**Lesson 36**

# CHOOSING A DOCUMENTING STYLE - APA

**Details that are needed for citation:**

- Author's or editor's or organization's full names
- Title of article, book or chapter (if each chapter has a different author)
- Name of the book, journal or periodical
- Version or edition
- Name of publisher
- Year of publication
- Place of publication (for books only)
- Volume and issue numbers (for journals only)
- Page numbers (for articles and chapters only)

**APA: supporting a thesis**

**Choosing a documentation style**

- Select a style appropriate for your discipline
- APA- American Psychological Association
- Supporting a thesis in a typical way
- Forming a working thesis and support with a well –organized evidence
- Organizing your ideas
- Using sources to inform and support your argument

**Example (Hacker & Sommers, 2011, p. 445).**

- RQ: Is medication the right treatment for the escalating problem of childhood obesity?
- WT: Treating cases of childhood obesity with medication alone is too narrow an approach for this growing problem.
- Organize your ideas: APA recommends headings – standard model - Method, Results, Discussion
- Providing background information or context

- Explaining terms or concepts
- Supporting your claims
- Back up your assertions with facts, examples, and other evidences from your research
- Lending authority to your argument – provide expert opinion
- Construct your argument in your own words – cite others' judgment on it
- Anticipating and countering alternative interpretations - don't ignore sources contrary to your position

**APA: citing sources – avoiding plagiarism**

**Choose an appropriate documentation style**

- Select a style appropriate for your discipline
- Citing quotations and borrowed ideas
- Enclosing borrowed language in quotation marks
- Putting summaries and paraphrases in your own words
- Use software preferably (EndNote) also built in (MS Word)
- Your research paper is a collaboration (sources)
- Three acts are plagiarism:

(1) failing to cite quotations and borrowed ideas

(2) failing to enclose borrowed language in quotation marks, and

(3) failing to put summaries and paraphrases in your own words

- Sources are cited for two reasons: (a) tell your readers about the sources of info (b) to give credit to the authors from whom you take it.

**APA: integrating sources**

**Choose an appropriate documentation style**

- Select a style appropriate for your discipline
- Using quotations appropriately
- Using signal phrases to integrate sources

- Synthesizing sources
- Quotations, summaries, paraphrases, and facts will help you develop your argument
- But they cannot speak for you – so integrate them

**Use quotations appropriately**

- When language is especially vivid or expressive
- When exact wording is needed for technical accuracy
- When it is important to let the debaters of an issue explain their positions in their own words
- When the words of an authority lend weight to an argument
- When the language of a source is the topic of your discussion
- Limiting your use of quotations

## Using signal phrases in APA papers

To avoid monotony, try to vary both the language and the placement of your signal phrases.

### Model signal phrases

In the words of Carmona (2004), ". . ."

As Yanovski and Yanovski (2002) have noted, ". . ."

Hoppin and Taveras (2004), medical researchers, pointed out that ". . ."

". . ." claimed Critser (2003).

". . ." wrote Duenwald (2004), ". . ."

Researchers McDuffie et al. (2003) have offered a compelling argument for this view: ". . ."

Hilts (2002) answered objections with the following analysis: ". . ."

### Verbs in signal phrases

| | | |
|---|---|---|
| admitted | contended | reasoned |
| agreed | declared | refuted |
| argued | denied | rejected |
| asserted | emphasized | reported |
| believed | insisted | responded |
| claimed | noted | suggested |
| compared | observed | thought |
| confirmed | pointed out | wrote |

**APA: documenting sources**

**Choose an appropriate documentation style**

- APA in-text citations
- APA list of references
- Software and manual uses
- EndNote
- Also built in MS Word
- Various kinds of documenting techniques required

**Ask yourself:**

- Which sources inform, support, or extend your argument?
- Have you varied the functions of sources — to provide background,
- Explain concepts, lend authority, and anticipate counterarguments?
- Do your signal phrases indicate these functions?
- Do you explain how your sources support your argument?
- Do you connect and analyze sources in your own voice?
- Is your own argument easy to identify and to understand, with or without your sources?

**The three types of in-text references:**

- APA – e.g. (Bailey, 1990, p.34)
- Harvard – e.g. (Bailey, 1990: 34)
- MLA – e.g. (Bailey 34)

**IN-TEXT CITATION**

Yanovski and Yanovski (2002) reported that "the current state of the treatment for obesity is similar to the state of the treatment of hypertension several decades ago" (p. 600).

**ENTRY IN THE LIST OF REFERENCES**

Yanovski, S. Z., & Yanovski, J. A. (2002). Drug therapy: Obesity. *The New England Journal of Medicine, 346,* 591-602.

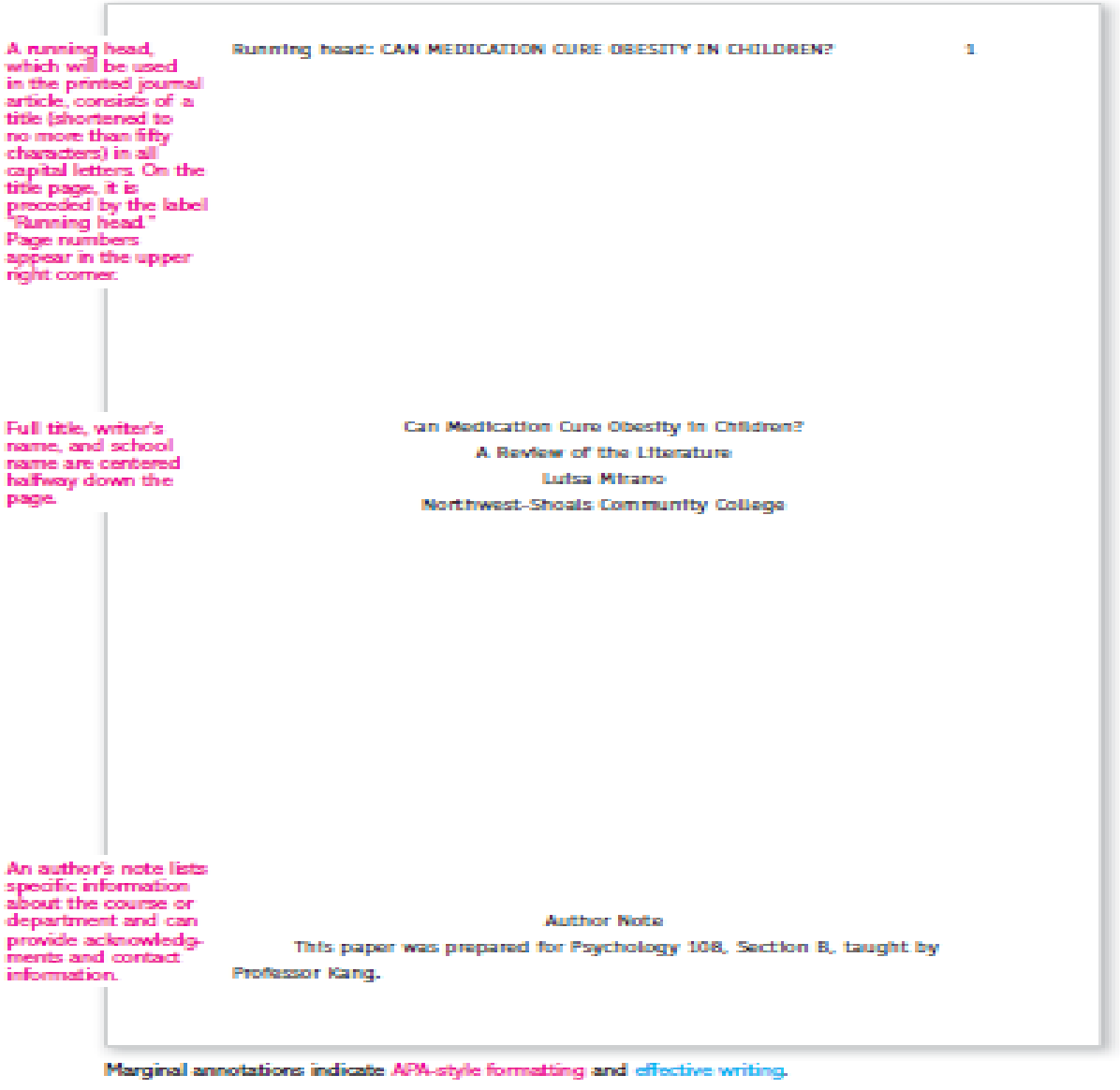
**APA: manuscript format and sample paper**

**APA - documentation style**

- Formatting your paper
- Manuscript format
- Sample  APA paper
- Font – title – page number and running head

- Margins, caps, headings
- End list references etc.

**APA: sample paper (Hacker& Sommers, 2011):**




Marginal annotations indicate APA-style formatting and effective writing.

Abstract

In recent years, policymakers and medical experts have expressed alarm about the growing problem of childhood obesity in the United States. While most agree that the issue deserves attention, consensus dissolves around how to respond to the problem. This literature review examines one approach to treating childhood obesity: medication. The paper compares the effectiveness for adolescents of the only two drugs approved by the Food and Drug Administration (FDA) for long-term treatment of obesity, sibutramine and orlistat. This examination of pharmacological treatments for obesity points out the limitations of medication and suggests the need for a comprehensive solution that combines medical, social, behavioral, and political approaches to this complex problem.

Abstract appears on a separate page.

Full title, centered.

# Can Medication Cure Obesity in Children?
## A Review of the Literature

In March 2004, U.S. Surgeon General Richard Carmona called attention to a health problem in the United States that, until recently, has been overlooked: childhood obesity. Carmona said that the "astounding" 15% child obesity rate constitutes an "epidemic." Since the early 1980s, that rate has "doubled in children and tripled in adolescents." Now more than 9 million children are classified as obese.[1] While the traditional response to a medical epidemic is to hunt for a vaccine or a cure-all pill, childhood obesity is more elusive. The lack of success of recent initiatives suggests that medication might not be the answer for the escalating problem. This literature review considers whether the use of medication is a promising approach for solving the childhood obesity problem by responding to the following questions:

Mirano sets up her organization by posing four questions.

1. What are the implications of childhood obesity?
2. Is medication effective at treating childhood obesity?
3. Is medication safe for children?
4. Is medication the best solution?

Mirano states her thesis.

Understanding the limitations of medical treatments for children highlights the complexity of the childhood obesity problem in the United States and underscores the need for physicians, advocacy groups, and policymakers to search for other solutions.

Headings, centered, help readers follow the organization.

### What Are the Implications of Childhood Obesity?

Obesity can be a devastating problem from both an individual and a societal perspective. Obesity puts children at risk for a number of medical complications, including Type 2 diabetes, hypertension, sleep apnea, and orthopedic problems (Henry J. Kaiser Family Foundation, 2004, p. 1). Researchers Hoppin and Taveras (2004) have noted that obesity is often associated with psychological issues such as depression, anxiety, and binge eating (Table 4).

In a signal phrase, the word "and" links the names of two authors; the date is given in parentheses.

Obesity also poses serious problems for a society struggling to cope with rising health care costs. The cost of treating obesity currently totals

[1]Obesity is measured in terms of body-mass index (BMI): weight in kilograms divided by square of height in meters. A child or an adolescent with a BMI in the 95th percentile for his or her age and gender is considered obese.

Mirano uses a footnote to define an essential term that would be cumbersome to define within the text.

$117 billion per year—a price, according to the surgeon general, "second only to the cost of [treating] tobacco use" (Carmona, 2004). And as the number of children who suffer from obesity grows, long-term costs will only increase.

Because the author (Carmona) is not named in the signal phrase, his name and the date appear in parentheses.

**Is Medication Effective at Treating Childhood Obesity?**

The widening scope of the obesity problem has prompted medical professionals to rethink old conceptions of the disorder and its causes. As researchers Yanovski and Yanovski (2002) have explained, obesity was once considered "either a moral failing or evidence of underlying psychopathology" (p. 592). But this view has shifted: Many medical professionals now consider obesity a biomedical rather than a moral condition, influenced by both genetic and environmental factors. Yanovski and Yanovski have further noted that the development of weight-loss medications in the early 1990s showed that "obesity should be treated in the same manner as any other chronic disease . . . through the long-term use of medication" (p. 592).

Ellipsis mark indicates omitted words.

The search for the right long-term medication has been complicated. Many of the drugs authorized by the Food and Drug Administration (FDA) in the early 1990s proved to be a disappointment. Two of the medications—fenfluramine and dexfenfluramine—were withdrawn from the market because of severe side effects (Yanovski & Yanovski, 2002, p. 592), and several others were classified by the Drug Enforcement Administration as having the "potential for abuse" (Hoppin & Taveras, 2004, Weight-Loss Drugs section, para. 6). Currently only two medications have been approved by the FDA for long-term treatment of obesity: sibutramine (marketed as Meridia) and orlistat (marketed as Xenical). This section compares studies on the effectiveness of each.

In a parenthetical citation, an ampersand links the names of two authors.

Sibutramine suppresses appetite by blocking the reuptake of the neurotransmitters serotonin and norepinephrine in the brain (Yanovski & Yanovski, 2002, p. 594). Though the drug won FDA approval in 1998, experiments to test its effectiveness for younger patients came considerably later. In 2003, University of Pennsylvania researchers Berkowitz, Wadden, Tershakovec, and Cronquist released the first double-blind placebo study testing the effect of sibutramine on adolescents, aged 13–17, over a 12-month period. Their findings are summarized in Table 1.

Mirano draws attention to an important article.

After 6 months, the group receiving medication had lost 4.6 kg

(about 10 pounds) more than the control group. But during the second half of the study, when both groups received sibutramine, the results were more ambiguous. In months 6–12, the group that continued to take sibutramine gained an average of 0.8 kg, or roughly 2 pounds; the control group, which switched from placebo to sibutramine, lost 1.3 kg, or roughly 3 pounds (p. 1808). Both groups received behavioral therapy covering diet, exercise, and mental health.

These results paint a murky picture of the effectiveness of the medication: While initial data seemed promising, the results after one year raised questions about whether medication-induced weight loss could be sustained over time. As Berkowitz et al. (2003) advised, "Until more extensive safety and efficacy data are available, . . . weight-loss medications should be used only on an experimental basis for adolescents" (p. 1811).

A study testing the effectiveness of orlistat in adolescents showed similarly ambiguous results. The FDA approved orlistat in 1999 but did not authorize it for adolescents until December 2003. Roche Laboratories (2003), maker of orlistat, released results of a one-year study testing the drug on 539 obese adolescents, aged 12–16. The drug, which promotes weight loss by blocking fat absorption in the large intestine, showed some effectiveness in adolescents: an average loss of 1.3 kg, or roughly 3 pounds, for subjects taking orlistat for one year, as opposed to an average gain of 0.67 kg, or 1.5 pounds, for the control group (pp. 8–9). See Table 1.

Short-term studies of orlistat have shown slightly more dramatic results. Researchers at the National Institute of Child Health and Human Development tested 20 adolescents, aged 12–16, over a three-month period and found that orlistat, combined with behavioral therapy, produced an average weight loss of 4.4 kg, or 9.7 pounds (McDuffie et al., 2002, p. 646). The study was not controlled against a placebo group; therefore, the relative effectiveness of orlistat in this case remains unclear.

For a source with six or more authors, the first author's surname followed by "et al." is used for the first and subsequent references.

### Is Medication Safe for Children?

While modest weight loss has been documented for both medications, each carries risks of certain side effects. Sibutramine has been observed to increase blood pressure and pulse rate. In 2002, a

Table 1

*Effectiveness of Sibutramine and Orlistat in Adolescents*

| Medication | Subjects | Treatment[a] | Side effects | Average weight loss/gain |
|---|---|---|---|---|
| **Sibutramine** | Control | 0–6 mos.: placebo<br>6–12 mos.: sibutramine | Mos. 6–12: increased blood pressure; increased pulse rate | After 6 mos.: loss of 3.2 kg (7 lb)<br>After 12 mos.: loss of 4.5 kg (9.9 lb) |
| | Medicated | 0–12 mos.: sibutramine | Increased blood pressure; increased pulse rate | After 6 mos.: loss of 7.8 kg (17.2 lb)<br>After 12 mos.: loss of 7.0 kg (15.4 lb) |
| **Orlistat** | Control | 0–12 mos.: placebo | None | Gain of 0.67 kg (1.5 lb) |
| | Medicated | 0–12 mos.: orlistat | Oily spotting; flatulence; abdominal discomfort | Loss of 1.3 kg (2.9 lb) |

Mirano uses a table to summarize the findings presented in two sources.

Note. The data on sibutramine are adapted from "Behavior Therapy and Sibutramine for the Treatment of Adolescent Obesity," by R. I. Berkowitz, T. A. Wadden, A. M. Tershakovec, & J. L. Cronquist, 2003, *Journal of the American Medical Association, 289*, pp. 1807–1809. The data on orlistat are adapted from *Xenical (Orlistat) Capsules: Complete Product Information*, by Roche Laboratories, December 2003, retrieved from http://www.rocheusa.com/products/xenical/pi.pdf

A note gives the source of the data.

[a]The medication and/or placebo were combined with behavioral therapy in all groups over all time periods.

A content note explains data common to all subjects.

consumer group claimed that the medication was related to the deaths of 19 people and filed a petition with the Department of Health and Human Services to ban the medication (Hitts, 2002). The sibutramine study by Berkowitz et al. (2003) noted elevated blood pressure as a side effect, and dosages had to be reduced or the medication discontinued in 19 of the 43 subjects in the first six months (p. 1809).

When this article was first cited, all four authors were named. In subsequent citations of a work with three to five authors, "et al." is used after the first author's name.

The main side effects associated with orlistat were abdominal discomfort, oily spotting, fecal incontinence, and nausea (Roche Laboratories, 2003, p. 13). More serious for long-term health is the concern that orlistat, being a fat-blocker, would affect absorption of fat-soluble vitamins, such as vitamin D. However, the study found that this side effect can be minimized or eliminated if patients take vitamin supplements two hours before or after administration of orlistat (p. 10). With close monitoring of patients taking the medication, many of the risks can be reduced.

### Is Medication the Best Solution?

The data on the safety and efficacy of pharmacological treatments of childhood obesity raise the question of whether medication is the best solution for the problem. The treatments have clear costs for individual patients, including unpleasant side effects, little information about long-term use, and uncertainty that they will yield significant weight loss.

In purely financial terms, the drugs cost more than $3 a day on average (Duenwald, 2004). In each of the clinical trials, use of medication was accompanied by an expensive regime of behavioral therapies, including counseling, nutritional education, fitness advising, and monitoring. As journalist Greg Critser (2003) noted in his book *Fat Land*, use of weight-loss drugs is unlikely to have an effect without the proper "support system"—one that includes doctors, facilities, time, and money (p. 3). For some, this level of care is prohibitively expensive.

A third complication is that the studies focused on adolescents aged 12–16, but obesity can begin at a much younger age. Few data exist to establish the safety or efficacy of medication for treating very young children.

Mirano develops the paper's thesis.

While the scientific data on the concrete effects of these medications in children remain somewhat unclear, medication is not the only avenue for addressing the crisis. Both medical experts and

policymakers recognize that solutions might come not only from a laboratory but also from policy, education, and advocacy. A handbook designed to educate doctors on obesity called for "major changes in some aspects of western culture" (Hoppin & Taveras, 2004, Conclusion section, para. 1). Cultural change may not be the typical realm of medical professionals, but the handbook urged doctors to be proactive and "focus [their] energy on public policies and interventions" (Conclusion section, para. 1).

Brackets indicate a word not in the original source.

The solutions proposed by a number of advocacy groups underscore this interest in political and cultural change. A report by the Henry J. Kaiser Family Foundation (2004) outlined trends that may have contributed to the childhood obesity crisis, including food advertising for children as well as

> a reduction in physical education classes and after-school athletic programs, an increase in the availability of sodas and snacks in public schools, the growth in the number of fast-food outlets . . . , and the increasing number of highly processed high-calorie and high-fat grocery products. (p. 1)

A quotation longer than forty words is indented without quotation marks.

Addressing each of these areas requires more than a doctor armed with a prescription pad; it requires a broad mobilization not just of doctors and concerned parents but of educators, food industry executives, advertisers, and media representatives.

Mirano interprets the evidence; she doesn't just report it.

The barrage of possible approaches to combating childhood obesity—from scientific research to political lobbying—indicates both the severity and the complexity of the problem. While none of the medications currently available is a miracle drug for curing the nation's 9 million obese children, research has illuminated some of the underlying factors that affect obesity and has shown the need for a comprehensive approach to the problem that includes behavioral, medical, social, and political change.

The tone of the conclusion is objective.

List of references begins on a new page. Heading is centered.

## References

List is alphabetized by authors' last names. All authors' names are inverted.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Hoppin, A. G., & Taveras, E. M. (2004, June 25). Assessment and management of childhood and adolescent obesity. *Clinical Update.* Retrieved from http://www.medscape.com/viewarticle/481633

McDuffie, J. R., Calis, K. A., Uwaifo, G. I., Sebring, N. G., Fallon, E. M., Hubbard, V. S., & Yanovski, J. A. (2002). Three-month tolerability of orlistat in adolescents with obesity-related comorbid conditions. *Obesity Research, 10*, 642–650.

Roche Laboratories. (2003, December). *Xenical (orlistat) capsules: Complete product information.* Retrieved from http://www.rocheusa.com/products/xenical/pi.pdf

Yanovski, S. Z., & Yanovski, J. A. (2002). Drug therapy: Obesity. *The New England Journal of Medicine, 346*, 591–602.


The first line of an entry is at the left margin; subsequent lines indent ½".

Double-spacing is used throughout.