

# **STIMULUS HANDOUT FOR CAP QUESTIONS**

**2020  
MOCK MCQ  
EXAM**

## **CAP Question 1 (18 marks)**

### **When unbearable suffering incites psychiatric patients to request euthanasia: qualitative study.**

Monica Verhofstadt, Lieve Thienpont and Gjalte-Jorn Ygram Peters (2017) *British Journal of Psychiatry* 211: 238-245.

*(Abstract excerpt)*

#### **Background**

The concept of 'unbearable suffering' is central to legislation governing whether euthanasia requests may be granted, but remains insufficiently understood, especially in relation to psychiatric patients.

#### **Method**

Testimonials from 26 psychiatric patients who requested euthanasia were analysed using QualiCoder software.

#### **Results**

Five domains of suffering were identified: medical, intrapersonal, interpersonal, societal and existential. Hopelessness was confirmed to be an important contributor. The lengthy process of applying for euthanasia was a cause of suffering and added to experienced hopelessness, whereas encountering physicians who took requests seriously could offer new perspectives on treatment.

#### **Conclusions**

The development of measurement instruments to assess the nature and extent of suffering as experienced by psychiatric patients could help both patients and physicians to better navigate the complicated and sensitive process of evaluating requests in a humane and competent way. Some correlates of suffering (such as low income) indicate the need for a broad medical, societal and political debate on how to reduce the burden of financial and socioeconomic difficulties and inequalities in order to reduce patients' desire for euthanasia. Euthanasia should never be seen (or used) as a means of resolving societal failures.

*(Methods excerpt)*

All patients were seen by L.T. at an outpatient psychiatric clinical setting in the Dutch-speaking region of Belgium, with intake beginning at the end of 2007 and ending in December 2011 (when L.T. joined a newly founded central institute in Belgium to manage end-of-life cases, therefore ceasing case management at her private practice).

... Between October 2007 and December 2011, 100 psychiatric patients presented themselves with a request for euthanasia at an out-patient psychiatric clinical setting in East Flanders. During or after their consultation, 26 of these patients spontaneously handed in a self-written or self-recorded testimonial to L.T. in which they expressed the reasons for their request and their experience of unbearable suffering.

*(Methods excerpt)*

L.T. and M.V. simultaneously coded one brief proof testimonial from a different medical record, received at a later date, in order to compare coding principles and to discuss and resolve any discrepancies. The 26 testimonials were then independently coded by L.T. and M.V.

... when the coding was completed, G-JYP (who has no research history in the area of euthanasia) was given access to the data in QualiCoder and inspected both the coding structure and coded fragments.

*(Findings excerpt)*

Five broad categories of codes emerged, each representing a dimension of unbearable suffering:

- Medically related suffering
- Intrapersonal suffering
- Suffering related to interpersonal interaction
- Suffering related to one's place and interaction in society
- Existential suffering

Quote from a subject:

*"The pain has become so overpowering. This is very confusing and depressing, not at least for XX [husband], who no longer knows how to react to it. While this endures, I'm dragging him into a depression. He gets totally exhausted."*

*(Findings excerpt)*

Five broad categories of codes emerged, each representing a dimension of unbearable suffering:

- Medically related suffering
- Intrapersonal suffering
- Suffering related to interpersonal interaction
- Suffering related to one's place and interaction in society
- Existential suffering

Quote from a subject:

*"I'm scared to wake up, scared to get myself through the day, and scared to go to sleep."*

*(Procedures excerpt)*

The current paper describes the qualitative analysis of a rich data-set of self-written or self-recorded 'testimonials' ... from 26 psychiatric patients who have made a request for euthanasia.

LT and MV simultaneously coded one brief proof testimonial from a different medical record, received at a later date, in order to compare coding principles and to discuss and resolve any discrepancies. The 26 testimonials were then independently coded by LT and MV

... when the coding was completed, G-JYP (who has no research history in the area of euthanasia) was given access to the data in QualiCoder and inspected both the coding structure and coded fragments ...

... codes were sorted into more abstract subcategories and then generally classified into overarching main categories.

*(Conclusions excerpt)*

... as the testimonials were written spontaneously they are profoundly and solely dependent on the written communication skills of each patient.

## CAP Question 2 (22 marks)

*(Abstract excerpt)*

### **Effects of psychological treatment of mental health problems in pregnant women to protect their offspring: randomised controlled trial**

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**Background:** Perinatal depression and anxiety are associated with unfavourable child outcomes.

**Aims:** To assess among women with antenatal depression or anxiety the effectiveness of prenatally initiated cognitive-behavioural therapy (CBT) on mother and child compared with care as usual (CAU).

**Method:** Pregnant women (n = 282) who screened positive for symptoms of depression and/or anxiety were randomised to either CBT (n = 140) or CAU (n = 142). The primary outcome was child behavioural and emotional problems at age 18 months, assessed using the Child Behavior Checklist (CBCL). Secondary outcomes were maternal symptoms during and up to 18 months after pregnancy, neonatal outcomes, mother–infant bonding and child cognitive and motor development at age 18 months.

**Results:** In total, 94 (67%) women in the CBT group and 98 (69%) in the CAU group completed the study. The mean CBCL Total Problems score was non-significantly higher in the CBT group than in the CAU group (mean difference: 1.38 (95% CI -1.82 to 4.57); t = 0.85, P = 0.399). No effects on secondary outcomes were observed except for depression and anxiety, which were higher in the CBT group than in the CAU group at mid-pregnancy. A post hoc analysis of the 98 women with anxiety disorders showed lower infant gestational age at delivery in the CBT than in the CAU group.

**Conclusions:** Prenatally initiated CBT did not improve maternal symptoms or child outcomes among non-help-seeking women with antenatal depression or anxiety. Our findings are not in line with present recommendations for universal screening and treatment for antenatal depression or anxiety, and future work may include the relevance of baseline help-seeking.

*(Methods excerpt)*

The PRenancy Outcomes after a Maternity Intervention for Stressful EmotionS (PROMISES) trial is a CONSORT-compliant parallel-group assessor-masked multicentre RCT with a published protocol.

*(Methods excerpt)*

All women during their booking visit at the collaborating practices between 10 and 12 weeks of pregnancy, which is part of standard care, were screened for the purpose of the study. They were provided with study information, a consent form and two self-report questionnaires: the 6-item State-Trait Anxiety Inventory (STAI) and the 10-item Edinburgh Postnatal Depression Scale (EPDS) to assess symptoms of anxiety and depression respectively.

Women with at least moderate anxiety or depression, defined as a score of 42 or higher on the STAI or 12 or higher on the EPDS, were eligible. Women were excluded if they had substantial physical disease, had a multiple pregnancy, showed a high suicide risk on the MINI-International Neuropsychiatric Interview, had a history of bipolar disorder, psychoses or manic disorder, had misused substances, were receiving psychotherapy or did not speak Dutch.

*(Methods excerpt)*

Licensed psychologists (n = 31) with at least 2 years' postdoctoral training including CBT and CBT supervision provided the CBT. They received for the study an additional 2 days of training on antenatal CBT (for depression, anxiety disorders and PTSD) and supervision during. The treatment protocol consisted of 10–14 individual sessions, of which 6–10 were intended to be delivered during pregnancy. Sessions were scheduled from 20 weeks' gestation up to 3 months postpartum; the exact timing of the sessions was planned on the basis of shared decision-making with the participant. The treatment encompassed several optional modules, with evidence-based CBT interventions focusing on the treatment of anxiety disorders (exposure, response prevention and cognitive-challenging work), depressive disorders (additional behavioural activation), or trauma

and PTSD (exposure, imagery and rescripting). In addition, the overall focus was on identifying and changing dysfunctional cognitions and beliefs. Each session also addressed pregnancy-related cognitions and attitudes, and selected evidence-based CBT interventions for specific anxiety and depressive disorders and PTSD were offered. All sessions were structured, explaining the rationale and giving and discussing homework assignments.

*(Methods excerpt)*

The sample size description in this study refers to an alpha of 5% and power of 80%.

**Table 1**

<b>Table 1</b> Baseline characteristics of participants according to treatment group <sup>a</sup>		
	CBT ( <i>n</i> = 140)	CAU ( <i>n</i> = 142)
Age, years: mean (s.d.)	33.4 (4.6)	32.1 (4.5)
Multiparous, <i>n/N</i> (%)	70/140 (50.0)	73/142 (51.4)
Marital status: single, <i>n/N</i> (%)	12/136 (8.8)	10/136 (7.4)
Ethnicity: Black and minority ethnic, <i>n/N</i> (%)	8/134 (6.0)	3/136 (2.2)
Smoking, <i>n/N</i> (%)	11/89 (12.4)	11/100 (11.0)
Use of antidepressants, <i>n/N</i> (%)	2/140 (1.4)	2/142 (1.4)
Socioeconomic status, <i>n/N</i> (%)		
Low	48/140 (34.3)	51/142 (35.9)
Moderate	36/140 (25.7)	35/142 (24.6)
High	56/140 (40.0)	56/142 (39.4)
STAI score, mean (s.d.) <sup>b</sup>	48.6 (8.7)	48.5 (8.4)
EPDS score, mean (s.d.) <sup>b</sup>	9.8 (4.1)	9.7 (4.1)
STAI score $\geq 42$ , <i>n/N</i> (%) <sup>b</sup>	120/138 (87.0)	119/137 (86.9)
EPDS score $\geq 12$ , <i>n/N</i> (%) <sup>b</sup>	45/135 (33.3)	43/137 (31.4)
DSM-IV diagnosis, <i>n/N</i> (%)		
Anxiety	48/138 (34.8)	36/142 (25.4)
PTSD	9/138 (6.5)	5/142 (3.5)
Depression	14/138 (10.1)	9/142 (6.3)
Comorbid anxiety and depression	12/138 (8.7)	12/142 (8.5)
Comorbid PTSD and depression	2/138 (1.4%)	8/142 (5.6)

CBT, cognitive-behavioural therapy; CAU, care as usual; STAI, State-Trait Anxiety Inventory; EPDS, Edinburgh Postnatal Depression Scale; PTSD, post-traumatic stress disorder.  
a. Based on complete data.  
b. Higher values indicate more severe symptoms.

**Table 2**

<b>Table 2</b> Anxiety and depression symptom levels according to follow-up time and treatment group <sup>a</sup>						
	$n_{\text{CBT}}/n_{\text{CAU}}$	CBT ( $n = 140$ ), mean (s.d.)	CAU ( $n = 142$ ), mean (s.d.)	Mean difference <sup>a</sup> (95% CI)	$z$	$P$
STAI score <sup>b</sup>						
Baseline (at 12 weeks' gestation)	138/137	48.6(8.7)	48.5 (8.4)	0.0 (−2.0 to 2.0)		
24 weeks' gestation	115/120	47.7 (11.5)	43.2 (10.9)	4.5 (2.0 to 7.0)	3.54	<0.001
36 weeks' gestation	98/108	43.2 (10.6)	41.5 (12.6)	1.5 (−1.2 to 4.2)	1.09	0.275
6 weeks postnatal	94/83	40.9 (11.5)	41.4 (13.5)	−1.4 (−4.4 to 1.5)	−0.95	0.342
3 months postnatal	76/87	43.8 (13.7)	41.1 (12.4)	2.2 (−0.9 to 5.4)	1.38	0.167
6 months postnatal	91/97	42.1 (13.6)	40.8 (11.7)	0.9 (−2.2 to 4.1)	0.58	0.560
12 months postnatal	79/75	41.0 (12.8)	41.4 (12.4)	0.7 (−2.9 to 4.3)	0.39	0.697
18 months postnatal	72/66	40.9 (11.3)	40.1 (10.2)	1.5 (−2.4 to 5.4)	0.74	0.460
EPDS score <sup>b</sup>						
Baseline (at 12 weeks' gestation)	135/137	9.8 (4.1)	9.7 (4.1)	0.1 (−0.9 to 1.1)		
24 weeks' gestation	120/120	10.4 (5.0)	9.2 (4.7)	1.2 (0.2 to 2.1)	2.43	0.015
36 weeks' gestation	97/104	9.4 (4.6)	8.3 (4.6)	0.8 (−0.2 to 1.8)	1.49	0.136
6 weeks postnatal	90/88	8.4 (4.6)	8.4 (4.9)	−0.1 (−1.2 to 1.0)	−0.20	0.844
3 months postnatal	74/88	8.7 (5.4)	8.2 (4.7)	0.3 (−1.0 to 1.5)	0.44	0.660
6 months postnatal	87/95	8.0 (5.3)	8.3 (5.3)	−0.3 (−1.6 to 1.0)	−0.46	0.647
12 months postnatal	75/77	7.9 (5.0)	7.8 (5.2)	0.5 (−1.0 to 1.9)	0.67	0.504
18 months postnatal	74/63	7.8 (5.0)	7.4 (4.1)	0.9 (−0.7 to 2.6)	1.12	0.263

CBT, cognitive-behavioural therapy; CAU, care as usual;  $n_{\text{CBT}}/n_{\text{CAU}}$ , numbers in CBT and CAU groups respectively; STAI, State-Trait Anxiety Inventory; EPDS, Edinburgh Postnatal Depression Scale.  
a. Means (s.d.) are based on complete data, mean differences between groups were quantified with linear mixed-effects models using all available data with follow-up time as a categorical independent variable.  
b. Higher values indicate more severe symptoms.

*(Statistical analysis excerpt)*

The proportion of missing data ranged from 0 to 49% (last follow-up) for the maternal data and from 0 to 38% (BSID-III scores) for the child variables. Multiple imputation was used for incomplete data under the missing at random (MAR) or missing completely at random (MCAR) assumption. The missing data mechanism was studied for each of the variables by predicting its missingness, for example because of loss to follow-up, from the other variables. This was done using multivariable logistic regression analyses.

**Table 3**

<b>Table 3</b> Child outcomes and quality of mother-infant bonding according to treatment group <sup>a</sup>						
	$n_{\text{CBT}}/n_{\text{CAU}}$	CBT ( $n = 140$ ), mean (s.d.)	CAU ( $n = 142$ ), mean (s.d.)	Mean difference <sup>a</sup> (95% CI)	$t$	$P$
Neonatal outcomes						
Birth weight, g	123/120	3413 (647)	3457 (561)	−53.5 (−196.3 to 89.2)	−0.74	0.462
Gestational age at delivery, weeks	122/121	38.5 (2.3)	38.8 (1.8)	−0.3 (−0.8 to 0.2)	−1.23	0.217
Apgar score at 1 min <sup>b</sup>	111/116	8.6 (1.4)	8.5 (1.3)	0.1 (−0.3 to 0.4)	0.37	0.710
Apgar score at 5 min <sup>b</sup>	121/120	9.5 (1.0)	9.5 (1.0)	−0.1 (−0.3 to 0.2)	−0.41	0.680
Child development (BSID-III) <sup>c</sup>						
Cognitive score	90/85	11.6 (2.2)	11.9 (2.0)	−0.27 (−0.88 to 0.33)	−0.89	0.376
Fine motor score	90/85	11.5 (2.6)	11.7 (2.6)	−0.27 (−1.03 to 0.50)	−0.69	0.492
Gross motor score	90/85	9.6 (2.4)	9.7 (2.4)	−0.08 (−0.78 to 0.63)	−0.21	0.835
Child behaviour (CBCL/1.5–5) <sup>d</sup>						
Internalising problems	94/98	4.6 (3.4)	3.9 (3.1)	0.76 (−0.11 to 1.63)	1.73	0.085
Externalising problems	94/98	10.1 (5.6)	9.6 (6.3)	0.39 (−1.12 to 1.91)	0.51	0.609
Total problems	94/98	21.8 (11.6)	19.8 (12.5)	1.38 (−1.82 to 4.57)	0.85	0.399
Mother-infant bonding (PBQ) <sup>e</sup>						
Total score	89/95	105.1 (5.1)	105.6 (5.4)	−0.3 (−1.8;1.2)	−0.34	0.733

CBT, cognitive-behavioural therapy; CAU, care as usual;  $n_{\text{CBT}}/n_{\text{CAU}}$ , numbers in CBT and CAU groups respectively; BSID-III, Bayley Scales of Infant and Toddler Development, Third Edition; CBCL/1.5–5, Child Behavior Checklist for Ages 1.5–5; PBQ, Postpartum Bonding Questionnaire.  
a. Means (s.d.) are based on complete data, mean differences between groups were quantified with linear regression models using multiply imputed data and are adjusted for parity and socioeconomic status.  
b. Higher values indicate better neonatal health.  
c. Higher values indicate better performance.  
d. Higher values indicate higher severity of problems.  
e. Higher values indicate a more problematic mother-infant bond.