

## M.J. Powers & Co. Continuing Education

# PSYCHIATRY ALERTS NOS

### Target Audience

This activity is intended for physicians and other healthcare providers who are involved with or have an interest in the management of psychiatric disorders.

### Learning Objectives

- Recognize and implement new diagnostic and treatment approaches for psychiatric disorders.
- Determine appropriate treatment selection for various psychiatric disorders.
- Identify and appropriately prescribe nonpharmacological therapeutic interventions for various psychiatric disorders.
- Determine appropriate patient evaluation and treatment selection for various psychiatric disorders.

### Activity Code 18MP01N / Exam #13

Issues to be included .....January–June 2018

Release date .....August 2018

Exam must be returned by .....December 31, 2019

Upon completing this activity as designed and achieving a passing score of 70% or higher on the post-test examination, participants will receive a letter of credit awarding *AMA PRA Category 1 Credit(s)*<sup>™</sup> and the test answer key four (4) weeks after receipt of the post-test and registration/evaluation form.

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1. Read the learning objectives and review *Psychiatry Alerts NOS*, Volume X, January 2018 through June 2018 (6 issues), and complete the post-test.
2. Complete the enclosed registration/evaluation form and record your test answers in the boxes using either pen or pencil.
3. Mail the form to **M.J. Powers & Co. Publishers, 45 Carey Ave, Ste 111, Butler, NJ 07405; scan and email it to [cme@alertpubs.com](mailto:cme@alertpubs.com); or fax it to 973-898-1201.**

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Kate Casano has no relevant financial relationships.

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PSYCHIATRY ALERTS NOS

**1. Urine screening, which can test simultaneously for illicit substances and levels of ingested medications including antipsychotics, can be useful in monitoring medication adherence and identifying causes of clinical deterioration in patients with serious mental illness. According to expert consensus of clinicians with considerable experience with testing, urine monitoring at initial intake is recommended for patients with:**

- A. New symptoms
- B. Risk factors for poor adherence
- C. Advanced age
- D. All of the above

*1/18, pgs. 1-2*

**2. Repeat testing is recommended if there were concerns about a previous result, the patient deteriorates or has an inadequate response, or if there is a substantial change in the patient's situation.**

- A. True
- B. False

*1/18, pgs. 1-2*

**3. The expert consensus also recommended periodic retesting, either at set intervals or randomly, and stable patients should be tested:**

- A. Monthly
- B. At 6-month intervals
- C. Annually
- D. Only if they deteriorate

*1/18, pgs. 1-2*

\*\*\*\*\*

**4. In a multicenter controlled study of adults with schizophrenia spectrum disorder partially responsive to antipsychotic medication, the addition of cannabidiol (CBD) produced modest improvement in which of the following Positive and Negative Syndrome Scale (PANSS) domains?**

- A. Negative symptom
- B. Positive symptom
- C. General psychopathology
- D. All of the above

*1/18, pg. 2*

**5. In the study, changes in weight, abnormal movements, and \_\_\_\_\_ did not differ between the CBD and placebo groups.**

- A. LDL cholesterol
- B. Prolactin levels
- C. Dizziness
- D. Illicit substance use

*1/18, pg. 2*

\*\*\*\*\*

**6. In a small pilot study of patients with a long history of schizophrenia, \_\_\_\_\_ of 10 patients who received adjunctive low-dose alpha-lipoic acid met response criteria of a  $\geq 25\%$  decrease in Brief Psychiatric Rating Scale (BPRS) score.**

- A. 0
- B. 4
- C. 7
- D. 10

*1/18, pg. 3*

**7. In these patients, which of the following BPRS symptom domains was not significantly improved?**

- A. Positive symptom
- B. Negative symptom
- C. Depressive symptom
- D. None of the above

*1/18, pg. 3*

\*\*\*\*\*

**8. According to the results of a randomized comparison study in patients with bulimia nervosa, patients who underwent face-to-face therapy improved more rapidly than those who underwent internet-based CBT, but by 1 year, binge-purge abstinence rates were similar in the 2 groups.**

- A. True
- B. False

*1/18, pgs. 3-4*

**9. Although efficacy and cost-effectiveness of internet-based CBT and face-to-face therapy were similar in this study, patients' out-of-pocket costs were substantially \_\_\_\_\_ for those receiving face-to-face therapy.**

- A. Lower
- B. Higher

*1/18, pgs. 3-4*

\*\*\*\*\*

**10. In a randomized trial, the web-based deprexis program, which was designed to provide some of the more routine aspects of therapy such as psychoeducation and cognitive-based homework, was an effective adjunct to psychotherapy in patients with depression. The program consists of 10 modules, covering such areas as cognitive restructuring, \_\_\_\_\_, exercise and nutrition, and emotion-focused interventions.**

- A. Reducing apathy
- B. Social withdrawal
- C. Behavioral activation
- D. Suicide risk

*1/18, pgs. 4–5*

**11. In the study, both clinicians and patients were asked to rate the working alliance. The results suggested that blending face-to-face psychotherapy with an adjunctive web-based intervention \_\_\_\_\_ have negative effects on the therapeutic alliance.**

- A. Does
- B. Does not

*1/18, pgs. 4–5*

\*\*\*\*\*

**12. According to a systematic review, ECT could produce clinically significant improvement in severe, resistant \_\_\_\_\_ in patients with dementia.**

- A. Agitation only
- B. Aggression only
- C. Both agitation and aggression
- D. Neither agitation nor aggression

*1/18, pgs. 5–6*

**13. The review found adverse effects of ECT to be generally mild and transient; however, more severe events, which were occasionally reported, included:**

- A. Delirium
- B. Seizure
- C. Postictal confusion
- D. All of the above

*1/18, pgs. 5–6*

\*\*\*\*\*

**14. Social recovery therapy is a manualized treatment to help patients with first-episode psychosis who have continuing severe problems in social functioning. In a randomized trial, social recovery therapy resulted in clinically important gains in time spent in:**

- A. Structured activity
- B. Constructive economic activity
- C. Both types of activity

*2/18, pgs. 7–8*

**15. Social recovery therapy may be particularly useful for those patients not motivated to engage in existing psychosocial interventions targeting functioning, or for those who:**

- A. Have a family history of schizophrenia
- B. Have comorbid difficulties that prevent them from doing so
- C. Are under age 30 years
- D. All of the above

*2/18, pgs. 7–8*

\*\*\*\*\*

**16. Conventional DBS is gaining favor as a treatment for refractory Tourette syndrome. However, the continuous operation of conventional DBS devices contributes to adverse effects and leads to:**

- A. Rapid battery depletion
- B. Frequent battery-replacement surgeries
- C. Both problems

*2/18, pg. 8*

**17. Adaptive deep brain stimulation (aDBS), which uses a closed-loop system that measures and analyzes a control variable reflecting the patient's clinical status and modifies stimulation settings based on the readings, appears to be a promising treatment for patients with refractory:**

- A. Tourette syndrome
- B. Major depression
- C. Schizophrenia
- D. Traumatic brain injury

*2/18, pg. 8*

\*\*\*\*\*

**18. In a randomized, sham-controlled trial, treatment with adjunctive transcranial direct current stimulation (tDCS) resulted in sustained response (HAM-D decrease >50%, lasting to study end) that occurred in \_\_\_\_\_ actively treated patients and in 8 controls (68% vs 30%; p=0.01).**

- A. 10
- B. 13
- C. 19
- D. 21

*2/18, pg. 9*

**19. During the trial, there were \_\_\_\_\_ episodes of emergent mixed features, mania, or hypomania.**

- A. 0
- B. 2
- C. 4
- D. 5

*2/18, pg. 9*

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**20. The integration of e-prescribing into clinical practice was anticipated to drastically reduce errors from:**

- A. Illegible handwriting
- B. Lost prescription slips
- C. Incomplete/inaccurate instructions
- D. All of the above

*2/18, pg. 10*

**21. According to a review, incorporating e-prescribing in psychiatric practice eliminates the potential for medication errors.**

- A. True
- B. False

*2/18, pg. 10*

\*\*\*\*\*

**22. Several lines of evidence suggest a role for \_\_\_\_\_ in substance use disorder.**

- A. Childhood trauma
- B. Stress-related brain systems
- C. PTSD
- D. All of the above

*2/18, pgs. 10–11*

**23. In a preliminary study, treatment with eye movement desensitization and reprocessing (EMDR) improved \_\_\_\_\_ psychiatric symptoms in patients with substance use disorder.**

- A. Post-traumatic
- B. Dissociative
- C. General
- D. All of the above

*2/18, pgs. 10–11*

\*\*\*\*\*

**24. In a large case series of patients with severe, refractory depression without psychotic features, a single treatment with onabotulinumtoxinA (BTX) to glabellar frown lines resulted in a nearly \_\_\_\_\_% decrease in depressive symptoms over 3 weeks post injection.**

- A. 20
- B. 25
- C. 30
- D. 35

*2/18, pgs. 11–12*

**25. Treatment effects of BTX were different for men and women.**

- A. True
- B. False

*2/18, pgs. 11–12*

\*\*\*\*\*

**26. According to a review, preliminary evidence suggests that \_\_\_\_\_ show(s) promise as treatment for substance use disorders.**

- A. rTMS
- B. tDCS
- C. DBS
- D. All of the above

*3/18, pgs. 13–14*

**27. Although efficacy varied across specific substance use disorders, all 3 neuromodulation techniques (i.e., rTMS, tDCS, DBS) had positive effects in \_\_\_\_\_ dependence.**

- A. Alcohol
- B. Nicotine/tobacco
- C. Cocaine
- D. All of the above

*3/18, pgs. 13–14*

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**28. In a small, naturalistic follow-up study of vagus nerve stimulation (VNS) in patients with treatment-resistant depression, response was achieved by \_\_\_\_\_% of the study patients at 72 months.**

- A. 30
- B. 70
- C. 80
- D. 100

*3/18, pg. 14*

**29. During the study period, quality of life also improved significantly with VNS treatment, although the magnitude of improvement was substantially larger on the \_\_\_\_\_ component.**

- A. Mental-health
- B. Physical-health
- C. Social

*3/18, pg. 14*

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**30. In a study in outpatients with a psychotic disorder experiencing paranoid ideation with avoidance of various public places, 3 months of treatment with virtual reality CBT was associated with large reductions in \_\_\_\_\_, compared with the control group.**

- A. Momentary paranoia and anxiety
- B. Time spent with others
- C. Quality of life
- D. All of the above

*3/18, pg. 15*

**31. In this study, use of safety behaviors (e.g., avoiding eye contact) decreased significantly in the virtual reality group at both 3 and 6 months. Treatment was also associated with improved social functioning and reduced:**

- A. Ideas of persecution
- B. Social reference
- C. Self-stigmatization
- D. All of the above

*3/18, pg. 15*

**32. In the study virtual reality CBT had no acute effects on time spent with others.**

- A. True
- B. False

*3/18, pg. 15*

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**33. In a randomized study comparing standard CBT with computer-assisted CBT (CCBT) in patients with major depression, efficacy and safety were similar, but CCBT used \_\_\_\_\_ of the therapist hours as standard CBT.**

- A. One-quarter
- B. One-third
- C. One-half
- D. Two-thirds

*3/18, pgs. 15–16*

**34. Because CCBT delivers a reduced “dose” of therapist time, it may not be appropriate for patients with:**

- A. Comorbidity
- B. More severe depression
- C. More longstanding depression
- D. Any of the above

*3/18, pgs. 15–16*

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**35. According to a post-hoc analysis of a clinical trial of augmentation of ongoing medication with exposure and response prevention (ERP) in patients with OCD, patients with high baseline avoidance are less likely to achieve well-ness than those with lower baseline avoidance scores.**

- A. True
- B. False

*3/18, pgs. 16–17*

**36. In this study, the relationship between high baseline avoidance and poor outcome was mediated by \_\_\_\_\_, which accounted for nearly 50% of the relationship.**

- A. Baseline Y-BOCS scores
- B. Poor socioeconomic status
- C. Poor adherence
- D. All of the above

*3/18, pgs. 16–17*

\*\*\*\*\*

**37. In a study measuring inflammatory markers in patients with treatment-resistant major depression who were scheduled to undergo ECT, levels of the inflammatory marker IL-6 were predictive of response to ECT, particularly in:**

- A. Women
- B. Men
- C. Patients aged 29 years or older
- D. Patients with the highest baseline MADRS scores

*3/18, pgs. 17–18*

\*\*\*\*\*

**38. In a cohort of Danish patients with a first diagnosis of unipolar major depression, the overall cumulative incidence of conversion to bipolar disorder was 8%. In these patients, the strongest predictor of conversion was:**

- A. Age at onset
- B. Gender
- C. Parental history of bipolar disorder
- D. Current alcohol abuse

*4/18, pgs. 19–20*

**39. Conversion risk in the cohort was greatest during the first \_\_\_\_\_ after the diagnosis of unipolar depression.**

- A. 2 weeks
- B. Month
- C. 6 months
- D. Year

*4/18, pgs. 19–20*

**40. Other significant predictors of conversion included presence of severe, recurrent, or psychotic depression, comorbid alcohol abuse, and the need for inpatient treatment. In contrast to previous evidence, age at diagnosis \_\_\_\_\_ associated with conversion in this sample.**

- A. Was
- B. Was not

*4/18, pgs. 19–20*

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**41. A large number of apps targeting mental health now exist, but there are no available tools that provide a reliable method of evaluating their safety or usefulness.**

- A. True
- B. False

*4/18, pgs. 20–21*

**42. An APA rubric designed to guide evaluation of these apps suggests that after gathering background information on a specific app, the clinician should assess:**

- A. Privacy and digital safety/risk
- B. Effectiveness
- C. Ease of use and interoperability
- D. All of the above

*4/18, pgs. 20–21*

**43. While the rubric does not rely on existing user ratings, these may be helpful in determining the effectiveness of an app that does not have documented clinical trial efficacy.**

- A. True
- B. False

*4/18, pgs. 20–21*

\*\*\*\*\*

**44. A longitudinal neuroimaging study in patients with major depression found a specific pattern of changes in brain structures involved in \_\_\_\_\_ in patients who experienced a relapse.**

- A. Autonomic function
- B. Emotion regulation
- C. Processing speed
- D. All of the above

*4/18, pgs. 21–22*

**45. In the study, longitudinal whole-brain analysis identified \_\_\_\_\_ in gray matter volume over time in patients who experienced a relapse.**

- A. A significant decrease
- B. A small increase
- C. No change

*4/18, pgs. 21–22*

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**46. In patients hospitalized with schizophrenia, a retrospective study found aggression to be associated with levels of creatine kinase (CK) \_\_\_\_\_ the normal range.**

- A. Within
- B. Above
- C. Below

*4/18, pg. 22*

**47. The exact relationship between aggression and CK is unclear, and in psychiatric patients \_\_\_\_\_ could also contribute to elevated levels of the enzyme.**

- A. Intramuscular injections
- B. Restraint/seclusion
- C. Neuroleptic malignant syndrome
- D. All of the above

*4/18, pg. 22*

\*\*\*\*\*

**48. Research suggests that transcranial direct current stimulation (tDCS) alone has \_\_\_\_\_ effect(s) on resistant depression.**

- A. Positive but not clinically relevant
- B. Small negative
- C. Little or no

*4/18, pg. 23*

**49. However, in a pilot study of patients with medication-resistant depression, augmenting tDCS with \_\_\_\_\_ produced significant improvement in depressive symptoms.**

- A. Interpersonal psychotherapy
- B. Antipsychotic medication
- C. Acupuncture
- D. Cognitive Emotional Training (CET)

*4/18, pg. 23*

**50. Contrary to the investigators' expectations, CET during tDCS \_\_\_\_\_ enhance patients' cognitive performance.**

- A. Did
- B. Did not

*4/18, pg. 23*

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**51. Results of a gene mapping study in schizophrenia indicate an overlap exists between the pathological mechanisms of the disorder and the pharmacological mechanisms of antipsychotics. Information regarding this overlap could be used to advance the development of more efficient multitarget drugs directed at poorly treated aspects of schizophrenia.**

- A. True
- B. False

*4/18, pgs. 23–24*

\*\*\*\*\*

**52. According to a post-hoc analysis of pooled data from 2 controlled trials, bilateral rTMS reduces suicidal ideation in patients with treatment-resistant depression; however, the reduction in suicidal ideation is completely dependent upon improvement in depression.**

- A. True
- B. False

*5/18, pgs. 25–26*

**53. In the pooled sample, suicidal ideation resolved in \_\_\_\_\_% of patients who received bilateral rTMS, compared with 27% of those who received unilateral treatment and 19% of those who received sham treatment.**

- A. 92
- B. 77
- C. 61
- D. 40

*5/18, pgs. 25–26*

**54. ECT has been shown to reduce suicidal ideation in patients with mood disorders. Patients may prefer rTMS over ECT because it is less invasive in nature, and:**

- A. Carries less stigma
- B. Does not cause cognitive adverse effects
- C. Does not require anesthesia
- D. All of the above

*5/18, pgs. 25–26*

\*\*\*\*\*

**55. A meta-analysis of 9 studies suggests that deep brain stimulation may be effective in the treatment of refractory depression, but evidence is insufficient to recommend its clinical use.**

- A. True
- B. False

*5/18, pgs. 26–27*

**56. In the studies, serious adverse effects including worsening depression or anxiety, infection, and \_\_\_\_\_ were common, with a total of 131 events occurring in 84 patients.**

- A. Suicidal ideation
- B. QTc prolongation
- C. Long-term memory loss
- D. All of the above

*5/18, pgs. 26–27*

**57. The study authors recommend using other less-invasive brain stimulation procedures, such as \_\_\_\_\_, which is/are associated with fewer adverse effects.**

- A. Vagus nerve stimulation
- B. Magnetic seizure therapy
- C. Repetitive transcranial magnetic stimulation
- D. All of the above

*5/18, pgs. 26–27*

\*\*\*\*\*

**58. Several small studies and case reports have raised concern about the potential for an increased risk of dementia following ECT. A large, registry-based study found the incidence of dementia in patients with affective disorders was 2–3 times higher than the general population; undergoing ECT \_\_\_\_\_ appear to confer additional risk.**

- A. Did
- B. Did not

*5/18, pgs. 27–28*

**59. In the study, rates of dementia onset ranged from 0.1% in patients aged <50 years to 12.5% in those aged 70 years or older. However, in patients in the oldest age group, risk of dementia was significantly \_\_\_\_\_ in those who had undergone more than 10 ECT treatments.**

- A. Reduced
- B. Increased

*5/18, pgs. 27–28*

**60. In a subsample of military draftees, ECT was associated with dementia risk but only in patients with the lowest:**

- A. Duration of military service
- B. Baseline depressive symptom scores
- C. Premorbid cognitive ability
- D. Levels of symptom improvement

5/18, pgs. 27–28

\*\*\*\*\*

**61. In a randomized trial of preventive cognitive therapy (PCT) in patients with major depression who had achieved remission, those who received \_\_\_\_\_ had the best outcomes in terms of sustained remission over 2 years.**

- A. PCT with antidepressant taper
- B. Antidepressant pharmacotherapy alone
- C. Combined PCT and continued antidepressant therapy

5/18, pgs. 28–29

**62. PCT is a manualized program consisting of 8 weekly sessions, aimed at:**

- A. Identifying dysfunctional attitudes
- B. Enhancing memories of positive experiences
- C. Formulating preventive strategies
- D. All of the above

5/18, pgs. 28–29

\*\*\*\*\*

**63. A meta-analysis found significant associations between presence of autoimmune thyroid disease and depression and anxiety, suggesting that laboratory testing for thyroid disease may be useful in patients presenting with depression or anxiety, as those with autoimmune thyroiditis require an adapted treatment approach. In these patients, \_\_\_\_\_ can improve mood symptoms.**

- A. Levothyroxine
- B. Selenium supplementation
- C. Both levothyroxine and selenium
- D. None of the above

5/18, pg. 29

**64. Because thyroid function affects the serotonin system, SSRIs may be an appropriate option when antidepressants are required. However, \_\_\_\_\_ may not be suitable for patients with autoimmune thyroiditis who are already likely to gain weight.**

- A. SNRIs
- B. MAOIs
- C. TCAs
- D. All of the above

5/18, pg. 29

\*\*\*\*\*

**65. In a randomized trial in patients with treatment-resistant depression, \_\_\_\_\_-based anesthesia, used in conjunction with remifentanyl and succinylcholine, reduced the number of ECT sessions needed to achieve response (i.e.,  $\geq 50\%$  reduction in Montgomery-Asberg Depression Rating Scale score).**

- A. Propofol
- B. Ketamine

6/18, pgs. 31–32

**66. In the study, all patients in the ketamine group and most in the propofol group achieved treatment response. However, response was achieved after a median of \_\_\_\_\_ ECT sessions with ketamine, compared with 4 sessions with propofol.**

- A. 2
- B. 3
- C. 6
- D. 8

6/18, pgs. 31–32

**67. There were no significant differences between the anesthetics in adverse effects or time to discharge readiness. Ketamine did not produce dissociation and only rare:**

- A. Headache
- B. Hypotension
- C. Memory impairment
- D. All of the above

6/18, pgs. 31–32

\*\*\*\*\*

**68. Results of a pilot study suggest that adding behavioral activation therapy (BAT), modified to be delivered by technicians during transcranial magnetic stimulation (TMS) sessions, is neither feasible nor effective in patients with resistant depression.**

- A. True
- B. False

6/18, pgs. 32–33

**69. The TMS technicians who delivered the BAT reported that it did not impair the flow of TMS delivery and that it enhanced \_\_\_\_\_ of daily clinical assessments.**

- A. Efficiency
- B. Quality
- C. Both quality and efficiency
- D. None of the above

6/18, pgs. 32–33

\*\*\*\*\*

**70. Components of the mobile phone-based health (mHealth) intervention FOCUS for patients with serious mental illness include:**

- A. A smartphone app
- B. A clinician dashboard
- C. An mHealth support specialist
- D. All of the above

*6/18, pg. 33*

**71. In a randomized trial comparing FOCUS with the clinic-based Wellness Recovery Action Plan in patients with schizophrenia, schizoaffective disorder, bipolar disorder, or major depression, \_\_\_\_\_ was significantly better in the FOCUS group.**

- A. Improvement in depression
- B. Duration of response
- C. Patient engagement
- D. All of the above

*6/18, pg. 33*

\*\*\*\*\*

**72. According to a position paper from the American Academy of Sleep Medicine, the only treatment with sufficient evidence to be recommended for treatment of nightmare disorders is:**

- A. Hypnosis
- B. Image rehearsal therapy
- C. Prazosin
- D. All of the above

*6/18, pgs. 34–35*

**73. Image rehearsal therapy is a modified CBT technique that involves altering the content of a nightmare by creating a new set of positive images and rehearsing the rewritten dream scenario daily while awake.**

- A. True
- B. False

*6/18, pgs. 34–35*

\*\*\*\*\*

**74. According to a large population-based study, disrupted circadian rhythmicity is associated with:**

- A. Depression and bipolar disorder
- B. Subjective well-being and personality
- C. Cognitive performance
- D. All of the above

*6/18, pgs. 35–36*

**75. Using a wrist accelerometer, circadian amplitudes were measured in >100,000 study participants. Lower relative amplitude of activity—i.e., the difference between the most active continuous 10-hour period and the least active 5-hour period in an average 24-hour day—was found to be associated with higher patient-ratings for loneliness and neuroticism, as well as slower reaction time on a neurocognitive test.**

- A. True
- B. False

*6/18, pgs. 35–36*

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# M.J. Powers & Co. Continuing Education

## Psychiatry Alerts NOS - Activity Evaluation Form

**Please note:** Credit letters will be issued upon receipt of this completed evaluation form. The planning and execution of useful and educationally sound continuing education activities are guided in large part by input from participants. To assist us in evaluating the effectiveness of this activity, please complete this evaluation form. Your response will help ensure that future programs are informative and meet the educational needs of all participants. Thank you for your cooperation!

### Program Objectives:

Having completed this activity, you are better able to:

	Strongly Agree		Strongly Disagree
Recognize and implement new diagnostic and treatment approaches for psychiatric disorders.	5	4 3 2 1	
Determine appropriate treatment selection for various psychiatric disorders.	5	4 3 2 1	
Identify and appropriately prescribe nonpharmacological therapeutic interventions for various psychiatric disorders.	5	4 3 2 1	
Determine appropriate patient evaluation and treatment selection for various psychiatric disorders.	5	4 3 2 1	

### Overall Evaluation:

	Strongly Agree		Strongly Disagree
The information presented increased my awareness/understanding of the subject.	5	4 3 2 1	
The information presented will influence how I practice.	5	4 3 2 1	
The information presented will help me improve patient care.	5	4 3 2 1	
The information demonstrated current knowledge of the subject.	5	4 3 2 1	
The program was educationally sound and scientifically balanced.	5	4 3 2 1	
The program avoided commercial bias or influence.	5	4 3 2 1	
Overall, the program met my expectations.	5	4 3 2 1	

Based on information presented in the program, I will

(please check one):

- |   |   |
|---|---|
| <input type="checkbox"/> Do nothing as the content was not convincing.                                | <input type="checkbox"/> Change my practice.  |
| <input type="checkbox"/> Seek additional information on this topic.                                   | <input type="checkbox"/> Do nothing as current practice reflects program's recommendations. |
| <input type="checkbox"/> Do nothing. Barriers at my institution prevent me from changing my practice. |   |

If you anticipate changing one or more aspects of your practice as a result of your participation in this activity, please provide us with a brief description of how you plan to do so: \_\_\_\_\_

Please provide any additional comments pertaining to this activity and suggestions for improvement: \_\_\_\_\_

Please list any topics that you would like to be addressed in future educational activities: \_\_\_\_\_

# ANSWER SHEET

## PSYCHIATRY ALERTS NOS

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\_\_\_\_\_  
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	A	B	C	D		A	B	C	D		A	B	C	D
1	A	B	C	D	26	A	B	C	D	51	A	B	C	D
2	A	B	C	D	27	A	B	C	D	52	A	B	C	D
3	A	B	C	D	28	A	B	C	D	53	A	B	C	D
4	A	B	C	D	29	A	B	C	D	54	A	B	C	D
5	A	B	C	D	30	A	B	C	D	55	A	B	C	D
6	A	B	C	D	31	A	B	C	D	56	A	B	C	D
7	A	B	C	D	32	A	B	C	D	57	A	B	C	D
8	A	B	C	D	33	A	B	C	D	58	A	B	C	D
9	A	B	C	D	34	A	B	C	D	59	A	B	C	D
10	A	B	C	D	35	A	B	C	D	60	A	B	C	D
11	A	B	C	D	36	A	B	C	D	61	A	B	C	D
12	A	B	C	D	37	A	B	C	D	62	A	B	C	D
13	A	B	C	D	38	A	B	C	D	63	A	B	C	D
14	A	B	C	D	39	A	B	C	D	64	A	B	C	D
15	A	B	C	D	40	A	B	C	D	65	A	B	C	D
16	A	B	C	D	41	A	B	C	D	66	A	B	C	D
17	A	B	C	D	42	A	B	C	D	67	A	B	C	D
18	A	B	C	D	43	A	B	C	D	68	A	B	C	D
19	A	B	C	D	44	A	B	C	D	69	A	B	C	D
20	A	B	C	D	45	A	B	C	D	70	A	B	C	D
21	A	B	C	D	46	A	B	C	D	71	A	B	C	D
22	A	B	C	D	47	A	B	C	D	72	A	B	C	D
23	A	B	C	D	48	A	B	C	D	73	A	B	C	D
24	A	B	C	D	49	A	B	C	D	74	A	B	C	D
25	A	B	C	D	50	A	B	C	D	75	A	B	C	D

I attest that I have completed the Psychiatry Alerts NOS activity as designed.

**Physicians:** I claim \_\_\_\_ *AMA PRA Category 1 Credit(s)*<sup>TM</sup> for participating in this activity (1 credit for each hour of participation, not to exceed 12 credits).

**Non-Physicians:** I claim (up to 1.2) \_\_\_\_ Continuing Education Units (CEUs). One CEU is awarded for 10 contact hours of instruction.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Exam must be returned by December 31, 2019

CME Activity Code: 18MP01N Test 13