Questions 1 through 5 are from the article “A Compassionate Response to a Request to Die” by James L. Griffith, MD; Sahana D’Silva, MD; and David Call, MD (pages 127–132).

1. A patient’s angry demand, “Stop treatment and let me die!” should be regarded initially as:
   A. A request for physician-assisted suicide.
   B. A moral decision based upon the ethical principle of patient autonomy.
   C. A marker of distress.
   D. A suicide threat.

2. In addition to compassion, professional skills most needed for compassionate care of hospitalized medically ill patients include:
   A. Skills for conducting family meetings.
   B. Skills for group therapy.
   C. Diagnostic interview skills for establishing an accurate DSM-IV diagnosis.
   D. Psychopharmacological expertise for treatment-resistant mood and anxiety disorders.

3. A clinician conducting a family meeting must provide structure and leadership because:
   A. Complexity of medical information usually exceeds the intellectual sophistication of family members.
   B. Family pathology commonly contributes to the patient’s distress.
   C. Most families prefer to turn over decision-making to the physician.
   D. Some family members are outspoken and dominate more reserved and submissive family members.

4. Important values and core identity of a hospitalized medically ill patient can be best discerned by:
   A. Asking directly what values matter most.
   B. Collecting collateral information from family members.
   C. Observing how the patient responds to harsh adversities.
   D. Taking a detailed psychodynamic history.

5. An example of an existential question is:
   A. Are you a religious person?
   B. During your most difficult days, what has kept you from giving up?
   C. Can you still feel pleasure when doing something that you ought to enjoy?
   D. Which symptoms have improved most since you began taking your antidepressant?
Questions 6 through 11 are from the article “Psychotherapies for Psychological Distress in the Palliative Care Setting” by Sanaz Kumar, MD; Michael Morse, MD; Peter Zemenides, MD; and Robert Jenkins, PhD (pages 133-137).

6. In dignity therapy, distress is addressed by the creation of a “generativity document,” which aims to promote meaning in one’s life by:
   A. Challenging cognitive biases and irrational negative thoughts.
   B. Exploring and countering defense mechanisms, such as denial.
   C. Creating a permanent record of one’s life, including accomplishments, lessons, and messages the person may wish to communicate to future generations.
   D. Reflecting on significant instances in one’s life over eight weekly sessions.

7. Meaning-centered group therapy focuses on a series of several concepts to facilitate the discovery of meaning and purpose in one’s life in the face of distress and despair. Which of these reflects the concept of historical sources of meaning?
   A. Describing significant memories, relationships, and traditions.
   B. Imagining being remembered by loved ones.
   C. Defining a “meaningful death.”
   D. Establishing a personal ego-ideal.

8. A key goal of short-term life review is to:
   A. Gradually explore unconscious conflicts causing distress.
   B. Help the individual simulate continuity in his/her life and achieve closure.
   C. Dismiss regrets and ignore negative elements of one’s life.
   D. Allow the individual to reflect his/her life’s history.

9. Based on The European Palliative Care Research Collaborative, which of these therapies is the most preferred in working with patients at the end of life?
   A. Psychodynamically informed psychotherapy.
   B. Cognitive-behavioral therapy.
   C. Supportive psychotherapy.
   D. Interpersonal psychotherapy.

10. Cognitive-behavioral therapy has been identified as a popular, if not preferred, psychotherapeutic approach in the palliative care setting. Which of the following characterizes theoretical advantages of CBT?
    A. It is an intuitive, manualized treatment that can be taught quickly and applied to a variety of psychiatric conditions.
    B. It effectively approaches unconscious variables and is reliable in addressing phenomenon such as denial, displacement, and projection.
    C. It is designed to be a time-limited therapy, with an aim at achieving some level of improvement in three to four sessions.
    D. A and C.

11. You are consulted to address suspicion of depression in a patient diagnosed with metastatic hepatocellular carcinoma. The patient’s primary team has yet to disclose to the patient that his prognosis is poor and that only palliative options are available. The team’s delay in addressing the patient’s prognosis can be considered an example of:
    A. Countertransference toward terminally ill patients and avoidance of discussing death in the medical setting.
    B. Appropriate decision to address all psychiatric issues before disclosing potentially distressing information.
    C. Need to initiate antidepressant medication as soon as possible.
    D. Evidence-based lack of therapeutic benefit in disclosing prognostic information in a timely manner.

Questions 12 through 14 are from the article “A 60-Year-Old Male with Hairy-Cell Leukemia and Existential Distress” by Robert C. Meisner, MD; Eindra Khin Khin, MD; and Julia Dorfman, MD, PhD (pages 138-141).

12. The prevalence rate of depression in the elderly with cancer is:
    A. 17% to 25%.
    B. 30% to 40%.
    C. 50%.
    D. 60%.

13. Older adults with cancer have:
    A. No increased risk of suicide.
    B. The same risk of suicide as compared with elderly patients with other medical conditions.
    C. An increased risk of suicide as compared with elderly patients with other medical conditions.
    D. Very low rates of desire for a hastened death.

14. Existential depression in an elderly cancer patient can be best addressed through:
    A. A selective serotonin reuptake inhibitor (SSRI) medication.
    B. Manualized cognitive-behavioral therapy.
    C. Manualized existential therapy.
    D. Tailoring therapeutic approach to the needs of the patient and by paying close attention to the therapeutic relationship.

Questions 15 through 20 are from the article “Psychopharmacological Treatment for Palliative Care Patients” by Lynsey P. Tamborello, MD; Lori H. Kels, MD; Dana L. Footer, MA, PsyDc; and Lisa A. Catapano, MD, PhD (pages 142-146).

15. Depression that is associated with morbidity and mortality is under-recognized and can impair cognition. Antidepressants should be used to relieve depressive symptoms for patients with:
    A. Mild depression.
    B. Moderate depression.
    C. Severe depression.
    D. Grief.
16. Which of the following is a stimulant frequently used for the treatment of fatigue in patients with advanced cancer?
   A. Methylphenidate.
   B. Modafinil.
   C. Mirtazapine.
   D. Sertraline.

17. Benzodiazepines should be limited in their use with the elderly and medically fragile because of the accompanying risk of all of the following except:
   A. Insomnia.
   B. Worsened memory.
   C. Falls.
   D. Delirium.

18. Delirium is often not detected in up to what percentage of cases of patients with end-stage illness?
   A. 30%.
   B. 50%.
   C. 60%.
   D. 45%.

19. Patient-controlled analgesia (PCA) pumps should not be used when treating pain in terminally ill patients due to the cause or exacerbation of the following symptom?
   A. Insomnia.
   B. Depression.
   C. Delirium.
   D. Loss of appetite.

20. When possible, when deciding which pharmacologic treatment to use, practitioners should prioritize selection by first choosing the drug that:
   A. Can be used safely with other drugs.
   B. Can treat multiple symptoms.
   C. Has a longer half-life.
   D. Has a short onset.

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1. The content of the article was accurately described by the learning objectives.  _____  _____
2. This activity will influence how I practice psychiatry.  _____  _____
3. The quiz questions were appropriate for assessing my learning.  _____  _____
4. Please rate the degree to which the content presented in this activity was free from commercial bias.
   No bias  Significant bias
   5  4  3  2  1
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