

Unit 5: Mental and Physical Health

Unit 5 covers stress, psychological disorders, and the therapies that treat them, plus the positive psychology that keeps people well. CED topics 5.1 through 5.5.

AP Psychology

Unit 5 - Mental and Physical Health

15-25% of the exam

About 14 minutes to read

How to use this guide

Read it once for the story of the unit. Then go through it a second time with each table covered up, so you have to retrieve the term from the example rather than recognize it. Finish with the practice questions without looking back, and check your reasoning when you look at the answers.

What this unit is worth. Unit 5 carries 15 to 25 percent of the multiple-choice section, the same as every other unit. Multiple-choice questions put a person in a short scenario and ask you to name what is happening. The free-response questions give you research you have not seen before and ask you to analyze it.

Unit 5 is the most applied unit on the exam. Multiple-choice questions put a person in a short scenario and ask you to name what is happening to them. You might be asked whether it is normal stress or a disorder, which disorder it fits, or which therapy would be used and why. The free-response questions work differently. They give you research you have not seen before and ask you to analyze it. This guide covers both kinds of questions.

What the College Board expects

- Explain stress, coping, and the links between stress and physical health (Topic 5.1).
- Describe positive psychology, including well-being, strengths, and what helps people flourish (5.2).
- Explain how psychologists define and classify disorders, and why classification helps and harms (5.3).
- Identify the signature features of the major disorder categories (5.4).
- Match treatments to the disorders and perspectives they come from (5.5).

Unit 5 accounts for 15-25% of multiple-choice questions. The exam as a whole is 75 multiple-choice questions in 90 minutes (66.7% of your score), then two free-response questions in 70 minutes (33.3%), an Article Analysis Question and an Evidence-Based Question described on page 6.

1. Stress is an appraisal, not just an event

The same event - a hard exam, a move, a breakup - can energize one student and flatten another. Health psychology explains this by focusing on appraisal. Stress is the process by which we appraise and respond to threatening or challenging events, and the event matters less than the interpretation.

Key ideas

- **Stressors** fall into three types: catastrophes (large-scale disasters), significant life changes (divorce, job loss), and daily hassles (traffic, deadlines). Daily hassles predict health outcomes surprisingly well because they never fully switch off.
- **Primary appraisal** (Lazarus): Is this a threat, a challenge, or irrelevant? **Secondary appraisal**: Do I have the resources to cope? Stress peaks when demands feel bigger than resources.
- **General adaptation syndrome (Selye)**: alarm (sympathetic arousal), resistance (sustained coping, elevated cortisol), exhaustion (resources depleted, vulnerability to illness rises). GAS describes the body's response over time, while Lazarus's model describes how the person interprets the event.
- **Fight-or-flight vs. tend-and-befriend**: Cannon's fight-or-flight is the classic sympathetic response. Taylor proposed tend-and-befriend - seeking and giving social support under stress, linked to oxytocin and more often documented in women.
- **Psychoneuroimmunology**: stress suppresses immune function. Stressed people heal more slowly, catch more colds, and show more inflammation, which is one way stress connects to physical health.
- **Perceived control**: uncontrollable, unpredictable stressors do the most damage. Even believing you could intervene lowers physiological stress responses.

Exam signal: If the scenario says someone *interprets* an event as manageable or overwhelming, the answer is appraisal. If it describes body stages over weeks, the answer is GAS.

2. What counts as a psychological disorder?

Psychologists define a disorder as a pattern of thoughts, feelings, or behaviors that is deviant, distressful, and dysfunctional, although context matters when you apply it. A behavior can be statistically unusual (deviant) without being disordered, and distress alone does not make a pattern a disorder.

- **DSM-5-TR**: the classification manual. It names disorders and lists diagnostic criteria so clinicians share a common language. It classifies disorders and does not explain their causes.
- **Biopsychosocial model**: disorders emerge from interacting biological (genes, brain chemistry), psychological (stress, learned helplessness, thinking patterns), and social-cultural (expectations, poverty, stigma) influences. This is usually the kind of explanation the exam wants when several causes interact.
- **Medical model**: disorders are illnesses of the brain or mind that can be diagnosed and treated, often with medication, though critics say it can label normal variation as illness.
- **Stigma and labeling**: Rosenhan's classic study showed labels shape how staff interpret ordinary behavior.

3. The disorder categories the exam actually targets

It helps to learn each disorder by its signature, the one feature that separates it from nearby disorders, rather than memorizing symptom lists out of context.

CATEGORY	SIGNATURE FEATURES	DO NOT CONFUSE WITH
Generalized anxiety disorder	Persistent, free-floating worry for 6+ months, not tied to one trigger	Phobia (specific trigger)
Panic disorder	Recurrent unexpected panic attacks; fear of the next attack	A single panic attack
Specific phobia / social anxiety	Irrational, disruptive fear of an object, situation, or social evaluation	Normal caution
OCD	Obsessions (intrusive thoughts) drive compulsions (rituals) that briefly reduce anxiety	OCPD (personality pattern, no rituals)
PTSD	After trauma: intrusive memories, avoidance, hyperarousal, negative mood	Normal grief
Major depressive disorder	Depressed mood or anhedonia plus sleep/appetite/concentration changes, 2+ weeks	Sadness after loss
Bipolar disorders	Depressive episodes plus mania: racing thoughts, little need for sleep, grandiosity	Depression alone
Schizophrenia	Positive symptoms (hallucinations, delusions) and negative symptoms (flat affect, avolition); disordered thinking	Dissociative identity disorder
Dissociative disorders	Disruptions of identity/memory; DID involves distinct identity states and amnesia	Schizophrenia ("split personality" myth)
Somatic symptom disorder	Real distress over physical symptoms with excessive anxiety about them	Faking (malingering)
Eating disorders	Anorexia (restriction, low weight), bulimia (binge-purge), binge-eating disorder	Dieting
Personality disorders	Enduring, inflexible patterns; antisocial (disregard for others' rights), borderline (unstable relationships/self-image)	Axis-style mood episodes

The three highest-yield distinctions are schizophrenia versus DID, obsession versus compulsion, and depression versus bipolar (treatment and course hinge on mania). Those pairs are in the Unit 5 flashcard deck, so drill those cards if you keep mixing one up.

4. Therapies: match the method to the model

THERAPY	PERSPECTIVE	WHAT ACTUALLY HAPPENS
Psychoanalysis / psychodynamic	Freudian / dynamic	Free association, dream analysis, transference; insight into unconscious conflicts
Humanistic (client-centered)	Humanistic (Rogers)	Unconditional positive regard, empathy, genuineness; active listening
Behavior therapy	Learning	Systematic desensitization, exposure, aversive conditioning, token economies
Cognitive therapy	Cognitive (Beck)	Identify and test distorted thoughts; gentle Socratic questioning
CBT	Cognitive + behavioral	Thought records plus behavioral experiments; gold standard for anxiety and depression
Group / family therapy	Systems	Treats interaction patterns, not just the individual
Biomedical	Biological	SSRIs (depression/anxiety), antipsychotics (schizophrenia), lithium (bipolar), ECT for severe depression

Evaluating therapy: meta-analyses show therapy works better than no treatment, and most major approaches help. The therapeutic alliance, or trust between client and therapist, predicts outcome across schools. Regression to the mean also matters because people often seek help at their worst, so some improvement would happen anyway. Mention both when you evaluate therapy.

5. The health half: what keeps people well

- **Positive psychology (Seligman):** studies strengths, engagement, meaning, and life satisfaction in addition to illness. PERMA stands for Positive emotion, Engagement, Relationships, Meaning, and Accomplishment.
- **Subjective well-being:** high life satisfaction + frequent positive affect + infrequent negative affect. In the feel-good, do-good phenomenon, happy people help more, and helping raises happiness.
- **Social support:** people with close relationships show lower stress hormones, stronger immunity, and longer lives.
- **Coping:** problem-focused coping attacks the stressor; emotion-focused coping regulates the response. Uncontrollable stressors call for emotion-focused strategies.
- **Aerobic exercise, sleep, and relaxation:** exercise reduces depression and anxiety about as much as therapy in mild cases; mindfulness lowers reactivity to stressors.
- **Resilience and posttraumatic growth:** many people recover from trauma without a disorder, and some report growth. Keep recovery, growth, and trauma distinct on the exam.

6. Trap answers to recognize on sight

- "Split personality" describes DID in pop culture - never schizophrenia.
- Compulsions are behaviors; obsessions are thoughts. Questions swap them deliberately.
- A phobia must be irrational *and disruptive*. Disliking spiders is not a disorder.
- Antisocial personality disorder is about violating others' rights, not avoiding people (that is avoidant).
- Depression medication questions usually want SSRIs; schizophrenia wants antipsychotics; bipolar wants lithium. Crossing these is the classic distractor.
- GAS is Selye; appraisal is Lazarus; tend-and-befriend is Taylor.

7. Practice questions

1. After months of caring for a sick parent, Mara catches every cold, sleeps poorly, and feels unable to recover even on quiet days. Selye would say Mara is most likely in which stage?

- A. Alarm
- B. Resistance
- C. Exhaustion
- D. Appraisal

Answer: C. Prolonged stress has depleted her resources; illness vulnerability is the exhaustion signature.

2. Jonah washes his hands 40 times a day because intrusive images of contamination will not leave his mind. The hand-washing is best classified as which of the following?

- A. Obsession
- B. Compulsion
- C. Delusion
- D. Phobia

Answer: B. The washing is the ritual behavior; the intrusive images are the obsession.

3. A therapist helps a client notice the thought "I ruin everything," test it against evidence, and practice a more accurate alternative. This is an example of

- A. Free association
- B. Systematic desensitization
- C. Cognitive therapy
- D. Aversive conditioning

Answer: C. Identifying and testing distorted thoughts is Beck's cognitive therapy (the core of CBT).

If you missed one, turn the scenario into a flashcard in the Unit 5 deck. It comes back in spaced reviews over the next few days.

8. How the free-response questions work now

Since the Fall 2024 course revision (first tested May 2025), you no longer get a scenario with a list of terms to apply. Both free-response questions give you research summaries and score how well you read evidence. Each is worth 7 points.

Question 1: Article Analysis Question (AAQ) - 25 minutes

You read one summarized study (10 minutes of reading time is built in), then answer six labeled parts. In your own words, the parts ask you to name the research method, state how a variable was measured, explain what a statistic means, name an ethical practice the researchers followed, judge who the findings can be generalized to, and argue whether the results support the hypothesis. Points come from tying each answer to details in the summary, such as the numbers reported, the sample characteristics, and the procedures used. A definition by itself does not earn a point.

Question 2: Evidence-Based Question (EBQ) - 45 minutes

You read three short sources on one topic (15 minutes of reading time is built in), pick two, and build an argument. First you state a claim about the topic. Then, for each of your two sources, you cite a specific finding and explain how it supports your claim, connecting it to a psychological concept. The claim must be defensible from the sources you chose. Responses tend to be stronger when the two sources point the same way, because each source then supports the same claim.

What this means for Unit 5: Health-psychology studies (stress, sleep, exercise, social support) make natural AAQ material, and disorder or treatment topics make natural EBQ material. When you practice, read a methods paragraph and ask yourself what was manipulated or measured, who was studied, and what the numbers actually showed.

Try it: two short drills in the current format

AAQ-style drill (original practice study). Researchers randomly assigned 120 college students to keep either their usual sleep schedule or a fixed 8-hour schedule for two weeks. Each evening, students rated their stress from 0 to 10. The fixed-schedule group averaged 4.1; the usual-schedule group averaged 5.6. Participants gave written consent and could withdraw at any time. For sample answers, the method is an experiment because students were randomly assigned to schedules, stress was operationally defined as the nightly 0 to 10 self-rating, and the fixed-schedule group reported lower average stress, which supports the idea that regular sleep is linked to lower stress in this sample. Each of those answers points back to a specific detail in the summary.

EBQ-style drill. Suppose three sources report that (1) students with strong friend support report lower stress during exams, (2) a gratitude journaling group reports higher life satisfaction after four weeks, and (3) a walking group shows fewer depressive symptoms than a waitlist group. A defensible claim is that everyday social and behavioral habits are associated with better mental health. Pick any two sources, put their findings in your own words, and explain the link. For example, source 1 fits because perceived support changes how a stressor is appraised, so the same exam feels more manageable.

Use the same rule here. If you cannot say part of a drill out loud in your own words, that part becomes a flashcard. Put it in the Unit 5 deck and review it spaced out rather than copying the sample answer into your notes.

Questions students ask about this unit

How much of the exam is Unit 5?

Unit 5 accounts for 15-25% of multiple-choice questions, the same range as each of the other four units. Free-response topics vary by year, so do not count on or rule out a Unit 5 study appearing there.

Should I memorize the DSM?

You do not need to memorize it. Know the categories, signatures, and classic distinctions. The exam tests recognition in scenarios rather than criteria counts, apart from a few durations that appear as anchors, such as 6 months for GAD and 2 weeks for major depressive disorder.

What is the single most tested therapy pairing?

The pairings that come up most are CBT for anxiety and depression, systematic desensitization for phobias, and SSRIs, antipsychotics, and lithium matched to the correct disorder.

Your 3-day study plan

- **Day 1:** Read sections 1-2. Do a brain dump of every stress term you can recall before rereading. Drill the stress/health flashcard set.
- **Day 2:** Read sections 3-4 with the tables covered - retrieve disorder from signature, therapy from description. Run a mixed MCQ set.
- **Day 3:** Timed practice questions, then one timed AAQ drill (25 minutes) and an EBQ claim outline using the drills above. Re-drill only the cards you missed.

Study this unit in Rycal

Open AP Psychology and run the Unit 5 flashcard deck. Its cards cover the terms and distinctions in this guide, and the Unit 5 practice questions go after the same traps named in section 6. Turn each miss into a flashcard and drill it spaced out over several days rather than in one sitting.

When you know your test date, enter it in the Test Planner so the review sessions are sized to the days you actually have.

About this guide. Written for Rycal and aligned to the College Board AP Psychology course framework. All questions and explanations are original Rycal writing. Rycal is independent and is not affiliated with or endorsed by the College Board.

Where to go next. Turn every missed item above into flashcards and drill them spaced out over several days rather than in one sitting. In Rycal, open the Mental and Physical Health deck under AP Psychology. The deck covers the terms in this guide, and its practice questions target the same traps named here. If you have a test date, add it in the Test Planner. You can also start your next review with a Brain Dump, then check what you missed against this guide.

Key terms for this unit

Acrophobia, Active listening, Adverse childhood experiences (ACEs), Agoraphobia, Alarm reaction, American Psychiatric Association, Anorexia nervosa, Antianxiety drugs, Antidepressants, Antipsychotic medications, Antisocial personality disorder, Anxiety disorders, Applied behavior analysis, Arachnophobia, Ataque de nervios, Attention-deficit/hyperactivity disorder (ADHD), Autism spectrum disorder (ASD), Aversion therapies, Avoidant personality disorder, Behavioral perspective (of psychological disorders), Biofeedback, Biological perspective (of psychological disorders), Biopsychosocial model, Bipolar cycling, Bipolar disorders, Bipolar I disorder, Bipolar II disorder, Borderline personality disorder, Bulimia nervosa, Catatonia, Catatonic stupor, Classification of character strengths (six virtues), Cluster A personality disorders, Cluster B personality disorders, Cluster C personality disorders, Cognitive-behavioral therapies, Cognitive perspective (of psychological disorders), Cognitive restructuring, Cognitive therapy, Cognitive triad, Compulsions, Consequences of diagnosing psychological disorders, Cultural humility, Culture-bound anxiety disorders, Daily hassles, Deinstitutionalization, Delusions, Dependent personality disorder, Depressive disorders, Dialectical behavior therapy, Diathesis, Diathesis-stress model, Disorganized motor behavior, Disorganized thinking or speech, Dissociative amnesia, Dissociative disorders, Dissociative identity disorder, Distress (as stress type), Dopamine hypothesis, Dream interpretation, DSM (Diagnostic and Statistical Manual of Mental Disorders), Eclectic approach, Electroconvulsive therapy, Emotion-focused coping, Ethical principles in treatment (APA), Eustress, Evidence-based

diagnostic tools, Evidence-based interventions, Evolutionary perspective (of psychological disorders), Exhaustion phase, Exposure therapies, Fear hierarchies, Feeding and eating disorders, Fight-flight-freeze response, Flat affect, Free association, Fugue, General adaptation syndrome (GAS), Generalized anxiety disorder (GAD), Gratitude, Group therapy, Hallucinations, Happiness, Health psychology, Histrionic personality disorder, Hoarding disorder, Humanistic perspective (of psychological disorders), Hypnosis, ICD (International Classification of Mental Disorders), Lithium, Lobotomy, Major depressive disorder, Mania, Narcissistic personality disorder, Negative symptoms (of schizophrenia), Neurodevelopmental disorders, Obsessions, Obsessive-compulsive and related disorders, Obsessive-compulsive disorder (OCD), Obsessive-compulsive personality disorder, Panic attacks, Panic disorder, Paranoid personality disorder, Persistent depressive disorder, Person-centered therapy, Personality disorders, Positive psychology, Positive symptoms (of schizophrenia), Posttraumatic growth, Posttraumatic stress disorder (PTSD), Prenatal virus exposure, Problem-focused coping, Psychoactive medications, Psychodynamic perspective (of psychological disorders), Psychodynamic therapy, Psychological disorder (factors used to identify), Psychosurgery, Psychotherapy, Psychotropic medication therapy, Rational-emotive behavior therapy, Resilience, Resistance phase, Schizoid personality disorder, Schizophrenia, Schizotypal personality disorder, Signature strengths, Social anxiety disorder, Sociocultural perspective (of psychological disorders), Specific phobia, Stress, Subjective well-being, Systematic desensitization, Taijin kyofusho, Tardive dyskinesia, Tend-and-befriend theory, Therapeutic alliance, TMS (transcranial magnetic stimulation), Token economies, Trauma and stressor-related disorders, Traumatic stressors, Unconditional positive regard, Psychoneuroimmunology, Hypertension, Immune Suppression, Coronary Heart Disease, Catharsis, Coping, Meditation, Personal Control, Self-Control, Well-Being, Feel-Good, Do-Good Phenomenon, Adaptation-Level Phenomenon, Virtues, Character Strengths, Wisdom, Courage, Humanity, Justice, Temperance, Transcendence, Broaden-and-Build Theory, Aerobic Exercise, Mindfulness Meditation, Dysfunction, Stigma, Maladaptive Behaviors, Maladaptive Thoughts, Maladaptive Relationships, Medical Model, Epigenetics, Schizophrenia Spectrum Disorders, Psychotic Disorders, Delusions of Persecution, Delusions of Grandeur, Stupor, Acute Schizophrenia, Chronic Schizophrenia, Depression, Hypervigilance, Flashbacks, Emotional Detachment, Hostility, Meta Analysis, Evidence-Based Interventions (Evidence-Based Practice), Biomedical Therapies, Asylums, Ethical Principles, Nonmaleficence, Fidelity, Integrity, Respect, Unconscious Mind, Resistance (psychodynamic therapy), Transference, Virtual Reality Exposure Therapy, Token Economy, Humanistic Therapy, Insight Therapies, Family Therapy, Individual Therapy, Dissociation, Psychopharmacology, Transcranial Magnetic Stimulation (TMS), Word salad, World Health Organization (WHO).