Universitetet i Bergen

KANDIDAT

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PRØVE

PSYK140 0 Atferd, helse og ernæring

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Opprettet av	Anna Laupsa Helvik

Praktisk informasjon / Practical information

PSYK140 - Åtferd, helse og ernæring
23. mai 2016
09.00-13.00

Bokmål: Klikk på tannhjulet i høgre hjørne

Ingen hjelpemiddel er tillatt
Du skal svare på 2 av 3 oppgåver
Du må svare tilfredsstillande på båe oppgåvene for å få greidd på eksamen.

Eksamensteksten og besvarelsen din vil vere tilgjengeleg i Inspera Assessment når eksamen er ferdig.

Sensur, grunngjeving og klage

Kunngjering av sensur er 13. juni. Du får ein e-post når sensuren er klar i StudentWeb.

Fristen for å be om grunngjeving for karakterfastsettinga er 20. juni. Du vil finne lenke til skjema eller kontaktinformasjon på Mi side etter kunngjering av sensur.

Fristen for å klage over karakterfastsettinga er 4. juli. Du finn klageskjema på uib.no/psyfa.

Du kan sende klagen til post@psyfa.uib.no / Det psykologiske fakultet, postboks 7807, 5020

Bergen / eller levere den i Informasjonssenteret i Christies gate 13.

Dersom du har bedt om grunngjeving for karakterfastsetting, eller klaga over formelle feil ved oppgavegjeving, eksamensavvikling eller gjennomføring av vurderinga, løper klagefristen frå du har fått grunngjevinga eller klagen er endeleg avgjort (jfr. § 5-3 i Lov om universiteter og høgskoler).

1 Eksamensoppgaven / Exam questions

Svar på 2 av 3 oppgåver her:

Question 1

This essay first discusses the definition of an eating disorder and the three main types: anorexia nervosa, bulimia nervosa and atypical eating disorder. Secondly, the development of eating disorders is discussed which gives a clear indication of the migration between different eating disorders. Then the core mechanisms of the transdiagnostic view are evaluated and elaborated in the treatment approach cognitive behavioral therapy. This treatment approach shows that the core mechanisms of an eating disorder are cognitive and contribute to the temporal movement between anorexia nervosa and bulimia nervosa and the self-maintaining process of eating disorders.

An eating disorder is characterized by abnormal eating and overevaluation of the body and shape and weight. There are three main types of eating disorder. The first type is anorexia nervosa. Anorexia nervosa is diagnosed when the patient is shows an overavaluation of shape and weight, sustains a low body weight with a BMI under 17,5 (Body Mass Index shows the relation between weight and height) and has amennorhea.

The second type of eating disorder is bulimia nervosa, the diagnosis for bulimia nervosa is also overevaluation of shape and weight combined with recurrent binge eating (binge is a episode of eating characterized by an aversive loss of control and an abnormally large amount of food is eaten), compensatory vomiting or laxative misuse and when the diagnosis of anorexia nervosa is not made.

The third type of eating disorder is atypical eating disorder. This exists out of three groups. The first group is binge eating disorder which is characterized by binge eating but without compensatory behavior and is highly associated with obesity. The second group is the subthreshold group wchich shows symptoms of anorexia nervosa or bulimia nervosa but do not meet the characteristics for diagnosis. The last and most common group is the mixed group, this group shows characteristics of both anorexia nervosa and bulimia nervosa. This could be an indication that anorexia nervosa and bulimia nervosa are not two seperate eating disorders but that it is just one eating disorder wihich develops in altering characteristics over time.

The development of an eating disorder mostly starts with a negative life event. The patient wants to gain control over their life and start to control their eating. This stage is called happy starvation. They can positive attention form peers and feel in control. The next stage is painful hunger, the pysiological consequences of the restricted dieting set in and the body starts to protest. The third stage is desperation, the patient starts to looses control of the control which is experienced as a double failure. The patient has intruding thoughts about food and cannot keep up with the inflexible diet rules. As a result the patient starts binge eating. In the last

stage the eating disorder becomes the identity of the patient. It is hard to imagine a life without the eating disorder and prolonged treatment is needed to help the patient.

These four development stages show that commonly the patients first develop anorexia nervosa during adolescence, but it is almost inevitable to not break the restricted dietary rules which resuts in binge eating and the compemsatory behavior of binge eating. Thus in young adultdhood anorexia nervosa mostly migrates into bulimia nervosa. Because of this common migration between eating disorders, a transdiagnostic view is developed. This view emphasizes the temporal movement between anorexia nervosa and bulimia nervosa and the core mechanisms that these two eating disorders share. The overevaluation of weight and shape and the control over these. Self-worth is based primarily on these core mechanisms which results in dysfunctional self-evaluation.

This dysfunctional self-evaluation is studied in the cognitive behavioral model, it shows that an eating disorder is not only physiological but that it is more the cognitive components that keep it maintained.

The core mechanism overevaluation of weight and shape result in restricted eating, this results in low body weight in anorexia nervosa. This low body weight has secondary effects: preoccupation with food and body, social withdrawal, heigtened fullness and heigtened obsessionality. These secondary effects reinforce the overavaluation and restricted dieting. But eventually the restricted eating becomes impossible to keep up and instead of resulting in low body weight, restricted eating results in binge eating. There is a migration from anorexia nervosa to bulimia nervosa. Compensatory laxative use or purging follows the binge eating. This compensatory behavior and the binge eating in turn have an effect on the overevaluation of body and weight and the restricted eating. Also negative mood and events have an effect on binge eating. This shows that the core mechanisms of the eating disorder result in a self-maintaining process of the eating disorder.

The most common treatment for anorexia nervosa and bulimia nervosa is cognitive behavioral therapy in which the dysfunctional self-evaluation is treated. In the first stage of the treatment a formulation is designed, a personalized visual representation of the mechanisms that keep seem to keep the eating disorder going. Also, patients are learned to self-monitor their eating and to eat regularly. In stage two the the maintaining mechanisms are identified. In stge three these maintaining mechanisms are tackled. The overevaluation of body and shape due to preoccupation with it, constantly checking or avoiding to check the body, dietary restriction, mislabbeling emotional states as 'feeling fat' or marginalizing other evaluations of self-worth is tackled through trying to make other parts of self-evaluation more important like family and friends. The restricted dieting which results in preoccupation with food, stereotyped and inflexible rules, binge eating, weight loss and is anxiety provoking is tackled through addressing food avoidance (food that is thought to be inherently fattening) and addressing dietary rules. The last core mechanism, mood sesitivity (being very sensitive to a certain mood) and mood modulatory behavior (avoiding the moos or neutralizing the mood) is tackled through proactive problem solvingby indetifying the trigger of the aversive mood and appropriate mood modulatory behavior by staying in the presentand recording mood to avoid amplification aversive mood.

This essay discussed the transdiagnostic view of eating disorders by evaluating the development of eating disorder, which is commonly a migration from anorexia nervosa to bulimia nervosa and by highlighting the core mechanisms that the eating disorders share and how these core mechanisms make the eating disorder a self-maintaining system. Because of this temporal movement between eating disorder, the question can be asked if anorexia nervosa and bulimia nervosa are two distinct eating disorders or one eating disorder with fluctuating symptoms.

Question 2

This essay first defines the concepts high-risk strategy and population-based strategy of disease prevention. After, it explains why poplulation-based strategy will usually prevent more cases of disease compared to high-risk strategy through the use of prevention paradox. Eventually, the advantages and disadvantages associated with both high-risk strategy and population-based strategy are discussed.

The population-based strategy of disease prevention is known as health promotion. Health promotion is supported by salutogenesis and studies the factors that support well-being and health in a population. High-risk strategy is supported by pathogenesis, the study of the cause of the disease.

In a population, the risk for a disease is mostly a normal distribution, with a large number of low risk individuals causing more disease than the small number of high risk individuals. Epidemiology studies the determinants of the distribution of the disease. The more widespread the disease is, the less influence of the determinants of the distibution. If the disease in universally present than there is no influence of the distribution of the determinants of the disease. For example, overweight is a universally present disease, because it is universally present, it is hard to find the determinants of the distribution of the disease. The causes of overweight could be more fat in the food, people engage in less physical activity, more internet use and television... A high-risk strategy is not appropriate in this case because it is hard to find the cause of the disease. Population-based strategy on the other hand influences the entire population and makes a shift in the whole (normal) distribution of the disease. This shift results in the entire population having a lower risk for the disease instead of only targetting the high risk group. This is called the preventive paradox: influencing the entire population will prevent more diseae than concentrating on only the high risk cases.

Eventhough health promotion prevents more disease, high-risk strategy has several advantages. The first advantage is appropriate treatment for the patient and also cost-effective use of the resources. The patient is motivated because they know they have a high-risk for the disease and the physician is motivated beacuse they know they will make a change. At last, the benefit: risk ratio is favourable. This means that if there are any risks or costs for the intervention and they are the same for everybody then it is more favourable if the benefit is higher than the cost.
But there are also disadvantages associated with the high-risk strategy. The high-risk strategies has some difficulties with borderlines, patients who are high risk but do not meet the requirements to get the appropriate treatment: Also, the screening for high-risk patient has to be done continually because disease is not a stable concept. Another disadvantage is that high-risk strategy is palliative but not radical, high-risk patients are treated but the undelying cause is not treated. High-risk strategies has a small potential for the individual and the population because a large group of small risk individuals cause more disease than the small group of high risk individuals. By only focusing on the high risk individuals, the amount of people affected by the disease will not diminish. The last disadvantage of the high-risk strategy is that it is behaviorally inappropriate. For instance, patient with obesity are told to exercise more and eat less fat food but in their environment are no recreational park to do sports and are a lot of fast food restaurants. So the healthy behavior is not supported by the environment or by social norms because none of their friends or family have a healthy lifestyle. Population-based strategy, on the other hand, by influencing the entire polutation could create a more healthy environment and change the social norm.

This is one of the advantages of population-based strategy: it is behaviorally appropriate. Because the environment supports healthy behavior, it will be easier to engange in healthy behavior. For intstance, recreational parks will be made more accessible, fast food restaurants will be replaced by more healthy restaurants and as a result more people will engage in healthy behavior making it a norm. Another advantage of health promotion is that it is radical, health promotion tries to change the underlying cause of the disease by supporting health and well-being in the entire pouplation. Health promotion also has a large potential for the population. By influencing the entire population, the large group of low risk individuals who create most of the disease will be made smaller, resulting is less disease and a healthier population. Polulation-based startegy can be done through taxation on unhealthy foods like fast food and candy and subsidizing of healthy foods like vegetables and fruits.
Unfortunately there are also some disadvatages of health promotion. The first disadvatage is that it has a small benefit for the individual, this is part of the prevention paradox. Because health promotion concentrates on the entire population as a whole, the individual does not have a immediate benefit. Another disadvantage is less motivation from individual, people like direct and immediate effects and health promotion is more indirect. Physicians are also less motivated because they cannot see disease as a population problem, but rather treat the individual. Furthermore, the benefit: risk ratio is worrisome, the benefit for the individual is small so it is common that the risk will be larger than the benefit. Population-based strategy can also create higher social differences beacause low socioeconomic class are more difficult to reach with for instance advertisement about healthy behavior. Eventually, health promotion can be experienced as too much intervention of the government in the lifestyle of individuals.

To conclude, population-based strategy for health-promotion can prevent more cases of disease than high-risk startegy because they influence the entire population in promoting healthy behavior. This way the large group of low risk individuals who create the most disease are made smaller and more disease is prevented. This is the advantage of the prevention paradox, the disadvantge is that is had a small benefit for the individual. In the future, a combination of high-risk strategy and population-based startegy should be implemented to increase the health and well-being of a population.

Svara på.