A.P. Language Summer 2018

Required Homework

1. Vocabulary Packet
2. Synthesis Essay

Required Textbook

- The Language of Composition: Reading, Writing, Rhetoric (Second Edition) by Renée H. Shea, Lawrence Scanlon, and Robin Dissin Aufses
- ISBN: 978-0-312-67650-6
- Available at amazon.com, chegg.com, half.com

Due Date

- The synthesis essay is due the first day of class
- The vocabulary packet is due the second day of class

Assessments and Grading

- The synthesis essay will be your first summative assessment ("test grade"). Rubric is in packet.
- The first few days of school, you'll take a vocabulary assessment on the terms, prefixes, suffixes, & roots you studied. This will be your first formative assessment ("quiz grade")
- The first few days of school, you will also take a pre-test for the A.P. Language exam

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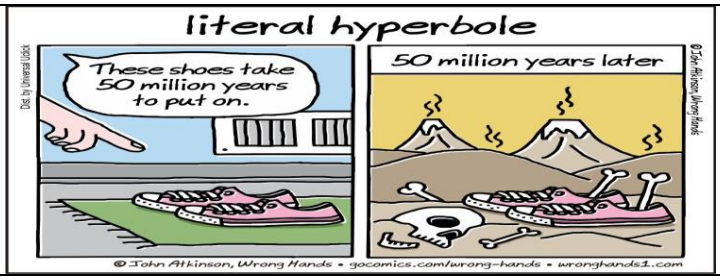
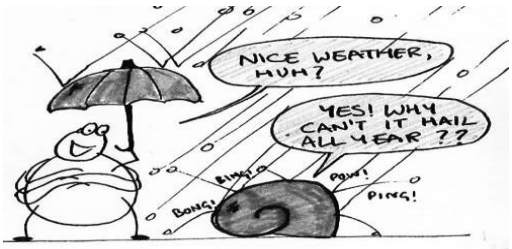
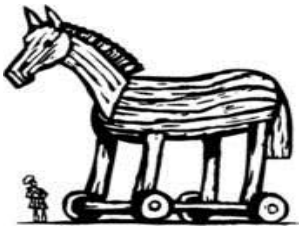
Rhetorical Vocabulary

On the AP Language exam, you will need to analyze rhetorical terms in many passages. This list will help you. For each, write a definition for the word on the left and illustrate its meaning or provide an original example on the right. There are some examples below.

1. ***Hyperbole*** *– A figure of speech that uses exaggeration to emphasize strong feelings or to create a satiric effect. To enlarge, increase, or represent something beyond normal bounds so that it becomes ridiculous and its faults can be seen. This is a literary device often used to create satire.*	
2. ***Verbal Irony*** *– When the opposite of what is said is implied or meant. Positive words convey criticism or criticism conveys praise. Sarcasm is a type of verbal irony in which the literal meaning is complimentary but the actual meaning is critical. This is a literary device often used to create satire.*	
3. ***Allusion*** *-*	 ***Global Warming: Today's Trojan Horse***
4. ***Understatement*** *–*	 ***"It' just a scratch."***
5. ***Rhetoric*** *-*	
6. ***Ethos*** *-*	

7. ***Pathos -***	
8. ***Logos -***	
9. ***Paradox -***	
10. ***Antithesis -***	
11. ***Anecdote -***	
12. ***Colloquial -***	
13. ***Anaphora -***	

14. ***Juxtaposition -***	
15. ***Parallelism (syntax)-***	
16. ***Jargon -***	
17. ***Defend -***	
18. ***Refute -***	
19. ***Antecedent -***	
20. ***Connotation -***	

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Tone Vocabulary

On the AP Language exam, you will need to identify the tone of many passages. This list will help you do that.

21. **Apprehensive-**	
22. **Pensive-**	
23. **Candid-**	
24. **Conciliatory-**	
25. **Contemptuous-**	
26. **Laudatory-**	
27. **Didactic-**	

28. **Sardonic-**	
29. **Elegiac-**	
30. **Callous-**	
31. **Indignant-**	
32. **Haughty-**	
33. **Pedantic-**	
34. **Sanguine-**	
35. **Pious-**	

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THE 30-15-10 LIST

Memorizing these most common prefixes, suffixes, and root words will help you define words by context on the AP Language exam which features difficult texts from the 18th century to now. On the right, for each row, add a new word and explain how its meaning is related to the prefix, suffix, or root.

Prefix	Meaning	Example	Your Example
1. A, ab, abs	away, from	absent, abstract	
2. anti	against, opposite	antisocial, antibody	
3. ad, ac, af, ag, an, ar, at, as	to, toward	adhere, annex, accede, adapt	
4. bi, bis, di	two	bicycle, biped, bisect, divide	
5. circum, peri	around	circumference, perimeter	
6. co, com, con, syn	together, with	combination, connect	
7. de	opposite, from, away	detract, defer, demerit	
8. dis, dif, di	apart, not	disperse, different	
9. epi	upon, on top of	epicenter	
10. equi	equal	equality, equitable	
11. ex, e	out, from, forth	eject, exhale, exit	
12. hyper	over, above	hyperactive, hypersensitive	
13. hypo	under, beneath	hypodermic	
14. im, il, in, un	not	immortal, incorrect, unbelievable	
15. In	in, into,	inject, insert	
16. inter	between, among	intercede	
17. mal, male	bad, ill	malpractice, malevolent	

18. mis	wrong	mistake, misunderstand	
19. mono	alone, single, one	monotone, monopoly	
20. non	not	nonsense	
21. ob	in front of, against	obvious	
22. omni	everywhere, all	omnipresent	
23. pro	forward	proceed, promote	
24. pre, fore	earlier, before	foreshadow, prehistoric	
25. re	again, back	recall, recede	
26. se	apart	secede	
27. sub	under	subway	
28. super	greater, beyond	supernatural, superstition	
29. trans	across, beyond	transfer, transition	
30. un, uni	one	unity, unilateral	
Root	**Meaning**	**Example**	
1. aster, astr	star	astrologist, astronaut	
2. audi	hear	audio, auditorium	
3. bene	good, well	benefit, benediction,	
4. cred	believe	credible	
5. dic, dict	speak	predict, dictionary	
6. graph	write	autograph, graphic	

7. jur, just	law	jury, justice,	
8. log, logue	word, speech, speak	monologue, apology, dialogue	
9. path	feeling	apathy, sympathy	
10. ped	foot, child	pedal, pedometer, pediatrician	
11. phil	like, lover of	Philadelphia, Philosophy,	
12. scrib, script	to write	scribble, transcribe, prescription	
13. ter, terr	earth	terrace, terrain	
14. vac	to empty	vacant, vacuum, vacate	
15. vid, vis	see	video, vision, evidence	
Suffix	**Meaning**	**Example**	
1. -ence, -ance	quality of, state of being	resistance, difference	
2. -or, -er	one who does	director, teacher, doctor	
3. -ment, -list, -ship	state of being, action	sportsmanship, merriment,	
4. -en, -ify, -ize, -ate	to make	justify, darken, exaggerate	
5. -able, -ible	capable of	portable, legible, stable	
6. -al, -tial, -tic	of, characteristics of, pertaining to	logical, personal, partial	
7. -ly, -ful, -ous	like, having	playful, happily,	
8. -tive, -ish	having the quality of…	active, English, pinkish	
9. -sion, -tion	state of being	action, decoration, conclusion	
10. -ness, -hood, -dom	state of	neighborhood, boredom, cleanliness	

Part 2: Preparing for the Exam

SYNTHESIS ASSIGNMENTS

SYNTHESIS QUESTION: DEPRESSION

Suggested reading time: 15 minutes
Suggested writing time: 40 minutes

INTRODUCTION

Use of prescription antidepressant medications is on the rise. Many experts question their efficacy; some worry that the risk of side effects, especially a possible increase in suicide rates, outweighs the benefit.

ASSIGNMENT

Read the following sources and any accompanying information carefully. **Then, in an essay that synthesizes at least three of the sources for support, examine the controversy surrounding various treatment options for depression, and evaluate what factors need to be considered when treating depression.**

Use the sources to support your position; avoid mere paraphrasing or summary. Your argument should be central; the sources should support this argument.

Remember to attribute both direct and indirect citations.

You may refer to the sources as Source A, Source B, and so on or by the descriptions in the parentheses. (Authors, titles, and publication data are included for your convenience.)

Source A (Carey)
Source B (Greenberg)
Source C (Robertson)
Source D (Stong)
Source E (Rosack)
Source F (Dobbs)
Source G (Rosack/CDC)

SOURCE A

Carey, Benedict. "FDA Expands Suicide Warning on Drugs." *New York Times* 3 May 2007. Print.

The following is an excerpt from a New York Times article on the risk of suicide for young people taking antidepressants.

The Food and Drug Administration ordered drug makers yesterday to add warnings to antidepressant medications, saying the drugs increase the risk of suicidal thinking or behavior in some young adults.

The drug labels, which have included similar warnings for adolescents and children since 2005, will now apply to people younger than 25.

The expanded warnings, which will appear in a black box displayed prominently on the prescribing information, are the strongest caution that regulators can impose.

The drug agency also recommended that the labels remind doctors to balance this risk against the "clinical need" for treatment and to mention that the drugs, which include well-known products like Paxil and Zoloft, are associated with no increased suicide risk in patients older than 25 and appear to reduce the risk in those older than 64.

It is highly unusual for warning labels to mention benefits like the lower risk of suicide in older adults, but the mixed message reflects the years-long debate over the risks and benefits of antidepressants, experts said. It also reflects concerns that the debate, and the headlines it has generated, have scared consumers and doctors away from medications that could help, the experts said.

In 2004, when the agency began publicly debating suicide risk for minors taking antidepressants, the rates of children's prescriptions tapered off. In that year, the suicide rate among adolescents rose significantly for the first time in more than 10 years, and some experts say the trends are linked.

The drug agency reached its conclusions after analyzing 295 studies of antidepressants, including 77,000 adults from college students to retirees. The analysis found no increased risk of completed suicides in patients taking the medications.

But 21 suicide attempts were reported among the 3,810 19- to 24-year-olds taking the drugs, working out to a 0.55 percent risk, twice the risk in adults of the same age who took placebo pills, the analysis found.

By age 25, the risk was not significantly different, the agency said. The agency said it did not know why the risk would drop suddenly after age 25. But neuroscientists say there is some evidence that brain development continues into the early 20s.

SOURCE B

Greenberg, Gary. "Manufacturing Depression: A Journey into the Economy of Melancholy." *Harper's* May 2007. Print.

The following is an excerpt from a Harper's magazine article on the treatment of depression.

But there is no lab to send my bodily fluids to in order to assay my level of depression. Instead, there are tests like the Hamilton Depression Rating Scale. The HAM-D was invented in the late 1950s by a British doctor, Max Hamilton. He was trying to find a way to measure the effects of the antidepressants that the drug companies were just bringing to market. To figure out what to test for, he observed his depressed patients and distilled their common characteristics into seventeen items, such as insomnia and guilt. Patients could get as many as four points per item, and a total of eighteen of the fifty-two possible points is now considered the threshold for depression. . . .

[I]n any given clinical trial, especially one for a psychiatric drug, people are very likely to respond to the fact that they are being given a pill—any pill, even one containing nothing but sugar. Which is why the FDA requires all candidate drugs to be tested against placebos—to try to separate the medicine from the magic, to see what the drug does when no one is looking. But, like a pain-in-the-ass brother-in-law, the placebo effect keeps showing up, curing people at a rate alarming to both regulators and industry executives. In fact, in more than half the clinical trials used to approve the six leading antidepressants, the drugs failed to outperform the placebos, and when it came time to decide on Celexa, an FDA bureaucrat wondered on paper whether the results were too weak to be clinically significant, only to be reminded that all the other antidepressants had been approved on equally weak evidence.[1]

[1]The advantage of antidepressants over placebos in those trials was an average of two points on the HAM-D, a result that could be achieved if the patient ate and slept better. The average improvement in antidepressant clinical trials is just over ten points, which means, according to Irving Kirsch, a University of Connecticut psychologist, that nearly 80 percent of the drug effect is actually a placebo effect.

SOURCE C

Robertson, Joel C. *Natural Prozac: Learning to Release Your Body's Own Anti-Depressants*. San Francisco: HarperCollins, 1998. Print.

The following is an excerpt from the introduction to a book on self-treatment of depressive disorders.

Depression . . . is the result of an imbalance in the chemical combination in your brain. This imbalance can become your baseline; in other words, some people's identities can become associated with depression. These people maintain their long-standing depression by sustaining the ways in which they think, eat, behave, and interact with others. Throughout this book, I will be talking about personality types that, taken to the extreme, support depression. You will have to look inside yourself to see whether these descriptions fit you and to determine which elements in your personality and behavior might be keeping you from achieving your optimal level of well-being.

Obviously, many depressed people do not have to look very hard to find the cause of their depression. The loss of a job or spouse or some other traumatic event can trigger a life crisis that may include depression. Such events can and do actually change our brain chemistry. Unless we fully grieve our losses, allowing ourselves to feel the pain until we are able to let it go, we can get stuck in such feelings and have trouble moving on. In such cases, the brain chemistry may establish a new pattern—a new baseline—that actually supports chronic or long-standing depression.

But loss is only one cause of depression. Some people have genetic imbalances that predispose them to depression. Others come from families in which there was abuse or some other behavioral pattern that has promoted the onset of depression later in life. Still others suffer from depression but cannot pinpoint its origins. . . .

For now, you should understand that no matter what the cause of your melancholy or despair, such feelings are rooted in a neurochemical imbalance in your brain. *You have the power to restore harmony and balance to these neurotransmitters and in the process alleviate and overcome your depressed feelings.*

SOURCE D

Stong, Colby. "Antidepressants and Suicide Risk—Has the Relationship Been Overstated?" *Neuropsychiatry Reviews* Mar. 2005. Print.

The following is an excerpt of an article that appeared in a journal of neuropsychiatry.

The overall relationship between antidepressant medication prescription and suicide rate was not significant, according to a study conducted by J. John Mann, MD, and colleagues—the latest entry in the ongoing debate concerning the safety of antidepressants. The researchers found that prescriptions for selective serotonin reuptake inhibitors (SSRIs) and other new-generation non-SSRI antidepressants were associated with lower rates of suicide. However, the investigators did find a positive association between tricyclic antidepressants (TCAs) and suicide rate. . . .

"The aggregate nature of these observational data preclude a direct causal interpretation of the results," the researchers reported. "A high number of TCA prescriptions may be a marker for those counties with more limited access to quality mental health care and inadequate treatment and detection of depression, which in turn lead to increased suicide rates. By contrast, increases in prescriptions for SSRIs and other new-generation non-SSRIs are associated with lower suicide rates both between and within counties over time and may reflect antidepressant efficacy, compliance, a better quality of mental health care, and low toxicity in the event of a suicide attempt by overdose."

Regarding the physician's role in helping a patient with depression, "Treatment is better than no treatment," Dr. Mann said, but clinicians should "monitor response and side effects carefully and adjust dose accordingly." As for the FDA's softened warning, "The data are not there to determine a causal role," he commented. "The safety record [of antidepressants] in adults is very good," he continued. "The studies in kids were too small and lacked a reference compound in all but one study, so no firm conclusions can be drawn beyond the need to monitor carefully." Dr. Mann is a Professor of Psychiatry and Radiology at Columbia University and Chief of the Neuroscience Department at New York Psychiatric Institute, New York City.

SOURCE E

Rosack, Jim. "Suicide Rates Began to Drop with Advent of SSRIs." *Psychiatric News* 1 Apr. 2005. Print.

The following is an excerpt of an article that appeared in a news journal for psychiatrists.

When researchers directly compare rates of antidepressant prescribing with rates of suicide, the results appear to indicate that as more antidepressants are prescribed, suicide rates go down.

A pair of recent studies have independently come to the same conclusion on the relationship between antidepressant prescribing and suicide rates. As prescribing of medications—especially newer antidepressants—increases, suicide rates go down.

Researchers at the UCLA David Geffen School of Medicine and the UCLA Neuropsychiatric Institute completed an extensive review of data and literature and concluded that suicide rates have declined steadily since the introduction of newer reuptake inhibitor antidepressants in 1988. While not proof, they said, the data strongly suggest that a direct relationship exists and that most persons who did commit suicide did so because of untreated mental illness. . . .

"Our findings strongly suggest that . . . individuals who committed suicide [while prescribed an antidepressant] were not reacting to their SSRI medication," Julio Licinio, M.D., a professor of psychiatry and endocrinology at UCLA and the lead author of the UCLA study, said in a written statement. "They actually killed themselves due to untreated depression. . . . The recent debate has focused solely on a possible link between antidepressant use and suicide risk, without examining the question within a broader historical and medical context," Licinio explained. "We feared that the absence of treatment may prove more harmful to depressed individuals than the effects of the drugs themselves."

Licinio said they were surprised by what they found. "Suicide rates rose steadily from 1960 to 1988, when Prozac [fluoxetine], the first SSRI drug, was introduced," he said. "Since then, suicide rates have dropped precipitously, sliding from the eighth to the 11th leading cause of death in the United States."

Intriguingly, while the actual numbers of suicides steadily increased from 1960 until the late 1980s and then leveled off, the suicide rate (per 100,000 population) rose between 1960 and the 1970s. Suicide rates peaked in the early 1970s and then fluctuated until the late 1980s, when they began a steady decline.

Licinio added that the pair reviewed several large European and U.S. reports in which "researchers found blood antidepressant levels in less than 20 percent of suicide cases." This, Licinio said, implies that the vast majority of suicide victims either never received treatment or were not compliant with prescribed treatment at the time of their deaths.

SOURCE F

Dobbs, David. "A Depression Switch?" *New York Times* 2 Apr. 2006. Print.

The following is an excerpt from a Harper's magazine article on the treatment of depression.

Deanna Cole-Benjamin never figured to be a test case for a radical new brain surgery for depression. . . . But in the last months of 2000, apropos of nothing—no life changes, no losses—she slid into a depression of extraordinary depth and duration.

"It began with a feeling of not really feeling as connected to things as usual," she told me one evening at the family's dining-room table. "Then it was like this wall fell around me. I felt sadder and sadder and then just numb."

Her doctor prescribed progressively stronger antidepressants, but they scarcely touched her. A couple of weeks before Christmas, she stopped going to work. The simplest acts—deciding what to wear, making breakfast—required immense will. Then one day, alone in the house after Gary had taken the kids to school and gone to work, she felt so desperate to escape her pain that she drove to her doctor's office and told him she didn't think she could go on anymore. . . .

Her depression would prove resistant to every class of antidepressant, numerous combinations of antidepressants and anti-anxiety drugs, intensive psychotherapy and about a hundred sessions of electroconvulsive therapy. Patients who have failed that many treatments usually don't emerge from their depressions.

Finally, in the spring of 2004, Deanna's psychiatrist . . . received a fax from a University of Toronto research team asking if he had an appropriate candidate for a clinical trial of a new, experimental surgery for treatment-resistant depression. The operation borrowed a procedure called deep brain stimulation, or D.B.S., which is used to treat Parkinson's. It involves planting electrodes in a region near the center of the brain called Area 25 and sending in a steady stream of low voltage from a pacemaker in the chest. . . .

The procedure, Dr. Abraham told Deanna and Gary, had worked safely in thousands of Parkinson's patients. But it would carry some risk of neural complications (it was, after all, brain surgery), it would be uncomfortable and it might not work.

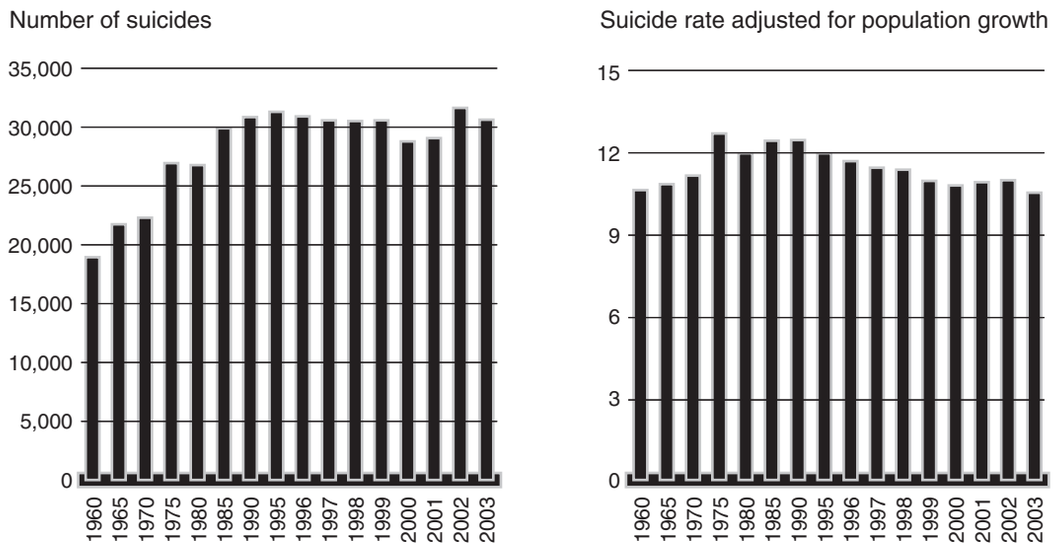
"We were in tears," said Deanna, who is now 41. "We felt we'd tried everything and nothing worked. But we talked about it and decided, 'Well, what have we got to lose?'"

SOURCE G

Rosack, Jim. "Better Drugs, Lower Rates?" *Psychiatric News* 1 Apr. 2005. Print.

These figures use data from the Centers for Disease Control and Prevention to examine the possible effects of antidepressant prescription drugs on the national suicide rate.

Better Drugs, Lower Rates?
As the U.S. population increased, so did the number of people who died by suicide. When adjusted for population growth, however, the data show that suicide rates began to decline in the late 1960s. Researchers theorize that the decline is linked to the availability of SSRIs.



Source: Centers for Disease Control and Prevention, 2004.

Sample Student Synthesis Essay

NAOMI DRUCKER

Antidepressants

Zoloft. Prozac. Celexa. Effexor. Lexapro. Paxil. The list goes on and on. Why must there be so many? What are the differences? Why do doctors, or patients, select one over the other? A lot of the answers lie in advertisements or the extent of side effects. Commercials tell us that "fifteen percent of people will suffer from depression in their lifetime." Society's definition of the word "depression" has changed so much over the past decade. People used to get along fine without antidepressants circling the area, so readily available. Now, everyone who gets upset after a difficult event rushes to the doctor for "immediate" relief. In many cases, the use of these antidepressants isn't warranted and the side effects could cause greater problems than the sadness would have if left untreated.

While depression is technically any chemical imbalance in the brain, the various degrees of depression are what separate one case from the next; one might require prescription treatment while another does not. According to Joel C. Robertson, author of the self-help book entitled *Natural Prozac: Learning to Release Your Body's Own Anti-Depressants*, each person has the power to alleviate and conquer his or her dejection (Source C). Most people know the cause of their depression. If they can come to terms with those circumstances, they could overcome their depression more quickly. However, most people turn to drugs instead of therapy sessions or help from friends and family. Once they start, they are on the drugs for much longer than it would have taken them to overcome the misery themselves. But people don't realize this right away. They are lazy and would rather take a pill once a day instead of participate in a few therapy sessions. People who can afford good therapy and need it choose not to because they think it is a waste of time when they could get the same effect by popping pills. However, they don't realize that they will not get the same effects and that the pills' effects will continue much longer. Today, the ease of just popping a pill is worth the risk of suffering from the side effects of antidepressant medication.

The federal government has begun to recognize the serious side effects of antidepressants and their increasing presence in our society. On May 2, 2007, the Food and Drug Administration ordered drug makers to increase the warnings found on antidepressant medications (Source A). The fact that antidepressants themselves have a side effect of suicidal thinking is hypocritical. If the culmination of depression is suicide, then in some cases, mostly patients under the age of twenty-five, the antidepressants are just rushing that end. From 295 studies of antidepressants' effects on people over the age of twenty-five, researchers could not determine an increased instance of suicide between those taking the drugs and those receiving placebo pills. In the same studies done on nineteen to twenty-four year olds, the risk increased by 0.55 percent (Source A). In still other studies, the drugs treated depression less effectively than the placebos did (Source B). The only explanation for this lies in society's belief that people need drugs to feel better.

Psychiatrists and doctors need to be more circumspect when they distribute antidepressant medication. There are many people whose depression does not warrant prescription medications, and yet society makes this treatment attractive and convenient. People desire "immediate relief" and comfort at all times and don't want any sadness getting in their way. Therefore, they turn to their doctor for relief and just hope for the best, with little self-help effort involved.