NETTSKJEMA

Eksamensoppgave og sensorveiledning

Lastet ned: 29. april 2025 kl. 14:16

Svar-ID: 36208046 **Levert:** 16.04.25 13:04

Dette skjemaet er for innhenting av informasjon til sensorveiledningen.
En god sensorveiledning er viktig for at alle sensorene skal ha all nødvendig informasjon for å gjøre en god, nøyaktig vurdering av studentenes besvarelser. En god sensorveiledning fører til bedre sensur og færre avvik og klager.
Sensorveiledningen vil også bli publisert til studentene etter sensuren, slik at de kan se akkurat hvilke kriterier de har blitt vurdert etter. Dette er en rettighet studentene har.

Emnekode *

PSYK4521

Emnenavn *

Prevention, Health Promotion, System and Management 1

Emneansvarlig/oppgavegiver *

Ruben Cano

Semester, år *

Spring 2025

Vurderingsform, lengde *

Skoleeksamen, varighet 4 timer

Skal du ellen noen andre møte opp i eksamenslokalet? *

nei

Telefonnummer og navn til faglig kontakt *

Her skal du oppgi telefonnummer til person som skal svare på eventuelle spørsmål om oppgave under eksamen (det kan være deg selv ellen noen andre - vennligst skriv både navn og telefonnummer)

Ruben [redacted]

Tillatte hjelpemidler *

E: Ingen hjelpemidler tillatt

Skal det legges opp til levering av håndtegninger på eksamen? *

Nei

Emnets læringsutbyttebeskivelser angitt i kunnskaper, ferdigheter og generell kompetanse. *

Henvisning med lenke til emnesiden på NTNUs nettsider er tilstrekkelig

https://www.ntnu.edu/studies/courses/PSYK4521#tab=omEmnet

Pensum *

Vennligst lim inn her, ikke bruk vedlegg.

Pensum PSYK4521 Vår 2025

1-2. Health concept and theories
Only 57-65 & 79-87 and only figures seen in the slides: Bashmi, L., Cohn, A., Chan, S. T., Tobia, G., Gohar, Y., Herrera, N., Wen, R. Y., IsHak, W. W., & DeBonis, K. (2023). The Biopsychosocial Model of Evaluation and Treatment in Psychiatry. In W. W. IsHak (Ed.), Atlas of Psychiatry (pp. 57–89). Springer International Publishing. https://doi.org/10.1007/978-3-031-15401-0_3
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3.Health promoting/risk behaviors
World Health Organization. (2018). Chapter 2: What is physical activity? In the Global action plan on physical activity 2018–2030: More active people for a healthier world. World Health Organization. https://iris.who.int/handle/10665/272722
Intro and Discussion: Clarsen, B., Nylenna, M., Klitkou, S. T., Vollset, S. E., Baravelli, C. M., Bølling, A. K., Aasvang, G. M., Sulo, G., Naghavi, M., Pasovic, M., Asaduzzaman, M., Bjørge, T., Eggen, A. E., Eikemo, T. A., Ellingsen, C. L., Haaland, Ø. A., Hailu, A., Hassan, S., Hay, S. I., … Knudsen, A. K. S. (2022). Changes in life expectancy and disease burden in Norway, 1990–2019: An analysis of the Global Burden of Disease Study 2019. The Lancet Public Health, 7(7), e593–e605. https://doi.org/10.1016/S2468-2667(22)00092-5
Discussion: Murray, C. J. L., Aravkin, A. Y., Zheng, P., Abbafati, C., Abbas, K. M., Abbasi-Kangevari, M., Abd-Allah, F., Abdelalim, A., Abdollahi, M., Abdollahpour, I., Abegaz, K. H., Abolhassani, H., Aboyans, V., Abreu, L. G., Abrigo, M. R. M., Abualhasan, A., Abu-Raddad, L. J., Abushouk, A. I., Adabi, M., … Lim, S. S. (2020). Global burden of 87 risk factors in 204 countries and territories, 1990–2019: A systematic analysis for the Global Burden of Disease Study 2019. The Lancet, 396(10258), 1223–1249. https://doi.org/10.1016/S0140-6736(20)30752-2
4. Health promotion and disease prevention
Gordon, R. S. (1983). An operational classification of disease prevention. Public Health Reports (Washington, D.C.: 1974), 98(2), 107–109.
From the beginning to health in the river of life, not including table 1: Eriksson, M., & Lindstrom, B. (2008). A salutogenic interpretation of the Ottawa Charter. Health Promotion International, 23(2), 190–199. https://doi.org/10.1093/heapro/dan014
Holte, A. (2024). Strategi for et psykisk sunnere folk 2024. Tidsskrift for Norsk psykologforening, 61(10), 662–677. https://doi.org/10.52734/WJKS5460
5. Psychosocial determinants of health and health equity
Eikemo, T. A., & Øversveen, E. (2019). Social Inequalities in health: Challenges, knowledge gaps, key debates and the need for new data. Scandinavian journal of public health, 47(6), 593–597. https://doi.org/10.1177/1403494819866416
Fosse E. (2022). Norwegian policies to reduce social inequalities in health: Developments from 1987 to 2021. Scandinavian journal of public health, 50(7), 882–886. https://doi.org/10.1177/14034948221129685
6. Adjustment to chronic illness
Only Discussion: Reynolds, N., Mrug, S., Wolfe, K., Schwebel, D., & Wallander, J. (2016). Spiritual coping, psychosocial adjustment, and physical health in youth with chronic illness: A meta-analytic review. Health Psychology Review, 10(2), 226–243. https://doi.org/10.1080/17437199.2016.1159142
7. Cardiovascular disease
Only Introduction and Discussion: Richards, S. H., et al. (2018). Psychological interventions for coronary heart disease: Cochrane systematic review and meta-analysis. European Journal of Preventive Cardiology, 25(3), 247–259. https://doi.org/10.1177/2047487317739978
Sabih, A., Tadi, P., & Kumar, A. (2021). Stroke Prevention. In StatPearls. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK470234/
8. Cancer
No tables. Grimmett, C., Heneka, N., & Chambers, S. (2022). Psychological Interventions Prior to Cancer Surgery: a Review of Reviews. Current anesthesiology reports, 12(1), 78–87. https://doi.org/10.1007/s40140-021-00505-x
Goddard, K. A. B., Feuer, E. J., Mandelblatt, J. S., Meza, R., Holford, T. R., Jeon, J., Lansdorp-Vogelaar, I., Gulati, R., Stout, N. K., Howlader, N., Knudsen, A. B., Miller, D., Caswell-Jin, J. L., Schechter, C. B., Etzioni, R., Trentham-Dietz, A., Kurian, A. W., Plevritis, S. K., Hampton, J. M., … Castle, P. E. (2024). Estimation of Cancer Deaths Averted From Prevention, Screening, and Treatment Efforts, 1975-2020. JAMA Oncology. https://doi.org/10.1001/jamaoncol.2024.5381
9. Forebyggende helsearbeid i kommune
Hoffart, M. (2021). Toleransevindumodellen i skolen. Tidsskrift for Norsk psykologforening, 58(8), 689–693. Toleransevindumodellen i skolen

10. Folkehelsearbeid i kommunene 11.Hverdagsglede Skole - et helsefremmende tiltak i kommune
FHI. (2021, December 17). Livskvalitet. Folkehelseinstituttet. https://www.fhi.no/he/folkehelserapporten/samfunn/livskvalitet-i-norge/
Only sections:
- Hva er livskvalitet?
- Livskvalitet i Norge: Nivå og fordeling
- Hvordan kan vi fremme livskvaliteten?
- Oppsummering og diskusjon

Kjerpeset, Ø. (2024). Den neglisjerte vidundermedisinen. Tidsskrift for Den norske legeforening. https://doi.org/10.4045/tidsskr.24.0240
Prydz, M. B. (2022). Fem grep for økt hverdagsglede. Tidsskrift for Norsk psykologforening, 59(7), 632–637.
12. Chronic pain
Ashar, Y. K., Gordon, A., Schubiner, H., Uipi, C., Knight, K., Anderson, Z., Carlisle, J., Polisky, L., Geuter, S., Flood, T. F., Kragel, P. A., Dimidjian, S., Lumley, M. A., & Wager, T. D. (2022). Effect of Pain Reprocessing Therapy vs Placebo and Usual Care for Patients With Chronic Back Pain: A Randomized Clinical Trial. JAMA psychiatry, 79(1), 13–23. https://doi.org/10.1001/jamapsychiatry.2021.2669
Breivik, H., Borchgrevink, P. C., Allen, S. M., Rosseland, L. A., Romundstad, L., Hals, E. K., Kvarstein, G., & Stubhaug, A. (2008). Assessment of pain. British journal of anaesthesia, 101(1), 17–24. https://doi.org/10.1093/bja/aen103
13. Obesity and eating problems
Wadden, T. A., Webb, V. L., Moran, C. H., & Bailer, B. A. (2012). Lifestyle modification for obesity: new developments in diet, physical activity, and behavior therapy. Circulation, 125(9), 1157–1170. https://doi.org/10.1161/CIRCULATIONAHA.111.039453

Eventuelle formelle krav til besvarelsen *

Fks. antall sider/ord, referansestil, format

The exam will consist of two parts and will last 4 hours:

Short essay questions (total weight: 60%): Students will be given 4 questions and must choose 2 to answer. Each question counts for 30% of the final grade.

Expected length: Approximately 500 words per question.

Case question (weight: 40%): There will be 1 case that everyone must answer. The structure and response format for the case will follow the approach presented during the seminars.

Expected length: Approximately 1000 words.

Hvordan de ulike oppgavene i eksamenssettet er vektlagt? *

Fks. likt vekting, eller om alle oppgavene/visse oppgaver må være bestått for å bestå totalt

The exam will consist of two parts and will last 4 hours:

Short essay questions (total weight: 60%): Each question counts for 30% of the final grade.

Case question (weight: 40%).

Eksamensoppgave skal være tilgjengelig for studenter i følgende mål: *

Her må du være så snill og sjekke vedlagt oversikt før du svarer. Oppgaven skal forekomme på alle målformer hvor det er oppmeldt en kandidat eller flere.

norsk bokmål

engelsk

Oppgavetekst bokmål: *

Angi oppgaveteksten - **vennligst lim inn oppgaveteksten her, ikke bruk vedlegg**.

Eksamensinstruksjoner – PSYK4521

Denne eksamenen består av én obligatorisk kasusoppgave og fire kortsvarsoppgaver i essayformat. Du skal svare på kasusoppgaven, og velge to av de fire kortsvarsoppgavene. Eksamenstiden er fire timer, og du har god tid til å strukturere og skrive svarene dine.

Kasusoppgave (obligatorisk)
Tenk deg at du er en del av et tverrfaglig team i en kommune i -Norge. Dere har fått i oppdrag å forebygge fedme blant voksne i lokalsamfunnet, samt tilknyttede problemer som lav fysisk aktivitet, høyt stressnivå, leddsmerter og milde depressive symptomer. Bruk denne informasjonen til å:
1. Beskriv definisjonen og forekomsten av fedme blant voksne i Norge.
2. Drøft viktige forskjeller i forekomst (f.eks. kjønn, alder, geografisk og/eller kulturelt).
3. Identifiser og forklar de viktigste helserisikoene i denne saken (biologisk/medisinsk, livsstil, psykologisk og sosialt/miljømessig). Bruk én teoretisk modell eller rammeverk (f.eks. biopsykososial modell, Behaviour Change Wheel, transteoretisk modell eller Theory of Planned Behavior).
4. Foreslå ett forebyggende tiltak som inkluderer en livsstilsendring med digital komponent, tilpasset dette tilfellet.
5. Foreslå to folkehelsetiltak som kan støtte langsiktig forebygging og håndtering.

Velg to av følgende fire kortsvarsoppgaver:
1. Hva er den biopsykososiale modellen for helse, og hvordan skiller den seg fra den tradisjonelle biomedisinske modellen? Beskriv nyere teoretiske utviklinger i den biopsykososiale modellen og forklar, ved å bruke et eksempel på hjerte- og karsykdom, hvordan du vil bruke denne modellen for å forstå og beskrive et klinisk tilfelle innen forebyggingsvitenskap.
2. Hva er Behaviour Change Wheel (BCW), og hvordan hjelper det med å strukturere utformingen av atferdsendrende intervensjoner? Beskriv modellens kjernedeler, og forklar hvordan du ville brukt den for å fremme fysisk aktivitet hos personer med kreft. Bruk et konkret eksempel for å støtte forklaringen din.
3. Kroniske smerter er blant de vanligste helseplagene i Norge og representerer en økende folkehelseutfordring. Beskriv hovedkomponentene som gjør det vanskelig å vurdere og håndtere kroniske smerter. Beskriv forekomst og risikofaktorer for kroniske smerter i Norge. Forklar deretter hvordan en biopsykososial tilnærming kan veilede forebygging eller behandling av kroniske smerter.
4. Helseforskjeller vedvarer i Norge til tross for landets universelle velferdssystem. Drøft de viktigste sosiale og politiske faktorene som bidrar til disse forskjellene. Forklar hvordan nasjonale strategier og politiske rammeverk forsøker å redusere ulikheter, og reflekter over utfordringene med å implementere strukturelle eller «oppstrøms» løsninger på kommunalt nivå.

Oppgavetekst engelsk

Angi oppgaveteksten på engelsk hvis det er aktuelt for ditt emne **-Vennligst lim inn oppgaveteksten her, ikke bruk vedlegg**.

Exam Instructions – PSYK4521
This exam consists of one mandatory case question and four short essay questions. You must answer the case question and choose two of the four short questions. You have four hours to complete the exam, which gives you enough time to structure and write your responses.

Case Question (mandatory)
Imagine that you are part of a multidisciplinary team working in a municipality in Norway. You have received a mandate to tackle obesity in adults in your community and associated problems such as low physical activity, high stress levels, joint pain, and mild depressive symptoms. Use this information to:
1. Describe the definition and prevalence of obesity in the adult population in Norway.
2. Discuss key differences in its occurrence (e.g., gender, age, geographic, and/or cultural).
3. Identify and explain the main health risk factors relevant to this case (biological/medical, lifestyle, psychological, and social/environmental). Use one theoretical model or framework (e.g., Biopsychosocial model, Behaviour Change Wheel, Transtheoretical Model, or Theory of Planned Behavior).
4. Propose one prevention intervention that includes a lifestyle modification with a digital component tailored to this case.
5. Suggest two public health policy actions that could support long-term prevention and management.

Choose two of the following four short essay questions:
1. What is the Biopsychosocial model of health, and how does it differ from the traditional biomedical model? Describe recent theoretical advances in the Biopsychosocial model and explain, using an example of cardiovascular disease, how you would apply this framework to understand and describe a clinical case in prevention science.
2. What is the Behaviour Change Wheel (BCW), and how does it help structure the design of behavior change interventions? Describe its core components and explain how you would use this framework to promote physical activity in individuals diagnosed with cancer. Use a concrete example to support your explanation.
3. Chronic pain is one of the most common health complaints in Norway and a growing public health concern. Describe the main components that make chronic pain difficult to assess and manage. Describe the prevalence and risk factors of chronic pain in Norway. Then, explain how a biopsychosocial approach can guide prevention or management strategies for chronic pain.
4. Health disparities persist in Norway despite the country's universal welfare system. Discuss the main social and political factors that contribute to these disparities. Explain how national strategies and policy frameworks attempt to reduce inequalities and reflect on the challenges of implementing structural or "upstream" solutions at the municipal level.

Sensorveiledning: *

Angi hvilke momenter som skal være med i besvarelsen for hver oppgave, og hvilke momenter som skal vektlegges spesielt i vurderingen. Skisse til løsningsforslag pr. oppgave kan erstatte dette.**-Vennligst lim inn teksten her, ikke bruk vedlegg**.

Case, to do for all students
Case Question – Obesity in Adults (1-2 pags.)

Question (English):
Imagine that you are part of a multidisciplinary team working in a rural municipality in Norway. You have received a mandate to tackle obesity in adults in your community and associated problems such as low physical activity, high stress levels, joint pain, and mild depressive symptoms. Use this information to:
1. Describe the definition and prevalence of obesity in the adult population in Norway.
2. Discuss key differences in its occurrence (e.g., gender, age, geographic, and/or cultural).
3. Identify and explain the main health risk factors relevant to this case (biological/medical, lifestyle, psychological, and social/environmental). Use one theoretical model or framework of your choice (Biopsychosocial, Behaviour Change Wheel, Transtheoretical Model, or Theory of Planned Behavior) to structure your explanation.
4. Propose one prevention intervention that includes a lifestyle modification with a digital component tailored to this case.
5. Suggest two public health policy actions that could support long-term prevention and management.

Spørsmål (norsk):
Tenk deg at du er en del av et tverrfaglig team i en kommune i distrikts-Norge. Dere har fått i oppdrag å forebygge fedme blant voksne i lokalsamfunnet, samt tilknyttede problemer som lav fysisk aktivitet, høyt stressnivå, leddsmerter og milde depressive symptomer. Bruk denne informasjonen til å:
1. Beskriv definisjonen og forekomsten av fedme blant voksne i Norge.
2. Drøft viktige forskjeller i forekomst (f.eks. kjønn, alder, geografisk og/eller kulturelt).
3. Identifiser og forklar de viktigste helserisikoene i denne saken (biologisk/medisinsk, livsstil, psykologisk og sosialt/miljømessig). Bruk én teoretisk modell eller rammeverk (biopsykososial, Behaviour Change Wheel, transteoretisk modell eller Theory of Planned Behavior) for å strukturere forklaringen din.
4. Foreslå ett forebyggende tiltak som inkluderer en livsstilsendring med digital komponent, tilpasset dette tilfellet.
5. Foreslå to folkehelsetiltak som kan støtte langsiktig forebygging og håndtering.
A-Answer
Obesity is defined as a BMI ≥ 30 kg/m². In Norway, about 25% of adults are obese. The condition is most prevalent among individuals aged 40–60 and in rural areas, where structural barriers are more common.

Differences in occurrence:
- Gender: While men are more likely to have abdominal obesity, women often face greater psychological consequences.
- Age: Highest prevalence is seen in middle adulthood.
- Geography: Rural municipalities experience greater prevalence due to socioeconomic disparities and infrastructure gaps.
- Culture: Immigrant and low-income groups face compounded risks related to access, cultural diet changes, and health literacy.

Risk factors explained using the Biopsychosocial model:
- Biological/Medical: Hormonal imbalances (e.g., leptin/grelina), comorbidities like joint pain, and metabolic adaptation after weight loss attempts.
- Lifestyle: High-calorie diets, sedentary behavior, and disrupted sleep patterns.
- Psychological: Stress, mild depressive symptoms, emotional eating, low self-efficacy.
- Social/Environmental: Rural isolation, poor food environments, fewer opportunities for physical activity, and stigma.

Other acceptable frameworks include (EXPECTED TO BE DEVELOP AS ABOVE):
- Behaviour Change Wheel (COM-B model): Behavior results from Capability, Opportunity, and Motivation.
- Transtheoretical Model: Focuses on stages of change (e.g., precontemplation to maintenance).
- Theory of Planned Behavior: Highlights attitudes, norms, and perceived behavioral control as predictors of intention and behavior.

Proposed lifestyle intervention:
A personalized mobile app combining:
- Daily goal-setting and habit-tracking.
- Gamified missions.
- CBT-based prompts for emotional regulation.
- Integration with local services like coaching or peer support groups.

Public health policy actions:
- Enable access to digital health programs in primary care.
- Subsidize healthy food in rural stores.
- Launch national media campaigns to promote healthy behaviors.
- Regulate marketing of ultra-processed foods.

Grading criteria

Grade	Criteria
A	Full, structured response tailored to the case. Correct prevalence, strong analysis using one theoretical model, deep risk factor explanation, specific and feasible digital intervention, and relevant systemic policy actions.
B	Covers all key elements with accurate use of one model. Minor lack of detail or connection in one section. Still clearly applied to the case.
C	General coverage. Uses a model but not fully integrated. May lack depth in risk factors or propose a weak intervention. Policies may be vague.
D	Partial understanding. May list risk factors but lacks theoretical explanation or case relevance. Intervention and policy are underdeveloped.
E	Minimal structure or accuracy. No theory applied. Weak or unrealistic intervention. Lacks public health relevance.
F	Incoherent, off-topic, or missing multiple parts. No understanding of key concepts. No model, no intervention, no policy relevance.

To select two of the following questions (1 pag. max.):
Biopsychosocial Model – Short Essay Exam Question
Question (English):
What is the Biopsychosocial model of health, and how does it differ from the traditional biomedical model? Describe recent theoretical advances in the Biopsychosocial model and explain, using an example of cardiovascular disease, how you would apply this framework to understand and describe a clinical case in health psychology.
Spørsmål (norsk):
Hva er den biopsykososiale modellen for helse, og hvordan skiller den seg fra den tradisjonelle biomedisinske modellen? Beskriv nyere teoretiske utviklinger i den biopsykososiale modellen og forklar, ved å bruke et eksempel på hjerte- og karsykdom, hvordan du vil bruke denne modellen for å forstå og beskrive et klinisk tilfelle innen helsesykologi.
Example of an A-answer:
The Biopsychosocial (BPS) model, introduced by George Engel in 1977, offers a comprehensive framework that explains health and illness as the result of dynamic interactions among biological, psychological, and social factors. In contrast, the biomedical model understands disease primarily as a malfunction of biological systems and tends to neglect the personal, emotional, and societal dimensions of illness.

Recent theoretical advances in the BPS model, as outlined by Bashmi et al. (2023), stress the importance of cultural factors, temporal considerations, and individual contextual meaning. This includes how cultural identity, belief systems, and values shape how illness is experienced and expressed. Temporal factors relate to the chronology of symptoms, life course, and the historical context in which illness develops. Additionally, current BPS formulations emphasize the subjective appraisal of illness, stigma, and the need to view the patient not only through static categories but through a dynamic, evolving psychosocial narrative.

For example, in a case of cardiovascular disease (CVD) in a 55-year-old man, a BPS approach would consider:
- Biological: Hypertension, family history, and inflammatory processes.
- Psychological: Stress reactivity, coping styles, and illness perceptions.
- Social: Occupational demands, socioeconomic constraints, and family support.
- Cultural and temporal context: Norms around masculinity and emotional expression, attitudes toward preventive care, and how life stage or recent losses may influence symptom interpretation.

Using the BPS model, the case is understood not as a purely medical event but as a multi-dimensional process shaped by the patient's environment, identity, and lived experience.
Grading criteria

Grade	Description
A	Accurate definition and comparison of BPS vs. biomedical model. Integrates recent theoretical advances (e.g., cultural, temporal, contextual) from Bashmi et al. (2023) or the lecture. Applies the model clearly to a cardiovascular disease case, covering all relevant dimensions.
B	Clear understanding and mostly complete. Uses case example and explains components well, though recent advances may be less detailed.
C	Basic explanation of the BPS model and case application. Some components may be generalized or missing. Advances not well integrated.
D	Limited or partial understanding. Case application is vague or oversimplified. Theoretical depth is lacking.
E	Inadequate explanation or significant omissions. May misrepresent the BPS model or provide little context.
F	No clear understanding of the BPS model. Missing, off-topic, or incoherent answer.

Behaviour Change Wheel – Short Essay Exam Question
Question:
What is the Behaviour Change Wheel (BCW), and how does it help structure the design of behavior change interventions? Describe its core components and explain how you would use this framework to promote physical activity in individuals diagnosed with cancer. Use a concrete example to support your explanation.
Spørsmål (norsk):
Hva er Behaviour Change Wheel (BCW), og hvordan hjelper det med å strukturere utformingen av atferdsendrende intervensjoner? Beskriv modellens kjernedeler, og forklar hvordan du ville brukt den for å fremme fysisk aktivitet hos personer med kreft. Bruk et konkret eksempel for å støtte forklaringen din.
Example of an A-answer:
The Behaviour Change Wheel (BCW), developed by Michie et al. (2011), is a comprehensive, theory-based framework for designing behavior change interventions. It is organized in three concentric layers:

1. The COM-B model (at the core)
2. Intervention functions (middle layer)
3. Policy categories (outer layer)

According to the COM-B model, behavior (B) arises from the interaction of:
- Capability: Physical and psychological ability
- Opportunity: Physical and social opportunity
- Motivation: Reflective and automatic drivers

Intervention functions include:
Education, Persuasion, Incentivisation, Coercion, Training, Restriction, Environmental restructuring, Modelling, Enablement.

Policy categories include:
Communication/Marketing, Guidelines, Fiscal measures, Regulation, Legislation, Environmental/social planning, Service provision.

Example – A 60-year-old woman recovering from breast cancer is sedentary and anxious post-treatment:
- Capability: Provide education and training on safe activity during recovery.
- Opportunity: Address lack of local services by offering virtual programs and community walking paths.
- Motivation: Use peer stories and coaching to increase belief in benefits and reduce fear.

Interventions might include a mobile app, home-based training videos, and personalized goal setting.
Policy support might involve national rehabilitation guidelines, subsidized local services, and awareness campaigns.
Grading criteria
Grade Description
A Accurately explains BCW and COM-B components. Clearly applies all three components to the case. Includes appropriate intervention functions and policy categories. Strong, tailored case example.
B Good understanding of BCW. Applies COM-B with minor omissions. Case example is appropriate but may lack depth.
C Basic understanding. Defines BCW correctly but lacks detail or clarity in application. General example.
D Partial understanding. Misapplies COM-B or offers vague links to the case. Theoretical explanation weak.
E Weak explanation. Confuses concepts or offers generic, unsupported statements.
F No understanding of BCW. Off-topic, incoherent, or missing required components.

Chronic Pain – Short Essay Exam Question
Question:
Chronic pain is one of the most common health complaints in Norway and a growing public health concern. Describe the main components that make chronic pain difficult to assess and manage. Describe the prevalence and risk factors of chronic pain in Norway. Then, explain how a biopsychosocial approach can guide prevention or management strategies for chronic pain.
Spørsmål (norsk):
Kroniske smerter er blant de vanligste helseplagene i Norge og representerer en økende folkehelseutfordring. Beskriv hovedkomponentene som gjør det vanskelig å vurdere og håndtere kroniske smerter. Beskriv forekomst og risikofaktorer for kroniske smerter i Norge. Forklar deretter hvordan en biopsykososial tilnærming kan veilede forebygging eller behandling av kroniske smerter.
Example of an A-answer:
Chronic pain is defined as pain lasting for more than three months and is recognized as a leading cause of disability in Norway. According to Breivik et al. (2008), around 19% of adults in Norway experience chronic pain, with higher prevalence in women, older adults, and individuals with lower income and education. It affects physical, emotional, and social functioning, and is linked to poor sleep, depression, and reduced quality of life.

Several factors make chronic pain complex to assess and manage. First, pain is subjective—there are no definitive biological markers. Breivik et al. highlight the multidimensional nature of pain, including sensory, affective, cognitive, and behavioral components. Assessment must go beyond simple pain scales to include functioning, mood, and coping.

Risk factors are biological (e.g., genetics, inflammation), psychological (e.g., anxiety, catastrophizing, depression), and social (e.g., isolation, workplace stress, socioeconomic status). Women and people living in rural areas are more likely to report disabling chronic pain.

The biopsychosocial model provides a holistic framework for understanding and treating chronic pain. It emphasizes the interaction between body, mind, and environment. Effective management involves interdisciplinary treatment, including:
- Education and reassurance to reduce fear-avoidance
- Graded physical activity
- Psychological therapies, particularly Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT)

A groundbreaking addition to psychological treatment is Pain Reprocessing Therapy (PRT), as explored by Ashar et al. (2021). PRT reframes chronic pain as a product of altered brain processing rather than ongoing tissue damage. Their RCT showed that patients receiving PRT had substantial and lasting reductions in pain and improved emotional wellbeing.

In conclusion, chronic pain in Norway is highly prevalent and multifactorial. Applying the biopsychosocial model—while integrating innovations like PRT and comprehensive functional assessments—can help patients regain quality of life and reduce healthcare costs.
Grading criteria:
Grade Criteria
A (Excellent) Fully answers all parts of the question with a clear and coherent structure. Demonstrates a strong understanding of chronic pain assessment challenges (e.g., subjectivity, multidimensionality), and clearly explains the biopsychosocial model. Integrates both Breivik et al. (2008) (on pain assessment tools, quality of life, and functional impact) and Ashar et al. (2021) (on brain-based pain mechanisms and Pain Reprocessing Therapy). Provides an insightful reflection on combining clinical and psychological perspectives.
B (Very Good) Covers most aspects of the question accurately. Refers to both readings but may describe one in more depth than the other. Shows a good grasp of chronic pain as a complex phenomenon and provides a reasonable explanation of the biopsychosocial approach. Structure and clarity are solid.
C (Good) Adequate response that covers the basics of pain complexity and the biopsychosocial model. Mentions only one paper (usually Breivik or Ashar) or refers to both but superficially. May miss details about assessment or intervention.
D (Satisfactory) Partial understanding. Discusses chronic pain in general terms but with little or unclear reference to the assigned readings. May show confusion about assessment or treatment models. Weak structure or incomplete arguments.
E (Poor) Minimal or inaccurate explanation of key concepts. No meaningful use of the papers. Shows limited understanding of the topic or omits core components (e.g., fails to address assessment or biopsychosocial model).
F (Fail) Off-topic, incoherent, or completely missing required elements. No use of relevant evidence or models. Fails to demonstrate understanding of chronic pain or the assigned literature.

Health Disparities – Short Essay Exam Question
Question:
Health disparities persist in Norway despite the country's universal welfare system. Discuss the main social and political factors that contribute to these disparities. Explain how national strategies and policy frameworks attempt to reduce inequalities and reflect on the challenges of implementing structural or "upstream" solutions at the municipal level.
Spørsmål (norsk):
Helseforskjeller vedvarer i Norge til tross for landets universelle velferdssystem. Drøft de viktigste sosiale og politiske faktorene som bidrar til disse forskjellene. Forklar hvordan nasjonale strategier og politiske rammeverk forsøker å redusere ulikheter, og reflekter over utfordringene med å implementere strukturelle eller «oppstrøms» løsninger på kommunalt nivå.
Example of an A-answer:
Despite Norway's strong welfare state and universal health coverage, health disparities persist, shaped by underlying social determinants of health. These include income, education, employment status, housing conditions, and neighborhood characteristics. People with lower socioeconomic status consistently experience worse health outcomes and shorter life expectancy than more privileged groups.

Fosse (2022) emphasizes that these disparities are structurally produced and not solely the result of individual behavior. She distinguishes between upstream policies, which address the root causes of health inequalities (e.g., taxation, labor markets, education policy), and downstream policies, which focus on individual-level factors (e.g., smoking cessation or dietary advice). Although upstream action is often endorsed in policy documents, implementation tends to drift downstream, especially at the municipal level where power and resources are limited.

The Public Health Act (2012) institutionalized the responsibility of municipalities to promote health equity and created tools like local health overviews. However, Eikemo (2019) points out a disconnect between evidence and policy. He highlights the need for policies that directly address the social gradient in health, advocating for "evidence-based politics" rather than just "policy-based evidence." He also emphasizes that current health monitoring systems often fail to capture inequality-sensitive indicators, making targeted intervention difficult.

Challenges at the local level include limited legal authority, insufficient intersectoral collaboration, and competing political priorities. Addressing health disparities requires multi-level governance, stronger national coordination, and the political will to tackle complex, long-term issues.

In summary, health disparities in Norway are deeply embedded in structural and social systems. While policy frameworks like the Public Health Act signal a commitment to equity, effective action depends on the capacity and willingness to implement upstream, systemic interventions at all levels of governance.
Grading criteria:
Grade Criteria
A (Excellent) Well-structured and comprehensive response. Demonstrates strong understanding of the social and political determinants of health inequalities in Norway. Clearly explains the rationale behind national public health policies and upstream strategies. Reflects critically on implementation challenges, including at the municipal level. Effectively integrates advanced perspectives consistent with academic literature (e.g., implicit use of concepts from Fosse and Eikemo), even if not cited by name.
B (Very Good) Covers all core elements of the question. Demonstrates a clear understanding of health disparities and policy responses. Discusses implementation issues in some depth. Includes informed insights that suggest engagement with relevant academic literature, though integration may not be complete.
C (Good) Adequate answer that addresses key points but may simplify complex issues. May generalize or overlook distinctions between upstream and downstream strategies. Limited or superficial discussion of implementation. Academic insight may be present but underdeveloped.
D (Satisfactory) Basic understanding of health disparities. May overlook structural or policy-level factors. Discussion of national strategies and implementation is vague or minimal. No clear signs of engagement with deeper theoretical or policy frameworks.
E (Poor) Superficial or confused explanation. Focuses largely on individual-level factors. Fails to address national policy or structural challenges. Lacks insight and shows little awareness of academic or policy discussions.
F (Fail) Off-topic, incoherent, or missing key content. No meaningful understanding of health disparities, policy strategies, or structural frameworks. Fails to demonstrate basic comprehension of the question.

Oppgavetekst er kvalitetssikret av *

Ruben and Laura

Karakterskala som er benyttet *

Karakterskalaen - Kunnskapsbasen - NTNU
Bestått - Kandidaten har oppnådd kravene til læringsutbytte og viser nødvendige kunnskaper, ferdigheter og kompetanse.
Ikke bestått - Kandidaten har ikke oppnådd kravene til læringsutbytte og viser ikke nødvendige kunnskaper, ferdigheter og kompetanse.

Bokstavkarakter

Eventuelle vedlegg (tabeller, bilder o.l.)

Merk at oppgaveteksten, pensum og og sensorveiledningen limes inn i feltene ovenfor.

Ikke besvart

Ikke besvart

Ikke besvart