Mood Disorders

TOPIC OVERVIEW

Unipolar Depression
- How Common Is Unipolar Depression?
- What Are the Symptoms of Depression?
- Diagnosing Unipolar Depression

What Causes Unipolar Depression?
- The Biological View
- Psychological Views
- Sociocultural Views

Bipolar Disorders
- What Are the Symptoms of Mania?
- Diagnosing Bipolar Disorders
- What Causes Bipolar Disorders?

Putting It Together: Making Sense of All That Is Known

LECTURE OUTLINE

I. DEPRESSION AND MANIA ARE THE KEY EMOTIONS IN MOOD DISORDERS:
   A. Depression—a low, sad state in which life seems dark and its challenges overwhelming
   B. Mania—a state of breathless euphoria or frenzied energy
   C. Most people with a mood disorder experience only depression
      1. This pattern is called unipolar depression
      2. There is no history of mania
      3. Mood returns to normal when depression lifts
   D. Others experience periods of mania that alternate with periods of depression
      1. This pattern is called bipolar disorder
   E. One might logically expect a third pattern—unipolar mania, in which people suffer from mania only—but this pattern is uncommon
   F. Mood disorders have always captured people's interest
G. Mood problems have been shared by millions and today the economic costs amount to more than $80 billion each year
   1. The human suffering is beyond calculation

II. UNIPOLAR DEPRESSION
   A. The term depression is often used to describe general sadness or unhappiness
      1. This loose use of the term confuses a normal mood swing with a clinical syndrome
      2. Clinical depression can bring severe and long-lasting psychological pain that may intensify over time
   B. How common is unipolar depression?
      1. Almost 7 percent of adults in the United States suffers from severe unipolar depression in any given year
      2. As many as 5 percent suffer mild forms
      3. About 17 percent of all adults will experience unipolar depression in their lifetime
      4. The prevalence is similar in Canada, England, France, and many other countries
      5. The risk of experiencing this problem has increased steadily since 1915
   C. Women are at least twice as likely as men to experience episodes of severe unipolar depression
      1. As many as 26 percent of women (as opposed to 12 percent men) may have an episode at some time in their lives
      2. Among children the prevalence is similar for boys and girls
      3. These rates hold true across socioeconomic classes and ethnic groups
   D. Approximately half of those with unipolar depression recover within six weeks, and 90 percent recover within a year, some without treatment
      1. Most will experience another episode at some point
   E. What are the symptoms of depression?
      1. Symptoms may vary from person to person
      2. Five main areas of functioning may be affected:
         a. Emotional symptoms
         b. Motivational symptoms
            (a) Between 6 and 15 percent of those with severe depression commit suicide
         c. Behavioral symptoms
         d. Cognitive symptoms
         e. Physical symptoms
   F. Diagnosing unipolar depression
      1. Criteria 1: Major depressive episode
         a. Marked by five or more symptoms lasting two weeks or more
         b. In extreme cases, symptoms are psychotic, including:
            (a) Hallucinations
            (b) Delusions
         c. Criteria 2: No history of mania
      2. Two diagnoses to consider:
         a. Major depressive disorder
            (a) Criteria 1 and 2 are met
         b. Dysthymic disorder
            (a) Symptoms are “mild but chronic”
            (b) Experience longer-lasting but less disabling depression
            (c) Consistent symptoms for greater than two years
            (d) When dysthymic disorder leads to major depressive disorder it is termed double depression

III. WHAT CAUSES UNIPOLAR DEPRESSION?
   A. Stress may be a trigger for depression
      1. People with depression experience a greater number of stressful life events during the month just before the onset of their symptoms than do others
2. Some clinicians distinguish reactive (exogenous) depression from endogenous depression, which seems to be a response to internal factors.

3. Today’s clinicians usually concentrate on recognizing both the situational and internal aspects of any given case.

B. The current explanations of unipolar depression point to biological, psychological, and sociocultural factors.

1. The biological view—Genetic factors
   a. Family pedigree, twin, adoption, and molecular biology gene studies suggest that some people inherit a biological predisposition to unipolar depression.
   b. Researchers have found that as many as 20 percent of relatives of those with depression are themselves depressed, compared with fewer than 10 percent of the general population.
   c. Twin studies demonstrate a strong genetic component:
      (a) Concordance rates for identical (MZ) twins are 46 percent.
      (b) Concordance rates for fraternal (DZ) twins are 20 percent.
   d. Adoption has implicated a genetic factor in cases of severe unipolar depression.
   e. Using techniques from the field of molecular biology, researchers have found evidence that unipolar depression may be tied to specific genes.

2. The biological view—Biochemical factors
   a. Low activity of two neurotransmitters—norepinephrine and serotonin—has been strongly linked to unipolar depression.
      (a) In the 1950s, medications for high blood pressure were found to cause depression; some lowered serotonin, others lowered norepinephrine.
      (b) The discovery of truly effective antidepressant medications, which relieved depression by increasing either serotonin or norepinephrine, confirmed the NT role.
         (i) In terms of NTs, it is likely not one or the other—a complex interaction is at work and other NTs may be involved.
   b. This model has produced much enthusiasm but has certain limitations.
      (a) Relies on analogue studies: depression-like symptoms created in lab animals.
         (i) Do these symptoms correlate with human emotions?
      (b) Measurement of brain activity has been difficult and indirect.
         (i) Current studies with modern technology are attempting to address this issue.

3. The biological view—Brain anatomy and brain circuits
   a. Biological researchers have determined that emotional reactions of various kinds are tied to brain circuits.
      (a) These are networks of brain structures that work together, triggering each other into action and producing a particular kind of emotional reaction.
      (b) It appears that one circuit is tied to GAD, another to panic disorder, and yet another to OCD.
   b. Although research is far from complete, a circuit responsible for unipolar depression has begun to emerge.
      (a) Likely brain areas in the circuit include: prefrontal cortex, hippocampus, amygdala, and Brodmann’s Area 25.
4. Psychological views
   a. There are three main psychological models:
      (a) Psychodynamic view—no strong research support
         (i) Developed by Freud and his student Abraham, this model links depression and grief
            1. When a loved one dies, an unconscious process begins, and the mourner regresses to the oral stage and experiences introjection—a merging of their own identity with that of the lost person
            2. For most people, introjection is temporary
            3. If grief is severe and long-lasting, depression results
         (ii) At greater risk for developing depression are those with oral stage issues—either unmet or excessively met needs
         (iii) Some people experience “symbolic” (or imagined) loss
         (iv) Newer psychoanalysts (object relations theorists) propose that depression results when people’s relationships leave them feeling unsafe and insecure
         (v) Strengths
            1. Studies have offered general support for the psychodynamic idea that depression may be triggered by a major loss (ex: anaclitic depression)
            2. Research supports the theory that early losses set the stage for later depression
            3. Research also suggests that people whose childhood needs were improperly met are more likely to become depressed after experiencing a loss
         (vi) Limitations
            1. Early losses and inadequate parenting don’t inevitably lead to depression and may not be typically responsible for development of depression
            2. Many research findings are inconsistent
            3. Certain features of the model are nearly impossible to test
      (b) Behavioral view—modest research support
         (i) Behaviorists believe that unipolar depression results from significant changes in rewards and punishments people receive
         (ii) Lewinsohn suggests that the positive rewards in life dwindle for some people, leading them to perform fewer and fewer constructive behaviors and they spiral toward depression
         (iii) Research supports the relationship between the number of rewards received and presence of depression
            1. Social rewards are especially important
         (iv) Strengths
            1. Researchers have compiled significant data to support this theory
         (v) Limitations
            1. Research has relied heavily on the self-reports of depressed subjects
            2. Behavioral studies are largely correlational and do not establish that decreases in rewards are the initial cause of depression
      (c) Cognitive views (two main theories)—considerable research support
         (i) Negative thinking
            1. Beck theorizes four interrelated cognitive components combine to produce unipolar depression:
               (1) Maladaptive attitudes
                  i. Self-defeating attitudes are developed during childhood
ii. Beck suggests that upsetting situations later in life can trigger an extended round of negative thinking.

(2) Negative thinking typically takes three forms called the cognitive triad:
   i. Individuals repeatedly interpret their (1) experiences, (2) themselves, and (3) their futures in negative ways that lead them to feel depressed.

(3) Depressed people also make errors in their thinking, including:
   i. Arbitrary inferences
   ii. Minimization of the positive; magnification of the negative

(4) Depressed people experience automatic thoughts, a steady train of unpleasant thoughts suggesting inadequacy and hopelessness.

2. Strengths
   a. Many studies have produced evidence in support of Beck’s explanation:
      i. There is a high correlation between the level of depression and the number of maladaptive attitudes held.
      ii. Both the cognitive triad and errors in logic are seen in people with depression.
      iii. Automatic thinking has been linked to depression.

3. Limitations
   a. Research fails to show that such cognitive patterns are the cause and core of unipolar depression.

(ii) Learned helplessness
1. This theory asserts that people become depressed when they think that:
   a. They no longer have control over the reinforcements (rewards and punishments) in their lives.
   b. They themselves are responsible for this helpless state.

2. The theory is based on Seligman’s work with laboratory dogs:
   a. Dogs who were subjected to uncontrollable shock were later placed in a shuttle box.
   b. Even when presented with an opportunity to escape, dogs that had experienced uncontrollable shocks made no attempt to do so.
   c. Seligman theorized that the dogs had “learned” to be “helpless” to do anything to change negative situations and drew parallels to human depression.

3. There has been significant research support for the model:
   a. Human subjects who undergo helplessness training score higher on depression scales and demonstrate passivity in laboratory trials.
   b. Animal subjects lose interest in sex and social activities—a common symptom of human depression.
   c. In rats, uncontrollable negative events result in lower serotonin and norepinephrine levels in the brain.

4. Recent versions of the theory focus on attributions:
   a. Internal attributions that are global and stable lead to greater feelings of helplessness and, possibly, depression; if they make other kinds of attributions, this reaction is unlikely.
i. Example: “It’s all my fault” [internal]. “I ruin everything I touch” [global] “and I always will” [stable]

ii. Example: “She never did know what she wanted” [external], but “The way I’ve behaved the past couple of weeks blew this relationship” [specific], “I don’t know what got into me—I don’t usually act like that” [unstable]

b. Some theorists have refined the helplessness model yet again in recent years—they suggest that attributions are likely to cause depression only when they further produce a sense of hopelessness in an individual

5. Strengths
a. Hundreds of studies have supported the relationship between styles of attribution, helplessness, and depression

6. Limitations
a. Laboratory helplessness does not parallel depression in every way
b. Much of the research relies on animal subjects
c. The attributional component of the theory raises particularly difficult questions in terms of animal models of depression

4. Sociocultural views
a. Sociocultural theorists propose that unipolar depression is greatly influenced by the social context that surrounds people
   (a) This belief is supported by the finding that depression often is triggered by outside stressors
   (b) There are two kinds of sociocultural views:
      (i) The family-social perspective
      (ii) The multicultural perspective

b. The family-social perspective
   (a) The connection between declining social rewards and depression (as discussed by the behaviorists) is a two-way street
      (i) Depressed people often display social deficits that make other people uncomfortable and may cause them to avoid the depressed individuals
      (ii) This leads to decreased social contact and a further deterioration of social skills
   (b) Consistent with these findings, depression has been tied repeatedly to the unavailability of social support such as that found in a happy marriage
      (i) People who are separated or divorced display three times the depression rate of married or widowed persons and double the rate of people who have never been married
      (ii) There also is a high correlation between level of marital conflict and degree of sadness that is particularly strong among those who are clinically depressed
   (c) Finally, it appears that people whose lives are isolated and without intimacy are particularly likely to become depressed at times of stress

c. The multicultural perspective
   (a) Two kinds of relationships have captured the interest of multicultural theorists:
   (b) Gender and depression
      (i) A strong link exists between gender and depression
      (ii) Women cross-culturally are twice as likely as men to receive a diagnosis of unipolar depression
      (iii) Women also appear to be younger, have more frequent and longer-lasting bouts, and to respond less successfully to treatment
      (iv) Various theories have been offered:
1. The artifact theory holds that women and men are equally prone to depression but that clinicians often fail to detect depression in men.
2. The hormone explanation holds that hormone changes trigger depression in many women.
3. The life stress theory suggests that women in our society experience more stress than men.
4. The body dissatisfaction theory states that females in Western society are taught, almost from birth, to seek a low body weight and slender body shape—goals that are unreasonable, unhealthy, and often unattainable.
5. The lack-of-control theory picks up on the learned helplessness research and argues that women may be more prone to depression because they feel less control than men over their lives.
6. The self-blame explanation holds that women are more likely than men to blame their failures on lack of ability and to attribute their successes to luck—an attribution style that has been linked to depression.
7. The rumination theory holds that people who ruminate when sad—keep focusing on their feelings and repeatedly consider the causes and consequences of their depression—are more likely to become depressed and stay depressed longer.

Each explanation offers food for thought and has gathered just enough supporting evidence to make it interesting (and just enough contrary evidence to raise questions about its usefulness).

Cultural background and depression
(i) Depression is a worldwide phenomenon, and certain symptoms seem to be constant across all countries, including sadness, joylessness, anxiety, tension, lack of energy, loss of interest, and thoughts of suicide.
(ii) Beyond such core symptoms, research suggests that the precise picture of depression varies from country to country.
   1. Depressed people in non-Western countries are more likely to be troubled by physical symptoms of depression than by cognitive ones.
   2. As countries become more Westernized, depression seems to take on the more cognitive character it has in the West.
(iii) Within the United States, researchers have found few differences in depression symptoms among members of different ethnic or racial groups, however, sometimes striking differences exist in specific populations living under special circumstances.
   1. Rate of depression in Native American women is 37 percent, versus 17 percent of men and 28 percent overall.
   2. These findings are theorized to be the result of economic and social pressures.

III. BIPOLAR DISORDERS
A. People with a bipolar disorder experience both the lows of depression and the highs of mania.
   1. Many describe their lives as an emotional roller coaster.
B. Unlike those experiencing depression, people in a state of mania typically experience dramatic and inappropriate rises in mood.
   1. Five main areas of functioning may be affected:
      a. Emotional symptoms
      b. Motivational symptoms
      c. Behavioral symptoms
         (a) Flamboyance is not uncommon
      d. Cognitive symptoms
(a) Especially prone to poor judgment and planning

C. Diagnosing bipolar disorders

1. Criteria 1: Manic episode
   a. Three or more symptoms of mania lasting one week or more
   b. In extreme cases, symptoms are psychotic

2. Criteria 2: History of mania
   a. If currently experiencing hypomania or depression

3. DSM-IV-TR distinguishes between two kinds of bipolar disorder:
   a. Bipolar I disorder
      (a) This disorder requires full manic and major depressive episodes
      (b) Most sufferers experience an alteration of mood
      (c) Some experience mixed episodes
   b. Bipolar II disorder
      (a) Hypomaniac episodes and major depressive episodes

4. Without treatment, the mood episodes tend to recur for people with either type of bipolar disorder
   a. If people experience four or more episodes within a one-year period, their disorder is further classified as rapid cycling
   b. If their episodes vary with the seasons, their disorder is further classified as seasonal

5. Regardless of particular pattern, individuals with bipolar disorder tend to experience depression more than mania over the years
   a. In most cases, depressive episodes occur three times as often as manic ones, and last longer

6. Between 1 and 2.6 percent of all adults suffer from a bipolar disorder at any given time, and as many as 4 percent over the course of their lives
   a. The disorders are equally common in women and men and among all socioeconomic classes and ethnic groups
   b. Women may experience more depressive and fewer manic episodes than men and rapid cycling is more common in women

7. Onset usually occurs between 15 and 44 years of age
   a. In most cases, the manic and depressive episodes eventually subside, only to recur at a later time
   b. Generally, when episodes recur, the intervening periods of normality grow shorter and shorter

8. A final diagnostic option:
   a. If a person experiences numerous episodes of hypomaniac and mild depressive symptoms, a diagnosis of cyclothymic disorder is appropriate
      (a) Mild symptoms for greater than two years, interrupted by periods of normal mood
      (b) Cyclothymia affects at least 0.4 percent of the population
      (c) May eventually blossom into Bipolar I or II

D. What causes bipolar disorders?

1. Throughout the first half of the 20th century, the search for the cause of bipolar disorders made little progress

2. More recently, biological research has produced some promising clues

3. These insights have come from research into NT activity, ion activity, brain structure, and genetic factors
   a. Neurotransmitters (NTs)
      (a) After finding a relationship between low norepinephrine and unipolar depression, early researchers expected to find a link between high norepinephrine and mania
      (b) This theory is supported by some research studies; bipolar disorders may be related to overactivity of norepinephrine
(c) Because serotonin activity often parallels norepinephrine activity in unipolar depression, theorists expected that mania also would be related to high serotonin activity.

(d) While no relationship with high serotonin has been found, bipolar disorder may be linked to low serotonin activity, which seems contradictory.

(i) This apparent contradiction is addressed by the “permissive theory” of mood disorders:

(ii) It may be that low serotonin “opens the door” to a mood disorder and permits norepinephrine activity to define the particular form the disorder will take:

1. Low serotonin + Low norepinephrine = Depression
2. Low serotonin + High norepinephrine = Mania

b. Ion activity

(a) Ions, necessary to send incoming messages to nerve endings, may be improperly transported through the cells.

(b) Some theorists believe that irregularities in the transport of these ions may cause neurons to fire too easily (mania) or to stubbornly resist firing (depression).

(c) There is some research support for this theory.

c. Brain structure

(a) Brain imaging and postmortem studies have identified a number of abnormal brain structures in people with bipolar disorder, in particular the basal ganglia and cerebellum, among others.

(b) It is not clear what role such structural abnormalities play.

d. Genetic factors

(a) Many theorists believe that people inherit a biological predisposition to develop bipolar disorders.

(b) Findings from twin studies support this theory:

(i) The rate of bipolar disorder among identical (MZ) twins is 40 percent.

(ii) The rate of bipolar disorder among fraternal (DZ) twins and siblings is 5 to 10 percent.

(iii) The rate of bipolar disorder among the general population is 1 to 2.6 percent.

(c) Recently, genetic linkage studies have examined the possibility of “faulty” genes.

(d) Other researchers are using techniques from molecular biology to further examine genetic patterns.

(e) Such wide-ranging findings suggest that a number of genetic abnormalities probably combine to help bring about bipolar disorders.

**LEARNING OBJECTIVES**

1. Compare depression and mania while discussing the symptoms of each.
2. Contrast unipolar depression and bipolar disorder while discussing the symptoms of each.
3. Describe the biological, psychological, and sociocultural perspectives of depression.
4. Describe the possible roles of neurotransmitters in unipolar depression.
5. Distinguish among the three diagnostic options for bipolar disorder.
6. Discuss the biological theory of bipolar disorder.
KEY TERMS

adoption studies  
anacritic depression  
analogue studies  
arbitrary inference  
automatic thoughts  
bipolar disorder  
bipolar I disorder  
bipolar II disorder  
brain circuits  
cognitive triad  
cortisol  
cyclothymic disorder  
delusion  
depression  
double depression  
dysthymic disorder  
endocrine system  
endogenous depression  
errors in thinking  
family pedigree study  
genetic linkage study  
hallucination  
hopelessness  
hormones  
hypomanic episode  
imagined loss  
introjection  
learned helplessness  
major depressive disorder  
major depressive episode  
maladaptive attitudes  
mania  
manic episode  
melancholic  
melatonin  
molecular biology  
negative thinking  
norepinephrine  
postpartum  
reactive (exogenous) depression  
recurrent rumination  
serotonin  
shuttle box  
sodium ion  
symbolic loss  
twin study  
umipolar depression

MEDIA RESOURCES

Abnormal Psychology Student Tool Kit
Produced and edited by Ronald J. Comer, Princeton University and Gregory Comer, Princeton Academic Resources. Tied directly to the CyberStudy sections in the text, this Student Tool Kit offers 57 intriguing Video Cases running three to seven minutes each. The Video Cases focus on persons affected by disorders discussed in the text. Students first view the video and then answer a series of thought-provoking questions. Additionally, the Student Tool Kit contains multiple-choice practice test questions with built-in instructional feedback for every option.

PowerPoint Slides
Available at the Instructor’s site on the companion Web site are comprehensive PowerPoint slide presentations and supplemental student handouts for Chapter 8. The slide files reflect the main points of the chapter in significant detail. Student handouts were created using the instructor slides as a base, with key points replaced as “fill-in” items. Answer keys and suggestions for use also are provided.

DSM-IV-TR Masters
B-26, DSM-IV-TR Criteria for Major Depressive Episode
B-27, DSM-IV-TR Criteria for Manic Episode
B-27, DSM-IV-TR Criteria for Mixed Episode
B-28 DSM-IV-TR Diagnostic Criteria for Hypomanic Episode
B-29, DSM-IV-TR Diagnostic Criteria for Major Depression Disorder, Single Episode
B-30, DSM-IV-TR Diagnostic Criteria for Dysthymic Disorder
B-31, DSM-IV-TR Diagnostic Criteria for Bipolar I Disorder, Single Manic Episode
B-31, DSM-IV-TR Diagnostic Criteria for Bipolar II Disorder
B-32, DSM-IV-TR Diagnostic Criteria for Cyclothymic Disorder

Internet Sites
Please see Appendix A for full and comprehensive references.
Sites relevant to Chapter 8 material are:
http://www.nimh.nih.gov/health/publications
This Web site, provided by the National Institute of Mental Health, supplies downloadable links to PDF files and booklets on a variety of mental health topics.
http://en.wikipedia.org/wiki/Mood_disorder
This free Internet encyclopedia offers a definition for mood disorders and links to the major types of disorders. In addition, there are links to other mood-related topics as well as to additional disorders related to mood disorders.
http://www.depression.com/  
This site, developed and funded by GlaxoSmithKline, is devoted to the understanding and treatment of depression as well as to coping with living with depression day by day.

http://bipolar.mentalhelp.net/  
A site that includes the symptoms, treatments, and online support groups for bipolar disorder.

http://sandbox.xerox.com/pair/cw/testing.html  
This site includes the Clinical Depression Screening Test, a quick test of depressive symptoms, as well as some advice for individuals who score in the depressed range.

http://www.adolescent-mood-disorders.com/  
This site reviews the difficulties in recognizing depression and other mood disorders among teenagers.

http://www.mdsg.org/  
This is a comprehensive site of the mood disorder support group of New York City.

http://www.psycom.net/depression.central.html  
Maintained by a private individual, this site is the Internet’s central clearinghouse for information on all types of depressive disorders and on the most effective treatments for individuals suffering from major depression, manic-depression (bipolar disorder), cyclothymia, dysthymia, and other mood disorders.

Mainstream Films

Films relevant to Chapter 8 material are listed and summarized below.

Key to Film Listings:
P = psychopathology focus  
T = treatment focus  
E = ethical issues raised

Please note that some of the films suggested may have graphic sexual or violent content due to the nature of certain subject matters.

It’s a Wonderful Life  
This film from 1946 stars Jimmy Stewart as George Bailey, a small-town man whose life seems so desperate he contemplates suicide. P, commercial film

Leaving Las Vegas  
This 1995 film stars Nicolas Cage as a Hollywood screenwriter who has become an alcoholic. After being fired, he takes his severance pay to Las Vegas, where he plans to drink himself to death. P, serious film

Mr. Jones  
This 1993 Richard Gere film follows the relationship between a bipolar man, Mr. Jones, and the female doctor who takes more than a professional interest in his treatment. P, T, E, commercial film

Ordinary People  
This 1980 film examines the treatment of a teenager suffering from depression, anxiety, and posttraumatic stress disorder in the aftermath of his brother’s death. P, T, serious film

Spellbound  
From 1945, this Hitchcock film (with scenery by Salvador Dali) stars Ingrid Bergman as a psychiatrist and Gregory Peck as an amnestic patient involved in a manhunt. P, T, E, commercial thriller/romance film

Other Films:

The Bell Jar (1979) anxiety and depression. P, T, serious film
Fear Strikes Out (1957) depression. P, T, serious film

Comer Video Segments

Available as a supplement, this revised set of videotapes contains short clips depicting various topics related to abnormal psychology. Please see the accompanying Video Guide for specific clips linked to Chapter 8.

Recommendations for Purchase or Rental

The Comer Video Segments include excerpts from many superb clinical documentaries. While the segments alone are ideal for use in lectures, it often is useful to assign the entire documentary for special class screenings or library use by students. The following videos and other media are available for purchase or rental and appropriate for use in class or for assignment outside of class.

When the Brain Goes Wrong  
Franklin Institute, Tulip Films  
Fanlight Productions
(800) 937-4113
info@fanlight.com
Case Study
Present a case study to the class.

Panel Discussion
Have students volunteer (or assign them) to portray mental health “workers” of different theoretical perspectives in a panel discussion. Each student should present the main explanation and treatment for the mood disorders from his or her theoretical background. Students in the audience can ask questions of the panelists. Additionally, other students can role-play patients suffering from particular mood disorders. [NOTE: A brief reminder about sensitivity and professionalism is worthwhile here.] Have the panelists attempt to diagnose based on their orientation.

Depression Inventories
Bring in depression inventories. Discuss why these inventories are useful in both therapy and research. Ask students to suggest changes or modifications that could improve these instruments.

“Pretend, for a moment, that you are a...”
Divide students into groups and assign each group a task similar to the following. Pretend they are a business owner who is interested in alleviating the negative (and costly) effects of depression on workplace productivity. Ask them to come up with creative and practical solutions to identifying and intervening with workers suffering from mood disorders. Similar roles are a high school principal, a medical doctor, a fraternity or sorority president, a college instructor, and a baseball team manager.

The Anonymous Five-Minute Essay
It is useful to ask students to take five minutes to explain the biological model of depression. Reviewing these answers can alert instructors to misconceptions and poor communication of important ideas. This can be done for the cognitive, behavioral, and psychodynamic models as well.

Women and Depression
Ask the class to brainstorm (see pages 261–262 in the text) why the rates of depression, even cross-culturally, are twice as high for women as for men.

Open Discussion: Manic Episodes
Discuss the idea that manic episodes can be extraordinarily pleasant. Encourage students to imagine aloud why such episodes might be enjoyable (more cheerful, more productive, more outgoing).

“Let’s Write a Self-Help Best-Seller”
Discuss the stigma associated with mood disorders. Many persons implicitly (and sometimes explicitly) presume that mood disorders occur only in persons who are weak or who “enjoy being sad.” Discuss the effect such attitudes might have on persons with mood disorders (reluctance to admit they have a problem or to seek help). Ask for ideas about how to educate the public about causes of these disorders, thus alleviating the stigma associated with them.

Open Discussion: Learned Helplessness
Martin Seligman and his colleagues suggested that depression is the result of learned helplessness. They proposed that depression, like learned helplessness, is the result of inescapable trauma or negative situations. The person learns that he or she has no control over these negative events and stops trying to respond in an efficient, adaptive manner. The individual thus learns to be helpless. Ask students for examples of how such a model of depression might apply.

Open Discussion: Beck’s Cognitive Theory
According to Aaron Beck and his colleagues, depression is caused by an individual’s tendency to think or reason in a certain fashion. In particular, people be-
come depressed because of their personal schema about themselves, their world, and their future. Introduce the notion of perceptual sets and bias, which influence the manner in which a person perceives things. Perceptual sets cause distortions and selective attention that support the negative schema. An interesting exercise is to provide such a set of assumptions (personal schema) and then present a series of experiences and ask students for “congruent” (with the schema) interpretations of the event. For example, a woman may have a schema of herself as a terrible person. Her daughter is caught smoking at school. Another example: A young man believes that he is unlovable. His girlfriend breaks up with him. (These two people will take one event and distort it, then ignore or minimize contrary evidence, such as the fact that the daughter is a straight-A student or, in the case of the young man, that he acted in a way that encouraged his girlfriend to break up with him.)

ASSIGNMENTS/EXTRA CREDIT SUGGESTIONS

“Write a Pamphlet”
With the use of a software program like Microsoft Publisher or simply paper and markers, students can create a pamphlet on one or all of the mood disorders. Students should be encouraged to be as accurate and up-to-date as possible and also to present all sides of the disorder (e.g., alternate treatment approaches or theories).

Keep a Journal
In addition to helping students synthesize material, this activity also is helpful in developing writing skills. Have students keep a journal of their thoughts on course material through the semester. This can be done in the first or last five minutes of class or as an out-of-class assignment. Faculty generally should have students submit their journals for review on an on-going basis as students can have the tendency to delay writing until the end of the semester. Some suggestions for journal topics include: reactions to the case examples; strengths and weaknesses of prevailing theoretical explanations; hypothetical conversations with sufferers of specific disorders, etc.

Abnormal Psychology Student Tool Kit
Video Questions
As a homework assignment, have students watch a video clip and answer the accompanying questions. Students can answer the questions directly into the on-line assessment feature. The results of these quizzes report to the site’s built-in grade book.

Web Site Quiz
For homework or extra credit, have students complete the quiz for Chapter 8 located on the companion Web site. Students can complete an on-line test of the key chapter material (using questions NOT from the test bank) and have their scores e-mailed directly to the course instructor.

Essay Topics
For homework or extra credit, have students write an essay addressing one (or more) of the following topics:

1. Write an essay discussing the power and acceptability of male vs. female tears (see The Media Speaks on p. 245 in the text)
2. Discuss the Rhythms of Depression (see A Closer Look on pp. 252–253 in the text), including the link between sleep and depression and the effectiveness of light therapy.
3. Write an essay discussing postpartum depression (see Psych Watch, p. 248 in the text). Address various theories/factors, the 4 Ds of the experience, and the shame and stigma experienced by many women.
4. Discuss the relationship between pet owners and their pets. What components of these types of relationships may help to explain the link between pet ownership and reduced depression? (See p. 260 in the text.)

Research Topics
For homework or extra credit, have students write a research report addressing one (or more) of the following topics:

1. Conduct a “Psych Info” search and write a brief report on seasonal affective disorder, circadian rhythms (see pp. 252–253 in the text), and depression. Compare and contrast.
(2) Conduct a “Psych Info” search and write an annotated bibliography on the various theories described on pp. 261–262 in the text to explain depression in women. Which of these models (if any) does the research most strongly support? With which of these models do you most agree?

(3) Conduct a literature review on abnormality and creativity (as discussed in Psych Watch, p. 268 in the text). Does research support the link between the two? Is this association simply anecdotal or have controlled studies examined the association? What famous examples can you find?

Film Review
To earn extra credit, have students watch one (or more) of the mainstream films listed earlier in this chapter and write a brief (3-5) page report. Students should summarize the plot of the film in sufficient detail to demonstrate familiarity, but should focus their papers on the depiction of psychological abnormality. What errors or liberties did the filmmaker take? What is the message (implicit or explicit) concerning the mentally ill?

Case Study Evaluations
To complement the Comer and Gorenstein supplemental case study text, case study evaluations have been created. Students can be assigned the appropriate case study and evaluation as homework or for class discussion. While case-study evaluation questions are listed in their entirety on the companion Web site at www.worthpublishers.com/comer, the relevant case studies are referenced next.

Case Study 4: Major Depressive Disorder
Case Study 5: Bipolar Disorder

Web-Based Case Studies
Nine Web-based case studies have been created and posted on the companion Web site. These cases describe the individual’s history and symptoms and are accompanied by a series of guided questions which point to the precise DSM-IV-TR criteria for each disorder. Students can both identify the disorder and suggest a course of treatment. Students can be assigned the appropriate case study and questions as homework or for class discussion. The case relevant to Chapter 8 is referenced below.

The Case of Ellen: Depression and Suicidality

Crossword Puzzles
As a homework assignment or for extra credit, have students complete and submit Crossword Puzzle #8.

Word Searches
As a homework assignment or for extra credit, have students complete and submit Word Search #8.