Anxiety and Mood Disorders

LESSON PLANNING CALENDAR

Use this Lesson Planning Calendar to determine how much time to allot for each topic.

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<td>Block Schedule (90 minutes)</td>
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**ACTIVITY PLANNER FROM THE TEACHER’S RESOURCE MATERIALS**

Use this Activity Planner to bring active learning to your daily lessons.

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<td><em>Analysis Activity:</em> Taylor Manifest Anxiety Scale (15 min.)</td>
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Module 31

Anxiety and Mood Disorders

This module covers two of the most common categories of psychological disorders—anxiety disorders and mood disorders. There is little doubt that you know individuals who struggle mightily with problems related to anxiety and mood. If you are "normal," you have probably struggled occasionally with such problems yourself.

An odd and sometimes troubling aspect of psychological disorders is that it’s easy to see the symptoms—almost all the symptoms—in yourself. The symptoms of psychological disorders usually fall along a continuum. They can be mild, serious, or anything between. Typically, there is a "gray area" where it's difficult to decide whether there is a significant problem. This is different from many medical conditions that are more likely to be either present or absent, with nothing between. It doesn’t make sense to talk about a woman being kind of pregnant, but it is surely possible to be sort of anxious.

So, I’m going to give you the warning I was given years ago: Don’t overreact if you begin to discover in yourself the symptoms we discuss in this module. That’s typical, and there’s even a name for it—"psychology student’s disease." The point

Anxiety Disorders
- Generalized Anxiety Disorder and Panic Disorder
- Phobia
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder
- Causes of Anxiety Disorders

Mood Disorders
- Major Depressive Disorder
- Bipolar Disorder
- Causes of Mood Disorders

Are you scared of snakes? Spiders? Maybe for you it’s heights or crowds. Almost all of us feel anxious under some circumstances, and we also experience a variety of moods in our daily lives. When these normal reactions make it difficult to function, we have anxiety or mood disorders. They are among the most common psychological disorders of all.

Getting Started

Have students consider the following questions:

- What does it mean to be anxious?
- What behaviors do anxious people exhibit?
- How many different moods do people normally experience in a day?

You may wish to use Critical Thinking Activity: Fact or Falsehood? as a prereading strategy to evaluate what students already know about anxiety and mood disorders. The activity, along with its results, will prime students to note terms and concepts in the text that confirm or dispel their preconceptions about these disorders.

Building Vocabulary

Students can complete Building Vocabulary/Graphic Organizer: Concept Web to help them learn the terms in this module and understand the relationships among them.

Resource Manager

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<td>No More Shame: Understanding Schizophrenia, Depression, and Addiction</td>
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Depression: Beating the Blues | 559 549
Anxiety Scale.

Analysis Activity: Taylor Manifest

Beyond the Classroom

Anxiety-Related Disorders.

- What causes you the most anxiety in
  the future, or your work? Explain why.

What are the anxiety disorders, and what
causes them?

Anxiety Disorders

When psychologists speak of anxiety, they are referring to a vague feeling of apprehension and nervousness. You’ve probably experienced anxiety in relation to specific events—big tests, school projects, or important medical tests, for example. You may also have experienced a more general anxiety, such as feeling ill at ease about the changes that college or a new job might bring or concern about how troubling world events will play out. These are both normal types of feelings. Anxiety disorders differ from these feelings in that anxiety—effort to control it—begins to take control and dominate life.

Anxiety

We all experience anxiety in our lives, often as a response to stressful events. Anxiety is not a disorder unless it begins to create significant difficulties in a person’s life.
When this happens, quality of life suffers (Olatunji et al., 2007), and unhappiness increases (Kashdan & Steger, 2006). We discuss five kinds of anxiety disorders (see Figure 31.1):

- **Generalized anxiety disorder**, marked by disruptive levels of persistent, unexplained feelings of apprehension and tenseness
- **Panic disorder**, marked by sudden bouts of intense, unexplained panic
- **Phobia**, marked by disruptive, irrational fears of objects, activities, or situations
- **Obsessive-compulsive disorder (OCD)**, marked by unwanted, repetitive thoughts and actions
- **Post-traumatic stress disorder (PTSD)**, characterized by reliving a severely upsetting event in unwanted, recurring memories and dreams

### Generalized Anxiety Disorder and Panic Disorder

Until pharmaceutical companies began advertising drugs to combat generalized anxiety disorder, many people had never heard of this condition. It doesn’t have the dramatic symptoms of many other psychological disorders and until recently had escaped public attention. The drug company advertisements probably leave many people uneasy because most of us have physical and psychological symptoms on occasion that characterize this disorder. However, the symptoms are more lasting for those who suffer generalized anxiety.

**Differentiation**

Patients who have **generalized anxiety disorder (GAD)** often also have major depression, an illness discussed later in this module. Effexor, a drug manufactured by Wyeth-Ayerst, has shown to be effective in treating both GAD and major depression. Paxil, an antidepressant drug in the same class as Prozac and Zoloft, is a serotonin reuptake inhibitor and is also approved for use to treat GAD as well as social phobia and panic disorder.

**Differentiation**

**Graphic Organizer** These options allow learners at all levels to complete **Building Vocabulary/Graphic Organizer: Concept Web.**

- **Independent learners** can fill out the organizer on their own or follow along in class during discussion and lecture.
- **Cooperative learners** can use the textbook as a resource and work in groups to find the answers that fit in the blanks.
- **Exceptional learners** can fill in the blanks independently, with a tutor, or during class discussion and lecture.

**Beyond the Classroom**

**Bellringers** Use the following prompts as discussion starters:

- Have you ever had a panic attack? Describe the experience.
- What are some things that you have a legitimate reason to be afraid of? How did you develop that fear?
- What are some things that you have an irrational fear of? How did that fear develop?

At this point, you may want to use **Application Activity: Fear Survey** or **Analysis Activity: Social Phobias.**
Agoraphobia, the fear of being in open spaces or in public, often accompanies panic disorder. Because people experience panic attacks at uncontrolled times and in uncontrolled situations, they will often develop a fear of being out in public and having a panic attack. This fear leaves them suffering in their homes afraid to leave at all.

At this point, you may want to use Application Activity: Fear Survey.

Beyond the Classroom

Analyze Phobias are one of the most successfully treated disorders around, yet few people with phobias seek treatment for them. Have students contemplate why this might be.

- Why would people be reluctant to get treatment for their everyday fears? (Everyday fears might not be crippling or disruptive. Also, people may successfully avoid their fear object, not seeing the need to rid themselves of the fear.)
- What types of fears are more crippling than others? Why?

At this point, you may want to use Scientific American Frontiers (2nd ed.), Segment 32: “Arachnophobia.”

Active Learning

Survey Have students conduct a study using Analysis Activity: Taylor Manifest Anxiety Scale and/or Application Activity: Fear Survey. Students can even create their own survey to see what students in your school typically fear.

- Establish an institutional review board (IRB) composed of fellow teachers and administrators who can review the experimental design to ensure all ethical standards are being followed.
- Be sure to obtain informed consent with each survey administered to conform with ethical standards.
- Have students write up their findings to publish in a high school journal or as a news item for the school’s newspaper. Be sure their report discusses anxiety based on well-researched facts.

Table 31.1

<table>
<thead>
<tr>
<th>Symptoms of Generalized Anxiety Disorder</th>
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<tbody>
<tr>
<td>Restlessness</td>
</tr>
<tr>
<td>Feeling on edge</td>
</tr>
<tr>
<td>Difficulty concentrating or mind going blank</td>
</tr>
<tr>
<td>Irritability</td>
</tr>
<tr>
<td>Muscle tension</td>
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<tr>
<td>Sleep disturbance</td>
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</table>

Source: Adapted from American Psychiatric Association (2000).

Phobia

Almost everyone has heard the word phobia, which many people use to mean fear. (“I have a phobia about taking tests.”) To psychologists, however, a phobia is more than just a fear—it is a fear that is both irrational and disruptive.

If you were being stalked on a dark street late at night, your fear of the stalker is not irrational. Fear of a dangerous stalker is normal and necessary. However, some fears are irrational.

Once the anxiety is accompanied by panic attacks—episodes of unexplained terror and fear that something bad is going to happen. The panic attacks, which may last several minutes, usually involve such physical symptoms as choking sensations or shortness of breath. Have you ever experienced panic? I can recall an episode when I was about 12 years old. My parents were out and I had watched a frightening show on television. Although I had no reason to do so, I became temporarily convinced that something horrible had happened to my parents. They were fine, of course, but the panic I experienced was so intense that I still remember it clearly almost 50 years later.

We may all feel panic at some point in our lives, but imagine having these attacks several times each day. You’re sitting in class, trying to take notes, and the waves of fear start to wash over you for no apparent reason. Your ability to concentrate is destroyed; all your energy is directed toward trying to regain control. Such is the life of a person with panic disorder.

Almost everyone has heard the word phobia, which many people use to mean fear. (“I have a phobia about taking tests.”) To psychologists, however, a phobia is more than just a fear—it is a fear that is both irrational and disruptive.
Why are phobias considered anxiety disorders? Because they focus general feelings of anxiety onto a feared object, activity, or situation (see Figure 31.2). Most phobias involve fear of a particular object, and their names are formed by combining the Greek word for the object with phobia, which is the Greek word for “fear.” Fear of spiders, for example, is called arachnophobia. Broader phobias also occur.

Social phobias produce fear in social situations. For example, some people have extreme difficulty speaking in public, even to the extent of being unable to respond to questions from a clerk in a store. Others cannot eat in the presence of others or use public restrooms. As you might imagine, social phobias can seriously impair a person’s ability to lead a normal life.

Agoraphobia is fear of situations the person views as difficult to escape from if panic begins to build. Many people with this disorder become trapped in their own homes or in similar safe zones. I once had dinner with a woman from my town who was recovering from agoraphobia. She was a middle-aged widow who lived by herself and could not leave her home without experiencing intense fear. She described to me the difficulty of ordinary tasks like grocery shopping, which was to her similar to a military commando raid. Only with intense planning and determination could she leave her car, quickly collect the two or three items she needed most, and make it through checkout before dashing back to her car. Often she began to feel panicky during her shopping.

Beyond the Classroom

**Guest Speaker** Contact a psychologist who specializes in treating anxiety disorders and ask about treatment options available to people who have this class of disorders.

- What types of medication are available?
- What types of behavioral or cognitive therapy are used?
- Do patients typically get completely rid of their fear through therapy, or is the goal of therapy to get patients to a comfortable level of functioning?

**Multicultural Connections**

**Fears in Other Cultures**

Have students research what things people in the United States fear most and whether people in other countries fear the same things.

- Do people in other cultures fear speaking in public as much as people in the United States seem to?
- Do fears differ among people of different socioeconomic groups? Why or why not?
- Do people in countries that have experienced war have higher incidences of certain anxiety disorders? What kinds?

At this point, you may want to use **Analysis Activity: Social Phobias**.
An Alternative Treatment.

Obsessive-Compulsive Disorder: the video resources

of the Obsessive Compulsive Foundation.

ally syndicated talk show, Unwrapped

shows. He currently hosts a nation-

slime and goo. He often felt consumed

on the show to being splattered with

game shows that regu-

and

the host of Double

obsessive-compulsive disorder. He was

host Marc Summers suffers from

Differentiation

● Hoarders collect things. They avoid

throwing things away because they fear they may need them in

the future. As a result, they keep everything, including leftover food,

papers, and broken items.

● Checkers recheck actions they have

already performed many times over. For example, someone who fears

she did not turn off the oven will

recheck it a certain number of times

before she feels better.

● Counters count everything, from

the steps they take to the words peo-

ple say to them. They become pre-

occupied with counting something

seemingly unimportant to the point

of stopping their daily progress.

● Cleaners clean excessively. Often,

they need to clean a certain number

of times in order to relieve the anxiety.

At this point, you may want to use

the video resources As Good as It Gets

and Obsessive-Compulsive Disorder: An Alternative Treatment.

Beyond the Classroom

Discuss Have students recall old child-

hood “rules” similar to “step on a crack

and break your mother’s back.” Some

rules they might remember could

include “cootie shots” and supersti-

tions like not breaking mirrors (or

you’ll get seven years of bad luck) or

not walking under ladders.

● Why do children develop these

rules? What purpose do they serve?

● How do children learn these rules?

● Do they remember being compulsive

about these rules? How did they feel

when they broke the rules? What

would they do to “make it right”?

Differentiation

Former Nickelodeon game show

host Marc Summers suffers from

obsessive-compulsive disorder. He was

the host of Double Dare and Family

Double Dare, game shows that regu-

larly subjected him and contestants

on the show to being splattered with

slime and goo. He often felt consumed

by anxiety as he struggled to put on

a cheerful face as the host of these

shows. He currently hosts a nation-

ally syndicated talk show, Unwrapped,

on the Food Network, and is the

national spokesman for the Obsessive-

Compulsive Foundation.

few minutes in the store, and sometimes she had to abandon her grocery

shopping only to face another trial the next day. Over the course of the last 15

years, which had included some therapy, she had largely conquered her ago-

raphobia. She was happy to say she had even been able to take a European

vacation a few years ago.

Obsessive-Compulsive Disorder

The two major symptoms of obsessive-compulsive disorder are, as you might

imagine, obsessions and compulsions. Obsessions are repetitive thoughts,

and compulsions are repetitive actions. Almost everyone experiences both

symptoms to some degree on a harmless level. In my classroom, I notice a

lot of faraway stares as homecoming and prom weekends approach. I know

many of these students can’t stop thinking about the upcoming event (at least

that was the case for me when I was a student!). Other times we may hear a

song and then be unable to get it out of our head.

We all have compulsions, too. One day I watched a student walk down the

hall tapping the eraser of his pencil on every locker. Somehow he missed the

last locker in the row and managed to make it about 10 yards down the hall

before having to return to tap that last locker. You could almost feel his dis-

comfort until the task was complete. You may have done something similar

as a child. Remember that old rhyme about “step on a crack and break your

mother’s back”? Were you able to step on sidewalk cracks easily after learning

that rhyme?

Obsessive-compulsive tendencies can be helpful sometimes. Most good

athletes are obsessed with winning and compulsive about training. And

most good students are a bit obsessed with grades and a bit compulsive

about studying. These tendencies help us develop important routines,

such as fastening our safety belt when we get in a car or brushing our

teeth regularly.

Obsessions and compulsions, however, begin to take control with some

people, and this is when helpful tendencies become OCD. One common
Beyond the Classroom

Bellringers Use the following prompts as discussion starters:

- What behavior do you exhibit that might be considered "compulsive"? Why do you behave that way?
- What compulsive behaviors do you exhibit that are helpful to you? What behaviors are hurtful?

Reteach

OCD and OCPD Help students differentiate between obsessive-compulsive disorder (OCD) and obsessive-compulsive personality disorder (OCPD).

- OCD is an anxiety disorder characterized by obsessive thoughts and corresponding compulsions. People with OCD must repeat tasks over and over to find relief from their anxieties.
- OCPD is a personality disorder characterized by an obsessive need for neatness, order, and symmetry. People with OCPD are likely to be called "neat freaks" or described as "anal-retentive."

At this point, you may want to use Analysis Activity: Obsessive-Compulsive Disorder.

Beyond the Classroom

Critical Thinking Remind students that behaviors are not considered abnormal unless they are maladaptive, unjustifiable, disturbing, and atypical. Have students answer the following questions:

- Where is the line between having a helpful, harmless obsession or compulsion and developing OCD?
- If you had a friend who exhibited a compulsion, what type of behaviors would cause you to become concerned about the person's welfare?

At this point, you may want to use Enrichment Lesson: Obsessive Thoughts.

Differentiation

Remind students that the frontal lobes are responsible for judgment and decision making. If people with OCD have overactive frontal lobes, then they are controlled by overzealous decision making. They cannot control the decisions they make, so they allow their behavior to be ruled by repetitive and overbearing thoughts.
Beyond the Classroom

Discuss For many people who experience trauma, the events occurring before, during, and directly after the event become etched into their minds, forming a flashbulb memory of the event. Ask:

- Do you remember vividly where you were when you heard about the events of September 11 or the space shuttle Columbia accident?
- Do your parents remember vividly the space shuttle Challenger accident, the attempted assassination of Ronald Reagan, or when John Lennon was killed?

Active Learning

PTSD and Traumatic Events

Have students research the changes that occurred during the last century regarding the diagnosis and treatment of PTSD. How were people in the past expected to behave after experiencing trauma? Were treatments available? Consider the following events that may have caused PTSD:

- Wars and conflicts, such as the two world wars, Korean, Vietnam, and the two Gulf Wars
- Terrorism, such as that which occurred on September 11, 2001
- Natural disasters, such as Hurricanes Andrew and Katrina

At this point, you may want to use Enrichment Lesson: Concentration Camp Survival.

Thinking About

Positive Psychology

Comprehensive Soldier Fitness

Stress is a constant in life—everybody experiences difficult events—but the response to stress is not the same for everyone. Why is it that some people struggle in the face of adversity while others seem to survive or even thrive? Far more people experience trauma than develop post-traumatic stress disorder (Ozer & Weiss, 2004). Most combat veterans and even most victims of political torture do not develop PTSD. What determines who does and who doesn’t?

Those who make it through the aftermath of trauma largely unscathed possess a quality known as survivor resiliency (Bonanno, 2004, 2005). Some go beyond resiliency and experience post-traumatic growth. Their suffering has led to inner strength, increased appreciation, and better relationships. A primary goal of positive psychology is to increase the percentage of people who can weather the storms of trauma more effectively. The key seems to be to prepare people in advance with cognitive and behavioral strategies that allow them to cope with stress more effectively.

Is this possible? It is increasingly looking like the answer is yes. Work done by Martin Seligman and his colleagues to develop positive education in school systems has resulted in programs that teach teachers how to develop resiliency skills in students (Seligman et al., 2009). These programs have shown lasting reductions in anxiety and depression among the students who are taught the new skills.

Perhaps the most ambitious initiative of all began in 2009 with the start of the U.S. Army’s Comprehensive Soldier Fitness (CSF) program (Casey, 2011). Under this program, Seligman’s team at the University of Pennsylvania is preparing thousands of Army master resiliency trainers. These master trainers will teach appropriate resiliency skills to Army leaders in every battalion and brigade. All new recruits will learn resiliency skills as a part of their basic training. The family members of soldiers and civilian workers in the military will be trained as well. All these individuals are, or are close to, people at high risk for PTSD, especially when soldiers are deployed in combat. The goal is to increase resiliency to prevent psychological disorders and help everyone live healthier, happier lives.

Active Learning

Personal Interviews

Have students interview people who experienced trauma in the twentieth century to see how they coped with the stress involved with a particularly tragic event. Some people students may consider interviewing include

- veterans of World War II or the Korean, Vietnam, or Gulf Wars.
- those who remember the assassinations of the 1960s.
- survivors of or witnesses to the Holocaust or the September 11 terrorist attacks.
- evacuees from Hurricanes Andrew, Hugo, or Katrina.

At this point, you may want to use Enrichment Lesson: Concentration Camp Survival.
Causes of Anxiety Disorders

Anxiety disorders could be caused by nature (the effect of our inherited biology) or nurture (the influence of our environment). As is almost always the case, both factors are important.

Biological Factors Anxiety disorders, like so many other areas that psychologists study, illustrate the interaction between our biology and our environment. Some biological factors that contribute to anxiety disorders are these:

- **Heredity**—Some of us inherit a predisposition, or likelihood, for developing anxiety disorders. Evidence for this comes from studies of identical twins, who are genetically the same. Even when raised in different families, identical twins sometimes have similar phobias (Carey, 1996; Eckert et al., 1981). The influence of heredity is also apparent in monkey studies demonstrating that fearful parents are likely to have fearful children (Suomi, 1986). The specific fear is not inherited, but the predisposition to be fearful is. The search is on for the genes that lead to this predisposition, and 17 genes with connections to anxiety disorder symptoms have been identified (Hovatta et al., 2005).
- **Brain function**—Brain-scanning techniques show that people with anxiety disorders have brains that literally function differently than those of people who do not have anxiety disorders. As Figure 31.3 illustrates, brain scans show a higher degree of activity in a part of the frontal lobes of people with OCD (Usro et al., 2003). Because the frontal lobes are involved with decision making, the bright red and yellow shown in that area of the brain of the person with OCD may indicate a source of the problem. An emotion center, the amygdala, also shows differences for people with phobias (Etkin & Wager, 2007; Kolassa & Elbert, 2007; Maren, 2007). It’s possible that their intense fear is caused by the activity in the amygdala. Because brain function is involved, anxiety disorders often respond to treatment with medication.
- **Evolution**—We are likely to fear situations that posed danger to the earliest humans. Dangerous animals, heights, and storms were common fears that have evolved to help further our species. Have them ponder how some of these fears might have evolved:
  - Public speaking
  - Flying
  - Germs
  - Failure

At this point, you may want to use The Mind (2nd ed.), Module 32: “Mood Disorders: Hereditary Factors.”

**Beyond the Classroom**

**Analyse** Have students name fears that have evolved to help further our species. Have them ponder how some common fears might have evolved:

- Public speaking
- Flying
- Germs
- Failure

At this point, you may want to use The Mind (2nd ed.), Module 32: “Mood Disorders: Hereditary Factors.”

**Differentiation**

**Life Without Fear** What would life be without fear? Have students offer scenarios in which fear is detrimental and useful to daily life. If fear weren’t an issue, how would these situations be different?

At this point, you may want to use Application Activity: Fear Survey.
Differentiation
Review with students the components of classical conditioning that caused Little Albert to develop a fear of white, furry objects:

- Unconditioned stimulus (US): the loud “bang” that occurred when the lead pipes were struck
- Unconditioned response (UR): fear of the loud “bang”
- Conditioned stimulus (CS): white, furry object
- Conditioned response (CR): fear, but this time in response to the white, furry object

Have students recall that the fear response John Watson cultivated so easily was reversed in other patients by his student Mary Cover Jones. She used classical conditioning to remove a fear response from individuals who had developed a fear of a certain object. She used a pleasant US, like candy or food, so patients could associate the pleasant feeling with the object they had come to fear.

Learning Factors Learning gone awry can also produce anxiety disorders. Sometimes we learn to respond well in stressful situations, but if we learn maladaptive responses they can blossom into anxiety disorders. These factors can contribute:

- Conditioning—Ivan Pavlov became famous for his studies in which dogs learned to associate the sound of a tuning fork with the taste of meat, salivating equally to both. Humans can also learn to associate fear with certain places or things. John B. Watson and Rosalie Rayner (1920) demonstrated this in their famous research with “Little Albert,” an infant who learned to fear white rats. Watson and Rayner established the fear by pairing the sight of a rat with loud, frightening noises. Few of us would deliberately teach a child fear, but the child might learn to associate fear and dogs if exposed to a menacing growl or bite when young. Unpredictable and uncontrollable bad events can contribute to the conditioning of anxiety (Field, 2006; Mineka & Zinbarg, 2006).

- Observational learning—Children can also learn fears at their parents’ knees. If a child sees a parent or older sibling responding with fear to thunderstorms, bees, or high places, the child may begin to experience the same fear. Even young monkeys learned to fear snakes when given the opportunity to watch other monkeys avoid situations in which a snake was present (Mineka, 1985).

threats, and people who didn’t have a healthy dose of fear were less likely to survive. Those who did survive passed on to us— their descendants—their tendency to fear these dangers. Many of us share these fears to this day, even though our modern world has made these threats less dangerous than they once were. For example, preschool children can find a snake in a scene more quickly than they can find a flower or a frog (LoBue & DeLoache, 2008). Unfortunately, we don’t have a similar inherited tendency to fear threats that have developed more recently. Cars, for example, kill far more people in the modern world than snakebites do, yet more people fear snakes than fear cars.
Mood Disorders

31-2 What are the mood disorders, and what causes them?

Mood disorders are disturbances of emotions. Like other psychological disorders you’ve read about in this module, mood disorders are magnifications of our normal reactions. The magnified states in mood disorders are mania and depression. Mania is a period of abnormally high emotion and activity. Has anyone ever said to you, “Don’t be so manic”? People often use that statement when they simply mean “Calm down—don’t get so excited.” Life would be dull if we could never feel elated or excited or wildly enthusiastic. But what if you felt intense mania for days or even weeks and just couldn’t calm down? As you’ll see later in this section, some people do, and it’s not pleasant.

It is a rare individual who never feels depressed. Can any of us say that we never feel down, sad, or drained of energy? Depression is a normal response to the loss of many of the important things in life, including the death of loved ones, the end of important relationships, the loss of a job, or even graduation from the comfortable familiarity of high school (Wakefield et al., 2007). We can even become depressed over distant events, such as famines or outbreaks of violence in far corners of the world. From an evolutionary perspective,

Reinforcement—We also learn to associate emotions with actions, depending on the results that follow those actions. A person with a fear of heights can reduce the fear by avoiding heights. That release from anxiety makes it more likely that the person will avoid heights in the future. A person with an obsessive-compulsive hand-washing ritual can reduce anxiety by washing and will therefore repeat that action. We tend to repeat responses that have good results and avoid those that have bad results.

No one has an anxiety-free life. But when the anxiety begins to take control (as in the case of a generalized anxiety disorder), refocus as fear (as in the case of a phobia), drive us to rigidly repeated thoughts and behaviors (as in the case of obsessive-compulsive disorder), or make it impossible to escape an earlier horror (as in the case of post-traumatic stress disorder), anxiety has crossed the line and has become a psychological disorder.

Beyond the Classroom TRM

Bellringers Use the following prompts as discussion starters:

- Have you ever felt depressed? What caused your depression? How did you handle it?
- Are certain points in your day, week, month, or year more likely to leave you depressed? Why?

At this point, you may want to use The Mind (2nd ed.), Module 31: “Mood Disorders: Mania and Depression.”

Differentiation TRM

National Depression Screening Day is held annually in October. This is a nationwide event at which mental health professionals offer free depression screenings to the public. The free screening includes completion of a self-rating depression scale; a 20-minute discussion about the causes, symptoms, and treatment of depression; and a 5-minute meeting one-on-one with a mental health professional. Based on the scale scores and the clinician’s probing, participants learn if they need more evaluation. No diagnosis or treatment is provided.

At this point, you may want to use Application Activity: The Zung Self-Rating Depression Scale.
Dysthymic disorder is a depressive state that lasts more than two years in adults or more than one year in adolescents and children. Patients must also present two or more of the following symptoms:

- Poor appetite or overeating
- Insomnia or hypersomnia
- Low energy or fatigue
- Low self-esteem
- Poor concentration or difficulty making decisions
- Feelings of hopelessness

At this point, you may want to use Enrichment Lesson: Postpartum Depression.

**Active Learning**

Survey

Have students conduct a study using Application Activity: The Zung Self-Rating Depression Scale. They should survey a sample of students to see the rates of depression among students in your building.

- Establish an institutional review board (IRB) composed of fellow teachers and administrators who can review the experimental design to ensure all ethical standards are being followed.
- Be sure to obtain informed consent with each survey administered to conform with ethical standards.
- Have students write up their findings to publish in a high school journal or as a news item for the school’s newspaper. Be sure their report discusses depression based on well-researched facts.

**Major Depressive Disorder**

Major depressive disorder is the most common disability in the world, affecting almost 6 percent of men and nearly 10 percent of women (World Health Organization, 2002). Among college students, 44 percent in one survey said that they had been depressed enough that it was difficult to function at least once in the past year (American College Health Association, 2006). Therapists say that depression has crossed the line from a normal reaction to major depressive disorder when five of the following nine symptoms have been present for two or more weeks (note that one of the first two symptoms must be included in those five) (American Psychiatric Association, 2000):

- Depressed mood most of the day, nearly every day (in children and adolescents, an irritated mood satisfies this requirement)
- Little interest or pleasure in almost all activities
- Significant changes in weight or appetite
- Sleeping more or less than usual
- Agitated or decreased level of activity
- Fatigue or loss of energy
- Feelings of worthlessness or inappropriate guilt
- Diminished ability to think or concentrate
- Recurrent thoughts of death or suicide

These symptoms must also produce distress or impaired functioning to qualify as indicators of major depressive disorder. One of the main differences between major depressive disorder and normal grief is the apparent...
reason for the emotions. Grief over the loss of a loved one is an understandable reaction. In contrast, there may be no apparent trigger for major depressive disorder.

Major depressive disorder feels like an inescapable weight affecting every aspect of life, and it can even lead to suicide (see Psychology in the Real World: Suicide on pages 562–563).

**Bipolar Disorder**

People with bipolar disorder (previously known as manic depressive disorder) alternate between the hopelessness of depression and the overexcited and unreasonably optimistic state of mania. This disorder is less common than major depressive disorder, but it has a more devastating effect on people’s ability to function. Twice as many workdays are lost each year to bipolar disorder than to major depression (Kessler et al., 2006).

It’s good to be optimistic, but the manic phases of someone with bipolar disorder are well beyond normal. During mania, the person may go long periods without sleeping and may experience racing thoughts, be easily distracted, and set impossible goals.

These manic phases, like the bouts of depression that occur in major depressive disorder, tend to have hills and valleys. Moods generally follow cyclical patterns—most people find that they swing through some periods when they feel a little down and others where they feel great. Mania is sometimes associated with bursts of creative energy (Jamison, 1993, 1995). Many well-known creative people, from Mark Twain to Vincent van Gogh, are believed to have suffered from bipolar disorder.

**Causes of Mood Disorders**

As with anxiety disorders, no single explanation sheds light on all mood disorders. Again, biology and environment interact. Stress also seems to play a role, providing a trigger that sparks mood disorders when other factors are present.

There are two main types of bipolar disorder:

- **Bipolar I** Patients experience periods of elevated mood (mania) accompanied by psychosis, followed by periods of major depression.
- **Bipolar II** Patients experience at least one episode of hypomania (a period of elevated mood but without psychosis) and at least one major depressive episode.

**Differentiation**

What reasons do people give for being lonely? One survey sorted them into five major categories.

1. **Being unattached** Having no spouse or partner; particularly breaking up with a spouse or significant other
2. **Alienation** Being misunderstood and feeling different; not being needed and having no close friends
3. **Being alone** Coming home to an empty house
4. **Forced isolation** Being hospitalized or housebound; having no transportation
5. **Dislocation** Being away from home; starting a new job or school; traveling often

At this point, you may want to use **Analysis Activity: Loneliness.**

**Differentiation**

How do people cope with loneliness? Rubenstein and Shaver have found four major strategies:

- **Sad passivity** Sleeping, drinking, overeating, and watching TV
- **Social contact** Calling or visiting a friend
- **Active solitude** Studying, reading, exercising, or going to a movie
- **Distractions** Spending money and going shopping

At this point, you may want to use **Analysis Activity: The Automatic Thoughts Questionnaire** and **Enrichment Lesson: The Sadder-but-Wiser Effect.**

Suicide may be a sensitive subject, especially if students have known someone who has attempted or committed suicide. Students may also have attempted suicide and not shared that with others. Students generally struggle with questions of life’s purpose, and these feelings are normal. Remind students that any indication of someone contemplating suicide should be taken seriously.

At this point, you may want to use Critical Thinking Activity: Depression and Memory.

Beyond the Classroom
Guest Speaker Invite your school’s guidance counselor to discuss what your school’s plan would be in the event of a student committing suicide.

- How was the plan developed?
- What outside resources would be called in?
- Is this plan similar to ones that would be in place if a student died from causes other than suicide? How would it be different?

At this point, you may want to use Critical Thinking Activity: The Revised Facts on Suicide Quiz.

Suicide

When I was a junior in high school, back in the late 1960s, a fellow student didn’t appear for class one day shortly after breaking up with a longtime girlfriend. As the day wore on, rumors that he had committed suicide began to travel through the student body. The rumors proved to be true, but nobody ever dealt with the issue openly. Teachers, counselors, administrators, and parents seemed united in their desire not to talk about something they found disturbing and unexplainable. Students were left to sort out their questions and feelings on their own, and the school never even issued an official acknowledgment of what had happened.

There have also been student suicides, and suicide attempts, in the school where I now teach. Seeing this important issue brought into the open has been gratifying. In recent years, the administration put into place a crisis response plan to help both students and faculty members cope with the emotional effect of the loss or injury of a student. Instead of pretending that nothing has happened, the school issues announcements, runs articles in the school newspaper, and ensures that counselors are available to help friends and classmates with their grief and questions. Bringing the topic of suicide into the light of day may prevent others from making this tragic choice.

One interesting fact about suicide is that people who are deeply depressed rarely kill themselves until after the depression starts to lift. This is confusing to friends, because the suicide occurs just as the person seems to be getting better. Ironically, this lifting of depression gives the person the energy to execute a plan developed when depression was so overwhelming that it effectively stopped action.

For adolescents, to have occasional, passing thoughts of suicide is neither unusual nor a cause for concern. But becoming obsessed with thoughts of suicide, or starting to develop plans for committing suicide, is. It’s quite likely that a suicide or suicide attempt of someone you know will touch your life, if it has not already done so. If you have a friend who appears deeply depressed, is preoccupied with death, begins to give away prized possessions, or talks openly about suicide, take the signs seriously. Encourage the

Biological Factors Our physical and psychological future is not written in our genes, but genetics does set limits on some of our choices. For mood disorders, both heredity and brain function appear to be important biological factors.

- Heredity—Many disorders run in families, and mood disorders are no exception. We can see the influence of heredity in twin studies. Genetically, fraternal twins (who develop from two fertilized egg cells) differ from each other as much as any other two siblings. If one fraternal twin has major depressive disorder, the other twin has a 20 percent
person to seek help immediately (one option is to call the National Suicide Prevention Hotline, available toll-free 24 hours a day at 1-800-273-TALK) and consult with a parent, teacher, counselor, physician, or religious leader to make sure you have done all that you can. If you begin to feel suicidal, seek help. The dark mood will lift, and better days do lie ahead.

Nearly a million people worldwide commit suicide each year (World Health Organization, 2008d). Consider these differences in suicide rates for different groups:

- In general, Western countries have a higher rate of suicide than non-Western countries, but there is great variation even among Western countries. The rate in England is about half the U.S. rate, and the rate in Finland is about double (World Health Organization, 2008d).
- In most parts of the world, men are more likely than women to commit suicide. Women, however, are at least twice as likely to attempt suicide. Men succeed more often because their method of choice is firearms, which are more lethal than the drug overdoses preferred by women (World Health Organization, 2008d).
- White Americans have a higher suicide rate than other racial groups (National Institute of Mental Health, 2002).
- Suicide rates increase with age. The highest rate of suicide is among older men (see Figure 31.5).
- Suicide rates have been increasing over time. For 15- to 25-year-olds, the suicide rate doubled between 1960 and 1990 (Eckersley & Dear, 2002).
- There is a strong link between drug and alcohol use and suicide. The risk of suicide is 100 times greater among those dependent upon alcohol (Murphy & Wetzel, 1990).

There have also been student suicides, and suicide attempts, in the school where I now teach. Seeing this runs articles in the school newspaper, and ensures that counselors are available to help friends and classmates cope with the emotional effect of the loss. The rumors proved to be true, but nobody ever mentioned what had happened.

Suicide rates have been increasing over time. The highest rate of suicide is among older men (see Figure 31.5). Suicide rates increase with age. The highest rate of suicide is among older men (see Figure 31.5). Suicide rates have been increasing over time. For 15- to 25-year-olds, the suicide rate doubled between 1960 and 1990 (Eckersley & Dear, 2002).

In recent years, the administration put into place a plan that counselors are available to help friends and classmates cope with the emotional effect of the loss. The rumors proved to be true, but nobody ever mentioned what had happened.

At this point, you may want to use Activity: The Revised Facts on Suicide Quiz.

Differentiation

Remind students that being genetically predisposed to a condition such as depression does not mean one is guaranteed to get the disorder. Genetic predisposition combined with the right environmental circumstances can help a person avoid the symptoms or incidence of disorder.

Figure 31.5

Suicide, Gender, and Age

Suicide is more common among men than women at all ages. Elderly males have the highest rate of suicide. (From Statistical Abstracts, 2008.)

Multicultural Connections

Suicide in Other Cultures

Have students investigate reasons why suicide rates differ among different cultures.

- Do some cultures view suicide as an honorable way of ending life?
- What about Finnish culture seems to encourage suicide? What about British culture discourages it?

At this point, you may want to use Critical Thinking Activity: The Revised Facts on Suicide Quiz.
Beyond the Classroom

Guest Speaker Invite a psychologist to class who specializes in treating mood disorders.

- Does the DSM make any special category for drug-induced mood disorders? (Yes, mood disorders caused by substance abuse reside in another diagnostic category.)
- How might a doctor tell the difference between a mood disorder and a substance-abuse mood disorder?
- What other disorders might drug use cause?

Social-Cognitive Factors Psychologists operating from the biological and cognitive perspectives have made tremendous progress in explaining behavior and mental processes in recent years. In addition to the biological influences described in the previous paragraphs, researchers have identified a number of important social and cognitive influences. Psychologists look closely at the interplay among the way we think, the situations we find ourselves in, and the way we feel. These social and cognitive factors actually affect brain chemistry and are affected by it. Complicated? Yes, but mood disorders are complex, and we would be unrealistic to expect simple explanations for these conditions. Consider a few social-cognitive influences:

- **Learned helplessness**—People develop a sense of helplessness when subjected to unpleasant events over which they have little or no control. As they acquire this feeling of helplessness, they give up and no longer try to improve their situation because they learned in the past that efforts to improve the situation will not work. This alone can produce depression. Learned helplessness may be one reason women suffer higher rates of depression than men do. Compared with men, women disorder. For bipolar disorder, 30 percent do not develop it if the other twin has it.

- **Brain function**—Depressed people have depressed brains (see Figure 31.6). Positive emission tomography (PET) scan studies indicate that the brain is less active during major depression, especially in frontal lobe regions that are normally active during positive emotions (Davidson et al., 2002). It is also true that certain neurotransmitters—the chemical messengers that allow individual neurons in the brain to communicate with one another—appear to be out of balance in the case of mood disorders. The two neurotransmitters that are most important for depression are serotonin and norepinephrine, which are lacking during times of depression. The levels of these neurotransmitters may ultimately be controlled by genes. People who experience major stress are much more likely to develop depression if there is a problem with a gene that controls serotonin levels (Moffitt et al., 2006). Prozac and other antidepressant medications help restore the proper levels of these neurotransmitters.

Art Invite your school's art teacher to class to discuss how the creative genius of several famous artists might have been their outlet for a mental illness.

- Does having a mental illness seem to diminish the quality of the art in the minds of viewers or critics?
- How does the teacher define creativity? Does that definition sound similar to mania?

At this point, you may want to use Enrichment Lesson: Commitment to the Common Good.
are more likely to be abused, stressed, and overwhelmed (Hankin & Abramson, 2001; Mazure et al., 2002).

- **Attributions**—When things go wrong, we try to explain them. Your explanatory style is determined by the nature of the explanations, or attributions, that you make. These attributions can vary from person to person. It turns out that depressed people are likely to make attributions with the following characteristics (see Figure 31.7):
  - **Stable**—The bad situation will last a long time.
  - **Internal**—This happened because of my actions, not because of the actions of someone else and not because of the circumstances.
  - **Global**—My explanation applies to many areas of my life.

If I fail a history test and explain this by saying, "I'm stupid," I've met all these conditions. This attribution is stable (stupidity doesn't come and go; it stays with me), internal (stupidity is a personal characteristic), and global (being stupid affects most of the things I do). One theory (Abramson et al., 1989; Panzarella et al., 2006) says that these attributions lead to a sense of hopelessness that produces depression.

Notice that this sense of hopelessness is less likely if attributions change. If I say I failed a history test because I was sick that day, even though being sick is internal and global, my explanation is not stable (I haven't said I'll

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### Learned Helplessness

When people find themselves in unpleasant situations over which they have little control (like this woman doing tedious, poorly paid factory work), learned helplessness can set in. This, in turn, is associated with depression.

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### Attribution and Learned Helplessness Help Explain Depression

**Beyond the Classroom**

**Brainstorm** Attribution and learned helplessness help explain depression, but what about explanations for mania? Have students brainstorm about different psychological explanations for mania:

- **How might learning theorists explain mania?**
- **What attributions might a manic make about his or her behavior? Would the person be optimistic or pessimistic?**
sustaining mental health. do not address the social and cognitive factors that contribute to the disorder. An eclectic approach is important to sustaining mental health.

Reteach
Use Figure 31.8 to emphasize the interaction of multiple factors in mood disorders. Students should see that while mood disorders are often treated with medications, medications alone do not address the social and cognitive factors that contribute to the disorder. An eclectic approach is important to sustaining mental health.

Active Learning
Research
Have students research which neurotransmitters are most related to both anxiety and mood disorders. Extend the research to include the types of drugs used to treat these conditions. Have students discover how the drugs act on the neural sites to affect behavior.

Active Learning
Understanding Social-Cognitive Factors
Have students imagine that their checking account is overdrawn. Ask:

- Does this explanation reflect something about you (internal) or something about other people or circumstances (external)?
- Is it something that is permanent (stable) or temporary (unstable)?
- Does it influence other areas of your life (global) or only your checking account balance (specific)?

Reiterate that internal, stable, and global attributions tend to be associated with depression.

Figure 31.8
What Determines Mood?
Mood flows from a complex interaction of biological and social-cognitive factors. These factors influence one another and are influenced by external events and internal moods. Attempts to improve mood can focus on controlling the environment, prescribing medications to change brain chemistry, or changing the way the person thinks.

Pause Now OR Move On
Turn to page 567 to review and apply what you’ve learned.

In this module, we examined two of the more common categories of psychological disorders: anxiety disorders and mood disorders. According to some estimates, roughly one-quarter of us will experience a disorder from one of these two broad categories at some point in life (Robins & Regier, 1991). Researchers have begun to unravel the complicated story of what causes anxiety and mood disorders. As they continue to make progress, even more effective treatment options will become available to help those who suffer from these widespread conditions.
SUMMARY AND FORMATIVE ASSESSMENT

MODULE 31
Thinking About Anxiety and Mood Disorders

Anxiety Disorders

1. All of a sudden, Roberto started sweating, his heart started racing, and he felt like he couldn’t breathe. Which of the following fits Roberto’s symptoms best?
   a. panic disorder
   b. social phobia
   c. post-traumatic stress disorder
   d. obsessive-compulsive disorder

2. A person with a(n) ______ might wash his or her hands 100 times each day.

3. Bagha fears flying and feels relieved whenever she can avoid traveling by air. This is an example of how phobias can be influenced by
   a. observational learning
   b. reinforcement
   c. heredity
   d. evolution

4. True or False: Obsessive-compulsive disorder produces increased activity in the rear of the brain.

Mood Disorders

1. Major depressive disorder is diagnosed when five of the following nine symptoms (including one of the first two) are present for two or more weeks: depressed mood most of the day, little interest in activities, changes in appetite, changes in sleep, changes in activity level, fatigue, feelings of worthlessness, inability to concentrate, and recurrent thoughts of suicide.

2. Researchers have identified a number of important social and cognitive influences on the development of mood disorders, including the way we think (attributions) and the situations in which we find ourselves (as with learned helplessness).

3. Several biological factors may contribute to anxiety disorders, including heredity and brain function.

4. People with bipolar disorder alternate between the hopelessness of depression and the overexcited and unreasonably optimistic state of mania.

5. Avin came out of a period of intense depression but now goes days without sleeping, has racing thoughts, and is unable to concentrate.

Exploring Psychological Disorders on the World Wide Web

Students can search the web for information on different disorders presented in Modules 30 through 32. Assign each student or group of students a disorder and have them gather information on it, creating a presentation to share with the class, school, or community. Some presentation options include the following:

- A formal research paper
- A poster presentation
- A public awareness campaign to educate people about the illness
- A documentary about someone with the disorder that educates people about the day-to-day life of people with the illness

Please refer to Alternative Assessment/Portfolio Project: Exploring Psychological Disorders on the World Wide Web for helpful websites and rubrics to aid in evaluating your students’ projects.

Check for Understanding

At this point, you may wish to review and confirm concepts about anxiety and mood disorders with Critical Thinking Activity: Fact or Falsehood? Suggest that students complete the handout in small groups, taking the time to look up information in the text to respond correctly to questions. Have all the groups meet to review the handout, again asking students to use the text to support their responses.

Reteach

This module focused on two of the most common psychological disorders: anxiety and mood disorders. In the right balance, anxiety and mood are adaptive and beneficial. Out of balance, they can have dramatic negative effects on one’s daily life. Have students create a chart with two columns: one column labeled “Benefits/Needs Met” and the other column labeled “Drawbacks/Hindrances.” Ask students to brainstorm about how the levels of anxiety and types of moods can be beneficial or detrimental in their lives.

Answers

Anxiety Disorders: Apply What You Know
1. (a)
2. compulsion
3. (b)
4. False
Using the Test Bank
The Test Bank that accompanies this textbook offers a wide variety of questions in different formats and levels of complexity. Use the software to construct whole tests or to integrate standardized questions into teacher-made tests.

Answers Mood Disorders: Apply What You Know
5. (b)
6. social-cognitive
7. Learned helplessness
8. True

thoughts, and sets impossible goals for himself. He may be experiencing
a. an anxiety disorder with mood swings.
   b. the manic phase of bipolar disorder.
   c. post-traumatic stress disorder.
   d. the major phase of his major depressive episode.

6. Psychologists studying the development of mood disorders who look for the effects of the way we think, the situations we find ourselves in, and the way we feel are searching for ________ factors that may influence the development of a mood disorder.
7. ________ may occur when we are exposed to unpleasant events over which we have little or no control.
8. True or False: Depressed people make attributions that are stable, internal, and global.

KEY TERMS
anxiety, p. 550
generalized anxiety disorder, p. 551
panic disorder, p. 551
phobia, p. 551
obsessive-compulsive disorder (OCD), p. 551
post-traumatic stress disorder (PTSD), p. 551
major depressive disorder, p. 560
bipolar disorder, p. 561