Universitetet i Bergen

CANDIDATE

119

TEST

PSYK140 0 Atferd, helse og ernæring

Subject code	PSYK140
Evaluation type	Skriftlig eksamen
Test opening time	15.05.2017 09:00
Standard closing time	15.05.2017 13:00
Grade deadline	--
PDF created	12.03.2018 09:24
Created by	Anna Laupsa Helvik

Praktisk informasjon

PSYK140 - Behaviour, health and nutrition
May 15th 2017, 09.00-13.00

- No examination aids allowed.
- You will receive three assignments, you are supposed to answer two of them. You are free to choose the two assignments yourself.
- Both assignments must be answered satisfactory in order to pass the exam.
- For å endra målform: Trykk på menystrekane oppe i høgre hjørne/For å endre målform: Trykk på menystrekene i høyre hjørne.

The exam assignment and your answer are available in Inspera Assessment when the examination is over.

Assessment, explanation of grades and right to appeal
Your result on the exam will be announced on June 8th. You will receive an e-mail when the result is published on StudentWeb. Information about explanation of grades and possibilities to appeal will be published on Mitt UiB when the grade has been announced

1 Eksamensoppgåva

Fill in your answer here

Assignment 1:

Eating disorders are defined by Fairburn as long lasting disturbances in eating behaviour or weight control behaviour with large negative consequences for physical health or psychosocial functioning. Eating disorders are categorised in the DSM-5 in 4 different disorders, namely bulimia nervosa, anorexia nervosa, binge eating disorder and eating disorders not otherwise specified (ED-NOS). Eating disorders are quite common, 0,3-0,7% of young females have to live with the difficulties of anorexia nervosa and 1-3% of female students are diagnosed with bulimia nervosa. But most people having an eating disorder do not meet the criteria for one of the diagnoses, so they have an eating disorder not otherwise specified. These categories are made in the DSM-5 but there are people who think that it is not right to categorise the specific diagnoses, because the different diagnoses have more in common than that they differ from each other. In this assignment this issue will be discussed. First, the different diagnoses and their specific criteria will be discussed. Then there will be shown what they have in common and thus why people think of a transdiagnostic perspective on eating disorders. In the end there will be a discussion of the mechanisms that are maintaining eating disorders. These mechanisms are addressed in cognitive behavioural treatment enhanced (CBT-E), which is based on the transdiagnostic perspective on eating disorders.

Anorexia nervosa
Anorexia nervosa is defined by three criteria. The first criterium that has to be met is a body mass index (BMI) score below 17.5 or less than 85% of expected body weight. BMI is defined as weight in kilograms divided by height in squared meters. The second criterium is an overevaluation of weight and body shape and the ability to have control over them. The last criterium is ammenorhea, meaning that girls with anorexia nervosa do not have their periods anymore. This criterium is debated because almost all people meeting the first two criteria have ammenorhea and people who still have their periods closely resemble patients who are ammenorheic.

Bulimia nervosa/binge eating disorder
Bulimia nervosa is also defined by three criteria. The first one being the same as in anorexia nervosa, namely an overevaluation of weight and shape and the control over them. The second criterium is recurrent binge eating, meaning that people with bulimia nervosa have moments that they lose control over their eating and eat an excessive amount of food at once. The third criterium is extreme weigth control behavior. Extreme weight control behaviour can be the use of laxatives or diuretics or excessive excercising. Binge eating disorder closely resembles bulimia nervosa but patients with binge eating disorder do not express extreme weigth control behaviour. This is probably one of the reasons why people with binge eating disorder are often obese.

Eating disorders not otherwise specified
Eating disorders not otherwise specified is a sort of restgroup. People in this group do not meet the criteria for one of the diagnoses, but closely resemble the people who do. Examples are people with an overevaluation of weight and shape that are ammenorheic but have a BMI-score that is just too high for meeting the criteria for anorexia nervosa or people that execute excessive weight control behaviour but do not binge eat often enough to meet the criteria for bulimia nervosa.

Transdiagnostic perspective
When looking at the above defined different diagnoses you see that the diagnoses have things in common, for example the overevaluation of weight and body shape and the ability to have control over them is present in all of the diagnoses. People with eating disorders all base their self-worth mainly on their weight and body shape. This is therefore what the transdiagnostic perspecive calls the core psychopathology of eating disorders. The transdiagnostic perspective states that this is the core of all the eating disorders and that the rest of the symptoms are secondary to and associated with this core. But there is another reason why the transdiagnostic perspective thinks that the eating disorders should be looked at without seeing them as different diagnoses. You can see this when taking a longitudinal view on eating disorders. Patients often do not stay having one diagnosis, but they switch between diagnoses. It is very common for example that people who do now meet the criteria for bulimia nervosa have met the criteria for anorexia nervosa before. Also, people that have been in treatment for their eating disorder, will often still have an eating disorder not otherwise specified after treatment, so they are still experiencing some symptoms.
According to this transdiagnostic perspective eating disorders in general come in four different stages. It is important to realise that this is a general pattern, but not everyone with an eating disorder goes through all of these stages, or has all of the characteristics of a state. The first stage is happy starvation in which people start to diet, often after an event that caused a decrease in self-confidence. They get positive comments from peers and they feel euphoric and confident again. In the second stage, named painful hunger, the body starts to react to the extreme dieting. Biological reactions start and people become to think about food most of the time. In this stage binge eating can start. The third stage is called desperation. In this stage people feel like they lost control and can feel anxious or depressive. This is the reason why some people start using alcohol or drugs. Sometimes people in this stage realise that their symptoms belong to an illness. Their symptoms started as a message but now their symptoms have become an illness. If people come to the last stage named eating disorder as an identity, they need prolonged treatment most of the time. It is often very hard for these people to give up their eating disorder because of the advantages they experienced by being ill, for example extra attention. Furthermore, they are completely used to this style of living and even their whole family can have adapted to the eating disorder.

Cognitive behavioural treatment enhanced (CBT-E)
CBT-E is the treatment approach based on the transdiagnostic perspective on eating disorders. The treatment approach is also divided in four stages in which the primary maintaining mechanisms are handled first and the secondary maintaining mechanisms afterwards. The primary maintaining mechanism in eating disorders can be seen when looking at the four different stages of eating disorders and has to do with the core psychopathology namely the overevaluation of weight and shape and the ability to have control over them. This belief makes people dieting. Sometimes the dieting succeeds, but it is hard to succeed so people are very busy with their food intake and because they are so busy with it the overevaluation of weight and body shape only increases which maintains the eating disorder. In other people the dieting does not succeed, and this people start to binge eat. Because of this they feel like losing control and feel fat and that's why they start using weight control behaviour and their overevaluation of weight and shape increases. Both ways this is a vicious circle which is the primary maintaining mechanism of eating disorders.
The first stage in treatment is called start well. In this stage physicians try to break the vicious circle in different ways. It is important to make patients realise that their dieting is a problem and one of the primary maintaining mechanisms of the eating disorder. Patients often believe that their binge eating is the problem and that because they do that they have to execute weight control behaviours. But they have to realise that it is the other way around, because they are dieting they starve themselves and that's why they binge eat. Furthermore, they should see that their behaviours hinder their social lives, for example because they can not go to a restaurant with friends, because they are afraid of what they will have to eat. In this first stage there are a lot of other things that have to be done. Patients get education about their eating disorder, they have to start to eat normal again, they have to start monitoring their food intake, the physician and the patient are weighing the patient together and keep track of the weight. This is because patients have to learn that they are not getting fat because of one or two fat snacks and because they have to learn that you can not base anything on one time of weighing. Also, mirror use can be adressed and there will be dealt with food avoidance. Food avoidance means that patients are scared to eat certain foods. In treatment they have to make a list of the foods that they are avoiding and categorise them in terms of how scary this certain food is. When the list is made they have to slowly introduce these foods into their diets again starting with the least scary items and going on with the scarier items. The second stage of treatment looks at the barriers that are hindering the steps being introduced in the first stage and tries to address them. This can for example be that the physician and the patient had agreed on that the patient had to eat bread for lunch but didn't dare to. They can then analyse together why she didn't dare to. The third stage has the most to do with secondary maintaining mechanisms. One common secondary maintaining mechanism are handling moods. Patients can feel sad and therefore start to binge eat for example. During a residual binge analysis this can be found out and the

physician can learn the patient how to deal with moods in a different way for example by listening to music that the patient likes. Another common secondary mechanism are that the symptoms of the eating disorder are a way of coping with difficult events. An example can be that a girl has a date that evening and is afraid that her date will think that she is fat. Her way of coping can be not eating anything that day. With proactive problem solving the physician can learn the patient to predict the problem beforehand and dealing with it another way for example by calling a friend helping her to pick out clothes that she feels confident in. The last stage called end well has to do with maintaining the learned things and preventing relapse.

This assignment was about the transdiagnostic perspective on eating disorders and the associated treatment being CBT-E. Many physicians and also insurance companies can learn a lot from this transdiagnostic perspective. The physicians are sticking with the differential diagnoses and when a patient does not exactly meet the criteria for one of the diagnoses they don't know which treatment to implement. When looking at the transdiagnostic perspective they can use it to treat these patients as well. Furthermore it is also important to look at this perspective for insurance companies, because people who do not meet the criteria for one of the diagnoses do not get compensation for their treatments although they closely resemble patients who do meet the criteria and for this people it's also very important that they can be helped and can afford treatment.

Assignment 2

There are many things that can make people sick and disease prevention workers are always searching for these risk factors. Fortunately we now know the risk factors for a lot of diseases, but some time ago we didn't even know that smoking was a risk factor for lung diseases. This example shows that we are making progress in getting to know the causes of diseases. But still, we don't know the causes or risk factors for a lot of diseases. You can imagine that it is hard to search for risk factors and causes but what makes this such a difficulty? In this assignment one of these difficulties will be tackled. When we know about this difficulty there is a strategy, the population-based strategy which is associated with this difficulty. This strategy will also be discussed and compared with another strategy, the high-risk strategy.

The difficulty

There are two different ways of searching for risk factors for disease. You can search for causes of cases or for causes of incidence. When you search for causes of cases you are comparing individuals, but when you are searching for causes of incidence you are comparing groups. A lot of health workers are searching for causes of cases, because it is easy to execute research in your own population. But this strategy has a problem which is best illustrated by giving an example. Kenyan nomads have a lower blood pressure population mean than people in London. This means that on average people in London have a higher blood pressure than the Kenyan nomads. You will not find high blood pressure as a risk factor for for example cardiovascular risk factors when you are comparing cases in one population. When you compare persons with and without cardiovascular diseases in Norway, you are most likely to conclude for example that the most important risk factor for cardiovascular diseases are certain genes. You will not think of high blood pressure as a risk factor when you execute this research because this risk factor is present in all of the persons. The hardest cause to identify is the one that is universially present.

The population based strategy and the high-risk strategy

There are different strategies to disease prevention. One distinction is the distinction between a population based strategy and a high-risk strategy of disease prevention. The population based strategy will provide the same health promotion or disease prevention interventions for all people in the population. On the other hand, the high-risk strategy will screen the people in the population and will provide health promotion or disease prevention interventions only for the people with the highest risk. People who argue for using the population based strategy have the argument that you can prevent more cases of disease by providing everyone in the population with the intervention than by only intervening in the high-risk group. This is called the preventive paradox and it is true because everyone in the population has at least some risk and a lot of people with a small risk will lead to more cases of disease than a small group of people with a high risk. Imagine for example that there are 5 million people living in Norway. If 10% (500000 people) have a high risk (15%) of getting the disease, then this will lead to 75000 cases of disease in this group. On the other hand 90% (4500000) of people have a low risk (5%). This will lead to 225000 cases of disease in this group. This example thus shows that you can prevent more cases of disease by intervening in the whole population by using the population based strategy.

The population based strategy versus the high-risk strategy

By using the population based strategy you can thus prevent more cases of disease but there are a lot of other advantages by using the population based strategy. One of them is that you don't need a screening to identify the high-risk people. Using a screening is difficult because you need to come up with a treshold. The first problem with this treshold is where you should lay this treshold. First you should do a lot of research to come

up with a logical and not just a random treshold. Another problem of screening is that people who are above the threshold level can be going to worry a lot and people who are beneath the threshold can feel like they are completely safe, but this threshold is of course not that black and white. The second advantage of the population based strategy is that it is cheaper than the high-risk strategy mainly because you don't need an expensive screening. Another positive characteristic of the population based strategy is that the intervention is behaviourally appropriate when you compare it with an intervention of the high-risk strategy. An intervention in the high-risk strategy can for example be that people are not allowed to drink alcohol anymore. But when these people are part of a group of friends who drink a lot, these friends will pressure the people to drink alcohol despite of the intervention. When using the population based strategy this problem does not count, because the same intervention is there for everyone. The last advantage of this strategy is that the intervention is radical and non-palliative. When you take away the cause of the disease next generations do not have the same problem again and again. For example when there is some chemical in the drinking water that is a risk factor and you can take this away the next generations do not have to deal with it. By contrast, when using the high-risk strategy it's non-radical and palliative, because in each generation there will be new people with a high-risk that you have to help with the intervention.

Unfortunately, every advantage has it's disadvantage, and so the population based strategy has also disadvantages when you compare it with the high-risk strategy. One of them is the fact that the risk ratio is worrisome. Most of the time there are some risks involved within an intervention, but when the risks of having the risk factor are high, the risk factors of the intervention are probably less of a risk, so there's a good risk ratio. This is not the case in the low risk group, so with the population based strategy the risk-ratio can be worrisome. Another factor is motivation. Motivation in patients is probably high when they are identified as having a high risk of getting the disease. But if you implement an intervention for the whole population people do not feel the need of working on it really hard. The motivation of the physician does also play a role and this works kind of the same way as with the motivation of the patients. When helping only a high-risk group they feel like they are really preventing something worse that can happen, but when implementing the intervention for the whole population they don't feel like there efforts have the same effects.

So, there are advantages and disadvantages to both approaches. Despite of the fact that the population based approach also has disadvantages there should be more attention given to it. Most interventions at the moment are high-risk strategy interventions, but disease prevention workers should realise that population based strategies can be very helpful at least next to the high-risk approaches. Unfortunately, at the moment it is not possible to use the population-based strategy for many diseases simply because we don't know the underlying causes for many diseases but only some of the risk-factors, which can sometimes even be very small risk factors. Therefore, it is important that researchers keep on searching for underlying causes so we can use the population based strategy more often and prevent more cases of diseases.

Answered.

Attaching sketches to this question?
Use the following code:

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