Mindful Continuing Education

Cognitive Behavioral Therapy for Patients with Cancer

1. According to the course content, how does the prevalence of anxiety and depression among people diagnosed with cancer compare with the general U.S. adult population?

A. Anxiety is more common in cancer than in the general population, but depression occurs less often because medical teams closely monitor mood.
B. Rates of anxiety and depression in people with cancer are similar to the general adult population, with about 3% having anxiety and 8% having depression.
C. People with cancer have slightly lower rates of anxiety and depression than the general population because their distress is usually explained by physical illness.
D. About 30% of people with cancer have anxiety symptoms and about 25% have depression, which is markedly higher than the roughly 3% prevalence of generalized anxiety disorder and 8% prevalence of major depressive disorder in the general adult population.

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2. Which description best reflects the National Cancer Institute's definition of psychosocial distress in the context of cancer?

A. A purely psychological reaction to cancer that excludes physical and spiritual dimensions and is defined by the presence of a DSM-5 depressive or anxiety disorder.
B. Any emotional reaction to a cancer diagnosis that resolves within a few weeks and does not interfere with social or occupational functioning.
C. A multifactorial unpleasant experience of psychological, social, spiritual, and/or physical nature that can interfere with coping, existing on a continuum from common feelings of vulnerability and sadness to disabling problems such as depression, anxiety, panic, social isolation, and existential or spiritual crisis.
D. A set of interpersonal conflicts and financial stressors unrelated to the person's emotional or cognitive response to cancer.

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3. A patient with newly diagnosed breast cancer reports persistent panic attacks, difficulty sleeping, social withdrawal, and feeling overwhelmed to the point that she has stopped attending appointments. Which statement best characterizes her presentation using the course's framework?

A. She is likely experiencing psychosocial distress at the more severe end of the continuum, with symptoms that are interfering with her ability to cope and function.
B. Her symptoms represent a normal, expected adjustment reaction that should not be considered clinically significant as long as she eventually attends treatment.
C. Her distress is purely physical because cancer and its treatments commonly cause sleep disturbance and fatigue, so a psychosocial assessment is unnecessary.
D. She is exhibiting spiritual distress only, as panic attacks and withdrawal are usually signs of existential concerns rather than psychological problems.

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4. Why does the course emphasize that social workers and other mental health professionals learn CBT skills specifically for patients with cancer?

A. Because CBT directly targets the thoughts and behaviors that contribute to cancer-related psychosocial distress, enabling personalized, effective treatment for common conditions such as adjustment disorder, anxiety disorders, depressive disorders, and PTSD across the medical continuum.
B. Because CBT replaces the need for psychiatric medications in most cancer patients, eliminating concerns about drug interactions with chemotherapy and other treatments.
C. Because CBT focuses primarily on family systems, allowing clinicians to address cancer-related conflict without needing to assess individual cognitive patterns.
D. Because CBT is designed to manage physical symptoms such as pain and fatigue and avoids confronting emotional responses to cancer, which can be destabilizing.

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5. Which clinical description best differentiates an adjustment disorder from generalized anxiety disorder (GAD) in a patient with cancer?

A. Adjustment disorder is reserved for patients with panic attacks and phobic avoidance, while GAD is applied when the primary symptoms are depression and anhedonia.
B. Adjustment disorder is diagnosed when anxiety symptoms last more than 6 months without a clear stressor, whereas GAD requires a documented cancer diagnosis within the previous 3 months.
C. Adjustment disorder involves emotional or behavioral symptoms that develop within 3 months of an identifiable cancer-related stressor, are out of proportion to that stressor, and usually resolve within 6 months after the stressor ends, whereas GAD features excessive worry for at least 6 months that is not typically tied to a single precipitating event.
D. Adjustment disorder requires a prior history of anxiety, while GAD is diagnosed only when anxiety symptoms first emerge after a cancer diagnosis.

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6. Which combination of factors best matches the general risk profile for developing an adjustment disorder in the context of cancer?

A. High educational attainment, stable finances, and long-term participation in psychotherapy before the cancer diagnosis.
B. High self-efficacy, strong problem-solving abilities, robust social support, and no history of mental health problems.
C. Older age, male gender, and a long history of successful adaptation to previous medical crises without psychological symptoms.
D. Limited coping skills, insecure attachment patterns, lack of social support, low self-efficacy, and a prior psychiatric condition.

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7. A patient with metastatic lung cancer develops sudden episodes of intense fear, tachycardia, and dyspnea that begin shortly after starting high-dose steroids for brain metastases. There is a clear temporal association between steroid initiation and symptom onset, and symptoms lessen when the

dose is reduced. Based on the course content, which diagnosis is most consistent with this presentation?

A. Panic disorder as a primary anxiety disorder.
B. Anxiety disorder due to another medical condition.
C. Adjustment disorder with anxiety in response to learning about metastases.
D. Generalized anxiety disorder precipitated by the stress of treatment.

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8. According to American Society of Clinical Oncology (ASCO) guidelines summarized in the course, when should adults with cancer be screened for anxiety?

A. Once at diagnosis and again only if the patient or family specifically requests mental health support.
B. At diagnosis or start of treatment; at regular intervals during treatment; at 3, 6, and 12 months post-treatment; at recurrence or progression; at end of life; and during personal transitions or reappraisals.
C. At the completion of active treatment and annually thereafter, because screening during treatment may increase distress.
D. Only when patients present to an emergency department or inpatient unit with severe behavioral symptoms.

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9. A patient two weeks after a cancer surgery reports feeling sad about losses, crying several times a week, but continues to attend treatment, enjoys visits from friends, and can describe meaningful future plans. Which interpretation best fits the course's distinction between normal sadness and depressive disorders in cancer?

A. The patient must have an adjustment disorder with depressed mood because sadness always meets criteria for a DSM-5 disorder in the context of cancer.
B. The patient meets criteria for major depressive disorder because any crying after a cancer diagnosis indicates a depressive episode.
C. The patient should be diagnosed with persistent depressive disorder because sadness has lasted at least two weeks after surgery.
D. This presentation is consistent with normal sadness or grief on the spectrum of depressive symptoms rather than a depressive disorder, because symptoms are time-limited and functioning remains largely intact.

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10. A survivor scores 3 on the PHQ-2 and then 17 on the PHQ-9. According to the ASCO-aligned guidance in the course, what is the most appropriate next mental health step?

A. Delay any psychological intervention until the patient's oncologist has ruled out all possible metabolic abnormalities, because these scores cannot inform treatment decisions.
B. Reassure the patient that these scores indicate mild, expected distress after cancer and repeat screening in one year without further assessment.
C. Refer the patient only to a peer-led support group, as group interventions are preferred over individual therapy regardless of severity.

D. Recognize this as moderate-to-severe depressive symptomatology, perform a comprehensive psychosocial and diagnostic assessment, and consider initiating individual CBT, with or without antidepressant medication.

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11. Which scenario best reflects a high-risk profile for developing a depressive disorder in a person with cancer, based on the course content?

A. A middle-aged survivor with high education, stable employment, and no prior psychiatric history who reports satisfaction with current social support.
B. An older adult with localized skin cancer, strong family support, no history of mental health conditions, and minimal physical symptoms.
C. A young adult with recurrent pancreatic cancer, a history of a mood disorder, limited social support, significant pain and fatigue, and low socioeconomic status.
D. A patient with early-stage thyroid cancer, robust social networks, and no functional impairment from treatment.

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12. According to ASCO recommendations cited in the course, how should CBT be used for adults with cancer and depressive symptoms of differing severity?

A. CBT is indicated only after at least one trial of antidepressant medication has failed to improve symptoms.
B. Group CBT is preferred for all levels of depressive severity because it enhances social support, and individual CBT is reserved for patients who refuse groups.
C. CBT should be restricted to patients with mild depressive symptoms, while pharmacotherapy alone is recommended for moderate or severe depression.
D. Individual or group CBT is recommended for patients with moderate depressive symptoms, whereas individual CBT is recommended for patients with moderate-to-severe or severe symptoms.

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13. Which cancer-related scenario is most likely to meet DSM-5 Criterion A for PTSD, as described in the course?

A. A patient who feels persistently worried about cancer recurrence despite normal follow-up scans but has not faced any sudden, catastrophic medical events.
B. A patient who experiences an acute, life-threatening chemotherapy reaction requiring emergency intubation and intensive care, followed by intrusive memories and avoidance of treatment settings.
C. A patient who develops fatigue and sleep disturbance during radiation therapy and worries about long-term side effects.
D. A patient who has intermittent thoughts about mortality when scheduling routine oncology visits but no specific trauma-related intrusions.

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14. According to the course, which combination of factors best represents a heightened risk for PTSD in people with cancer?

A. Stable finances, robust social network, and use of active problem-solving coping strategies during treatment.
B. Older age, strong family support, absence of prior mental health problems, and early-stage disease successfully treated with surgery alone.
C. High health literacy, consistent engagement with psychotherapy before cancer, and no exposure to prior traumatic events.
D. History of adverse childhood experiences, limited social support, high general psychological distress, recurrent disease or bone marrow transplant, and avoidance-based coping.

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15. Why does the course describe diagnosing PTSD in the oncology setting as particularly challenging?

A. Because PTSD cannot be diagnosed when a medical illness is present, so clinicians must wait until the patient is disease-free to assess symptoms.
B. Because validated PTSD screening tools do not exist for use with any medical populations, so clinicians must rely solely on unstructured interviews.
C. Because cancer is not a single acute event but an experience marked by repeated trauma of indeterminate length, making it difficult to determine the optimal timing for assessment and to distinguish full PTSD from post-traumatic stress symptoms.
D. Because cancer-related distress is always classified as an adjustment disorder rather than PTSD, which makes the differential diagnosis straightforward.

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16. Which set of components reflects the CBT approach to treating PTSD in patients with cancer, as outlined in the course?

A. Psychoeducation about distress and PTSD after diagnosis, relaxation training, imaginal and in vivo exposure, cognitive restructuring, activity scheduling, enhancing social support, and generalizing skills.
B. Supportive listening without exploring trauma, exclusive use of pharmacologic sedation, and avoidance of any discussion of traumatic cancer experiences.
C. Insight-oriented exploration of childhood relationships without linking current symptoms to trauma-related cognitions or behaviors.
D. Hypnosis to eliminate traumatic memories, combined with strict behavioral contracts that prohibit the patient from discussing cancer-related thoughts.

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17. Which description best summarizes core principles of CBT emphasized in the course?

A. A primarily medication-based intervention in which therapist and patient meet briefly and infrequently, without a focus on skill-building or goal setting.
B. An open-ended, past-focused approach that prioritizes uncovering unconscious conflicts over changing current patterns of thinking and behavior.
C. An actively collaborative, time-limited, structured, problem-focused, and goal-oriented therapy that emphasizes how current thoughts and behaviors contribute to ongoing difficulties and can be changed.
D. A non-directive modality where the therapist minimizes structure and avoids setting goals to allow symptoms to resolve naturally over time.

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18. A patient with cancer-related major depression is isolating, has stopped participating in previously valued activities, and describes feeling unable to initiate any changes. Which CBT behavioral strategy from the course is most central to addressing this pattern?

A. Exclusive mindfulness meditation without any planning of specific activities or changes in daily behavior.
B. Behavior activation that identifies valued life domains, selects life-giving activities, rates their difficulty, orders and schedules them, and supports gradual completion from easier to harder tasks.
C. Free association to explore early memories, without linking these memories to current activity patterns or goals.
D. Encouraging the patient to wait for spontaneous improvements in mood before attempting any new activities.

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19. A patient experiences intense fear and physiological arousal before each chemotherapy infusion and has begun postponing treatments. Which CBT-based intervention described in the course is especially suited to reducing this type of procedural anxiety?

A. Systematic desensitization that teaches deep muscle relaxation, develops a fear hierarchy for treatment-related cues, and uses imaginal and/or in vivo exposure starting with the least anxiety-provoking items.
B. Unstructured reassurance without exposure, encouraging the patient to ignore fears and proceed directly to the most anxiety-provoking situations.
C. Short-term psychodynamic therapy focused on transference, with no direct practice of relaxation or exposure to feared stimuli.
D. Medication-only management of anxiety symptoms without addressing learned fear responses to treatment settings.

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20. A cancer survivor has persistent health anxiety and catastrophic thoughts about recurrence despite normal scans. Based on the course, which CBT focus would most directly target her symptoms?

A. Relying entirely on repeated medical reassurance from oncologists without exploring how she interprets bodily sensations and test results.
B. Limiting access to medical information and instructing her to avoid thinking about cancer to prevent triggering anxiety.
C. Identifying automatic thoughts and cognitive distortions about recurrence, evaluating evidence for and against these thoughts, generating more realistic alternatives, and pairing this with relaxation or mindfulness strategies.
D. Encouraging her to repeatedly check her body for signs of cancer so that she can quickly seek reassurance when worried.
