmier, 2002; Peterson et al., 1993). Treating a patient with LH includes

teaching the patient beliefs related to personal control in situations initially perceived as

uncontrollable (Peterson et al., 1993). Treatment needs to incorporate elevating the patient's

mood. The patient needs to learn to analyze past failures to identify ineffective strategies and to

suggest alternative strategies that enhance a feeling of self-control.

Pessimism versus optimism represents a central personal belief structure that significantly

impacts health (Seligman, 1998). Research indicates that LH negatively impacts immune

functioning. As previously stated, elevated sympathetic activity is associated with LH (Henkel

et al., 2002; Tortora, 1994). A long-term elevation in sympathetic activity negatively impacts

and reduces immune system functioning (Irwin & Friedman, 1999). In addition to negatively

impacting immune functioning, LH impacts the time of survival following a diagnosis of cancer

and recovery from a heart attack (Peterson et al., 1993).

LH contributes to patient apathy and giving up (Seligman, 1998). A pessimistic attitude

inhibits an individual seeking medical intervention and decreases the probability of the patient

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adhering to medical treatment. The frequency of bad life events is associated with an increase in

illness. Individuals with pessimistic attitudes are less likely to initiate preventative strategies to

avoid negative life events; therefore, individuals with pessimistic attitudes experience a higher

frequency of negative life events. Individuals with pessimistic attitudes are also less likely to

develop social support, which correlates with an increase in illness.

Cognitive-Behavioral Treatment

The theory of LH includes motivation, cognitions, and behavior (Peterson et al., 1993).

Henkel et al. (2002) explained that a patient may experience an uncontrollable event, but the

patient's belief of having no control over the outcome of the situation leads to LH. Seligman

(1998) defined LH as the patient believing he or she cannot change the current situation and

giving up. The primary intervention to address motivation, cognitions, behavior, and emotion is

cognitive therapy. Cognitive-behavioral therapy can serve to treat LH and prevent the

development of LH in patients at risk. The goal of therapy is to change the patient's explanatory

style.

Changing the patient's explanatory style necessitates identifying the causal explanations.

Seligman (1998) underscored the need for the therapist not to automatically accept the most

frequent negative explanations but to carefully work with the client to identify the exact negative

explanations that contribute to LH. Once identified, the therapist challenges the patient's

explanations to initiate the change process. In the A-B-C theory of personality in rational emotive

behavioral therapy, a patient who is subject to or experiencing LH maintains irrational

beliefs that compose a negative self-explanatory style (Corey, 1996).[32] The patient experiences an uncontrollable event, which serves as the activating event. As a result of the negative beliefs making up the self-explanatory style, the patient suffers the emotional and behavioral consequences of LH. In treatment, the therapist utilizes the scientific method to help the patient to detect irrational beliefs, to debate or challenge irrational beliefs, and to facilitate learning to discriminate between irrational and rational beliefs.

A tenet of rational emotive behavior explains that a negative explanatory style results in emotional anguish because the patient places change externally and beyond self-control, as noted by Ellis (1973). Thus, change begins with the patient accepting responsibility as a primary agent in the development and maintenance of LH (Corey, 1996). Next, the patient accepts the belief that the emotional and behavioral consequences of LH can be altered. Once the patient accepts potential for change, the patient learns that his or her irrational beliefs are largely responsible for LH. The therapist and patient then work to specifically identify the irrational beliefs that make up the patient's negative explanatory style. The therapist then works with the patient to challenge and dispute the identified irrational beliefs. The patient is encouraged to understand that hard work can alter his or her irrational beliefs and improve the emotional and behavioral consequences of LH. Finally, the patient learns that utilizing the steps of rational emotive behavioral therapy is a life-long process for altering irrational beliefs, which promotes emotional and behavioral well-being.

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[32] **Reference is missing from the reference list.**

Peterson et al. (1993) noted that LH is often associated with a depressive disorder. A comparison of pharmacological intervention and cognitive therapy indicated that both interventions relieve depression; however, participants' negative self-explanatory styles only changed as a result of cognitive therapy. A long-term follow-up of patients who participated in cognitive therapy for depression indicated that relapse occurred in patients who demonstrated the least amount of improvement in explanatory styles. Changing explanatory style through cognitive behavior demonstrates a significant improvement in depressive symptoms. Alterations in explanatory style are stable and durable.

Grzesiak, Ury, and[33] Dworkin (1996) highlighted the feelings of helplessness associated with depression in patients experiencing chronic pain and indicated that tricyclic antidepressant treatments were successful in addressing depression and chronic pain. The researchers noted the importance of identifying the temporal relationship between the onset of pain and the onset of depression. Understanding the temporal relationship is an important factor; however, if a chronic pain patient develops LH, the temporal relationship is not as significant as the self-explanatory style of the patient (Seligman, 1998). The chronic pain condition is the activating event, but the negative self-explanatory style and not the chronic pain condition results in LH (Corey, 1996). A perception of lack of control and feelings of uncontrollability are frequently associated with chronic pain (Turk, 1996). Turk states that pain severity and feeling of uncontrollability are more highly associated with levels of pain and disability than a disease-related process.

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[33] Use *and* instead of *&* when the citation is integrated into the sentence—that is, when it is not within the parentheses.

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LH and the Medical Setting

Because a patient's efforts fail to impact his or her medical condition, the patient can begin to anticipate failure as a natural consequence (Peterson et al., 1993). With no alternatives for changing the course of his or her medical condition, the patient may become susceptible to developing LH (Gluck, 1997). A sense of uncontrollability can lead to cognitive impairment and restrict the patient's ability to learn adaptive behaviors. Seligman (1998) posited that when a patient accepts the belief that personal effort will not facilitate change, he or she may develop LH and give up.

In the cognitive model of LH, an irrational belief system and not the medical condition results in a patient developing LH (Henkel et al., 2002). The belief of uncontrollability is the precipitant of LH. Beliefs of uncontrollability and personal incompetence, Barder et al. (1994)[34] argued, may lead to the development of a global expectation that no one can or will alter the patient's medical condition. Negative global expectations can contribute to a patient developing a sense of personal helplessness (Peterson et al., 1993). Patients who should respond to treatment but do not may be experiencing a sense of personal helplessness. Identification of the belief that personal effort will not change conditions across multiple life circumstances is indicative of personal helplessness.

A condition of learned dependency is similar to LH (Baltes, 1995). LH represents a deficit in learning (Peterson et al., 1993), and learned dependency is a learning process that sacrifices personal independence for attention and social contact (Baltes, 1995). Learned

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[34] **Reference is missing from the reference list.**

dependency is most often seen in elderly populations and in treatment conditions where the treatment staff unnecessarily takes over the patient's personal responsibility. While different from LH, learned dependency can facilitate the development of LH.

Patients with active coping styles are likely to develop LH and experience significant health problems when faced with an inability to take action when faced with an uncontrollable event (Zhukov & Vinogradova, 2002). Patients with active coping styles who can take action and experience some sense of personal influence upon their condition are less likely to develop LH. Even if patients' efforts do not actually impact the course of their condition, the belief that personal action does have an impact prevents the onset of LH.

Patients with passive coping styles may be resistant to the onset of LH (Zhukov & Vinogradova, 2002). Patients with passive coping styles focus on the present and focus on allowing the process of treatment to occur (Peper, 1979a). In contrast, patients with active coping styles look to future outcomes and need to feel in control of the process. Teaching patients with active coping styles passive volition serves to decrease sympathetic arousal and to increase parasympathetic activity. In Selye's (1984) GAS model, a passive coping style consumes less personal energy. The conservation of personal resources prolongs patient's ability to sustain resistance to a medical condition (Zhukov & Vinogradova, 2002).

Patients with an internal locus of control and an external causal belief style assume personal responsibility for the gains and losses in life and view causation as something that can happen to all people. In contrast, patients with an external locus of control and an internal causal belief style assign responsibility to others and view causation as something done to just them (Grunfeld et al., 2003). Locus of control is the patient's belief of the origin of life's rewards and

punishments (Peterson et al., 1993). LH is the patient's negative causal beliefs regarding an uncontrollable circumstance. Both locus of control and LH are fluid, and effectively treating patients necessitates an awareness of the potential for change (Grunfeld et al., 2003; Peterson et al., 1993).

LH is a cognitive condition with physiological consequences. LH reduces NE levels in the brain. A significant reduction in NE can result in mood alterations, motor deficits, and learning deficits. Significant reductions in the levels of GAMA associated with LH can lead to the onset of anxiety (Peterson et al., 1993). LH increases the activity of the HPA system and results in an increase in sympathetic arousal (Henkel et al., 2002; Tortora, 1994).

Assessing LH in the medical setting requires an efficient and cost-effective approach. Assessing the patient's attributional style is a means to identify the cognitive and most important factor in identifying the risk for developing LH or the presence of LH. Assessment seeks to identify a negative personal attributional style that is enduring, attributes causation as personal, and predicts failure across multiple life areas (Seligman, 1998). Initially assessing attributional styles as a screening measure could provide a cost-effective manner for assessing LH in the general medical population and across multiple medical practice settings.

Specific strategies can prevent and treat LH. Faulkner (2001) argued that medical personnel and facilities that work with older individuals and residential populations need to assess for practices and environments that disempower patients and adapt them to empower patients. Disempowerment removes control from the patient and does not encourage the patient's participation in the treatment process. Empowerment encourages patient participation and personal responsibility in the treatment process. Identifying a patient's negative beliefs

related to personal control and then teaching the patient how to change irrational beliefs into positive beliefs of personal control improves the patient's ability to cope with future negative events (Overmier, 2002; Peterson et al., 1993). In general, identifying a patient's generalized pessimistic belief style and working with the patient to develop an optimistic belief style can positively influence the patient's health (Seligman, 1998). LH is associated with increased sympathetic arousal (Henkel et al., 2002; Tortora, 1994), immune system impairment (Irwin & Friedman, 1999), survival time following a diagnosis of cancer, and recovery from a heart attack (Peterson et al., 1993).

Because of the emphasis in addressing a negative explanatory style in the treatment of LH, cognitive-behavior therapy can address the cognition, motivation, behavior, and emotions related to LH (Seligman, 1998). Cognitive-behavior therapy can serve to treat LH and to prevent the onset of LH. Rational emotive behavior therapy seeks to identify the patient's irrational beliefs, to actively challenge the identified irrational beliefs, and to help the patient learn to discriminate between irrational and rational beliefs (Corey, 1996). Cognitive therapy demonstrates effectiveness in treating depression, which is significantly associated with LH and produces enduring alterations in attributional style. In contrast, pharmacological treatment demonstrates similar results in the treatment of depression, but it has no effect on altering a negative attributional style (Peterson et al., 1993).

Conclusion[35]

Screening for LH is simple and requires minimal patient or staff time (Seligman, 1998). Treatment with cognitive therapy is effective and durable. Preventing, identifying, and treating LH can have a positive influence on patient adherence to medical treatment. Physicians can initiate prevention strategies to inoculate patients against LH. Treating LH improves the probability that a patient will seek needed medical interventions. Effectively addressing LH can improve a patient's adherence to medical treatment regimens and improve the patient's efforts to establish and maintain a social support system. Identifying and treating LH could significantly improve the cost-therapeutic-effectiveness index for medical care.

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[35] **Level 1 heading.**

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