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COUN 6785: Social Change in Action:
Prevention, Consultation, and Advocacy

Social Change Portfolio

Sheaunna Guary

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Obesity in Thurston County Washington

Thurston County Washington is experiencing a steady increase in the rates of adult obesity within our community. Obesity can have a negative impact on the mental, physical, and financial health of individuals and the county at large (Pul & Suh, 2015). As such, the author proposes addressing this community issue through a social change project that contains both preventative measures as well as postvention efforts to address and decrease rates of obesity in Thurston County Washington.

PART 1: SCOPE AND CONSEQUENCES

Obesity in Thurston County Washington

Thurston County Washington is experiencing a problem with Adult Obesity. Adult Obesity has been steadily rising since 2004 in my community (Country Health Rankings & Roadmaps, 2018). Presently adult obesity occurs in Thurston County at rates nearly 10% higher than the rest of Washington State and 5% higher than national averages (Country Health Rankings & Roadmaps, 2018).

Obesity touches every aspect of individual and community life from physical health to community economics. Common physical consequences include cardiovascular disease, Type two diabetes, hypertension, ischemic stroke, cancer, dyslipidemia, and reproductive disorders (Chu et al., 2018). Mental health issues are linked to being overweight and obese. Psychological distress, major depressive episodes, mood disorders, anxiety disorders, and other mental health issues frequently coincide with Obesity (Romain, Marleu, & Baillot, 2019). Mental health and physical issues with obesity can be linked to social, family, and educational problems as well. Evidence has examined stigmatization as a unique contributing factor to negative health outcomes that exacerbate obesity (Pul & Suh, 2015). With stigma, individuals are

more likely to self-isolate thus decreasing the likelihood of individuals with obesity to have positive interactions with others and be active contributors to their community or seek out higher education (Pearl & Lebowitz, 2014). Furthermore, families are likely to feel the negative consequences of having obese family members. Those who have physical and mental health issues are likely to place higher stress on their families mentally and financially (Moxley et al., 2019). Furthermore, studies show that when adults in a family are obese, their children are more likely to be obese and suffer from a lifetime of negative physical, economic, social, and mental health issues (Moxley et al., 2019). Finally, obesity can further lead to numerous lethal health issues, decreased ability to contribute to community resources and income, and can cost communities more in mitigating the cost of mental and physical health problems in preventing and decreasing obesity (Chu et al., 2018).

When examining the rise of obesity in Thurston county as well as the negative consequences tied to obesity, the author proposes the following goal: To decrease obesity by at least five percent in the next five years, through partnering with local organizations and governments, to increase access to and promote community gardens, distributing information on obesity through community centers, as well as creating a community fitness goal and activities.

PART 2: SOCIAL-ECOLOGICAL MODEL

Obesity in Thurston County Washington

It is important that recommendations keep in mind the social-ecological model. The social-ecological model takes into account that all individuals are a part of a community and that context of the environmental influence individual choices (Swearer & Hymel, 2015). Individual, family, and community beliefs, attitudes, availability, culture, and so forth impact the choices one makes (Swearer & Hymel, 2015). Various factors influence the rates in which obesity occurs. The development of difficulties involves and

interaction of both biological, cognitive, and environmental contexts (Swearer & Hymel, 2015). Risk factors are something that influences the causation of a problem (American Mental Wellness Association, n.d.).

Protective factors are things that help prevent problems (American Mental Wellness Association, n.d.).

There are various risk and protective factors that influence obesity on individual, peer, family, and community/cultural levels.

Individual Risk and Protective Factors of Adult Obesity

There are many protective and risk factors of adult obesity that occur on an individual level. Some contributing risk factors that have been identified include the following: insufficient sleep duration (Buxton & Marcelli, 2010), access to insurance and care (Buxton & Marcelli, 2010), lower education level (Buxton & Marcelli, 2010), having been a smoker (Buxton & Marcelli, 2010), Exhibiting psychological distress (Buxton & Marcelli, 2010), being middle-aged to older (Chen, 2015), physical inactivity (Chen, 2015), insufficient knowledge as it relates to healthy living (Reed et al., 2016), negative attitudes about eating and exercise (Reed et al., 2016), lack of time (Reed et al., 2016), financial insecurity or not being able to afford healthier foods (Reed et al., 2016), personal dislike of the taste of healthy foods (Reed et al., 2016), working more than 40 hours a week (Reed et al., 2016), and lack of desire ((Reed et al., 2016). Various individual protective factors exist such as: receiving seven to eight hours of sleep (Buxton & Marcelli, 2010), having attained higher levels of education (Buxton & Marcelli, 2010), never having smoked (Buxton & Marcelli, 2010), being physically active (Chen, 2015), increased knowledge about healthy lifestyle choices (Chen, 2015), positive regard and belief systems around healthy eating and physical activity (Reed et al., 2016), working between 30 and 40 hours a week (Reed et al., 2016), emotional self-regulation (American Mental Wellness Association, n.d.), good coping skills (American Mental Wellness Association, n.d.), positive self-regard (American Mental Wellness Association, n.d.), and being future-oriented (American Mental Wellness Association, n.d.).

Family Risk and Protective Factors of Adult Obesity

Family can either support healthy habits or reinforce less than healthy habits. Studies have identified the following risk factors with family and Obesity: family history of obesity (Cederberg, Stancakova, Kussisto, Laakso, & Smith, 2015), being married (Buxton & Marcelli, 2010), living alone (Reed et al., 2016), Lack of family support with dietary and exercise changes (Reed et al., 2016). Protective familial elements include having a supportive family relationship (American Mental Wellness Association, n.d), having at least one college-educated family member (Buxton & Marcelli, 2010), being single (Buxton & Marcelli, 2010), living with others (Reed et al., 2016).

Community and Cultural Factors of Adult Obesity

Community and cultural factors, combined with family factors, are as equally influential in the risk and prevention of obesity as individual factors (Buxton & Marcelli, 2010). Community and cultural risk factors consist of: Residing in the Midwest and Southern regions of the United States (Buxton & Marcelli, 2010), being Black, Hispanic, or Pacific Islander (Chen, 2015), types of foods in a community (Chen, 2015), being in a community with higher amounts of fast-food restaurants (Chen, 2015), lack of neighborhood accommodations such as parks, sidewalks, bike lanes, recreational activities, etc. (Chen, 2015), lack of community centers (Chen, 2015), lack of access to grocery stores and gardens (Reed et al., 2016), and glamorization of unhealthy foods presented in the community (Reed et al., 2016). Protective factors against obesity in the community involve: Residing in the Northeast or West (Buxton & Marcelli, 2010), being of Asian heritage or foreign-born status (Buxton & Marcelli, 2010), Having access to supermarkets and full-service restaurants (Chen, 2015), Access to neighborhood accommodations such as parks, sidewalks, protected bicycle lanes, public transportation, and recreational facilities (Chen, 2015), Community centers and churches with a focus on physical activity (Chen, 2015), access to gardens (Reed et al., 2016), good peer and community relationships (American Mental Wellness Association, n.d),

participation in sports teams, club, community, or religious groups (American Mental Wellness Association, n.d), access to supportive services (American Mental Wellness Association, n.d).

PART 3: THEORIES OF PREVENTION

Obesity in Thurston County Washington

Many medical professional intervention models recognize the importance of prevention. It is often beneficial and more cost-effective to prevent a problem before it happens than to mitigate the effects afterward (Hage & Romano, 2013). Theories help inform practice and increase the likelihood of effectiveness of interventions (National Cancer Institute, 2005). The author proposes the use of the theory of reasoned action and planned behavior (TRA/PB) as well as the health belief model (HBM) to implement in designing a prevention program in Thurston County to target adult obesity.

The theory of reasoned action and planned behavior, or TRA/PB theory, is a combination of a belief that there is a relationship between a person's attitudes, beliefs, and behaviors that are under the person's control (TRA) and the person's belief about the extent that behavior is under their control (PB) (Hage & Romano, 2013). TRA/PB contends that attitudes are a strong predictor of behavior change (Hage & Romano, 2013), as well as that behavior is a function of intentions, and intentions are a function of attitudes, social norms, and perceived beliefs about control (Hage & Romano, 2013). As previously cited in this paper, one of the predictors of obesity within a community center around individual, community, and cultural beliefs about contributing factors of obesity such as diet, exercise, and sedentary living (Hage & Romano, 2013) as well as access to healthy foods and medical interventions within the community on individual and community levels (Reed et al., 2016). If practitioners can increase individual and community perceived beliefs about their control with regards to these issues preventively (i.e.: involving community

members in creating community gardens, normalizing community exercise, etc.), instead of what may be the present belief, that individuals and community have little to no control over these preventative measures, it may decrease obesity rates preemptively (Stewart & Ogden, 2019). Further research has demonstrated that if individuals believe that they are capable of managing their weight and it is culturally normative to do so, as a health preventative measure, obesity rates decrease (Lau et al., 2019).

Health Belief Model (HBM) theory utilizes an ecological model that was formulated as a way to study and address why individuals may not participate in preventative programs that would benefit them ((National Cancer Institute, 2005). This theory utilizes individuals and communities perceived susceptibility (beliefs about the chances of getting a condition as well as its seriousness and consequences), perceived benefits from taking action to reduce the risk of developing a condition (cost of preventative action versus cost of potentially developing condition), the potential to change strategies, and cues to action (factors that activate awareness such as television messages, alarms, and community reminders) ((National Cancer Institute, 2005). HBM is an appropriate preventative theory when working with adult obesity in Thurston County, Washington because it considers prevention on an ecological model level. Through using this theoretical preventative model, practitioners can assess and increase awareness of the serious side effects of obesity for the community, individuals, and families, the cost and benefits of preventative actions, as well as implementing more cues to action within the community (such as posters, radio announcements, commercials, etc.). Studies have found that HBM based interventions decrease rates of obesity in communities (Hattar, Pal, & Hagger, 2016).

An obesity treatment program in Baltimore is an evidence-based program that Thurston County could model a preventative program after. This obesity treatment program was a randomized controlled trial program in Baltimore, that utilized the theory of reasoned action and planned behavior (TRA/PB) as well as the health belief model (HBM) (Appel et al., 2011). This program found that individuals who were

randomly assigned to participate in learning modules as well as support from coaches and medical teams were more likely to lose and maintain weight loss over time than those who did not receive interventions (Appell et al., 2011). The cost of this program was less than \$200 per participant for a three-year program (Appell et al., 2011). Other programs that have implemented similar HBM and TRA/PB based interventions have found similar results (Apell et al., 2011).

PART 4: DIVERSITY AND ETHICAL CONSIDERATIONS

Obesity in Thurston County Washington

Obesity is considered a universal issue across all cultures in the United States, including Thurston County, however, studies show that obesity is more prevalent among adults in diverse populations. Ethnic minorities, low socioeconomic status individuals, and sexual minorities experience rates of obesity higher than their counter populations (Circiurkaite & Perry, 2018) (Cuevas, Ortiz, & Ransom, 2019) (Kumanyika, 2019) (Lincoln, Abdou, & Lloyd, 2014) (Newlin Lew, Dorsen, Melkus, & Maclean, 2018) (Stanford, Lee, & Hur, 2019). Within these three diverse populations, obesity consistently occurs at higher rates specifically amongst African-American females (Circiurkaite & Perry, 2018) (Cuevas, Ortiz, & Ransom, 2019) (Kumanyika, 2019) (Lincoln, Abdou, & Lloyd, 2014) (Newlin Lew, Dorsen, Melkus, & Maclean, 2018) (Stanford, Lee, & Hur, 2019). Females who are African-American are 51% more likely to be obese when compared to non-Hispanic White Americans (Licoln, Abdou, & Lloyd, 2014). Furthermore, of the African American females who are considered medically obese, 31% will experience comorbid disorders associated with obesity (Stanford, Lee, & Hur, 2019). This means that not only do African American females have higher than any other population in obesity, but also in obesity-related medical issues such as high blood pressure, metabolic disorders, etc.

When addressing obesity in Thurston County, it is important to increase cultural relevance specific to African American (AA) females. There are various means to increase the cultural relevance of prevention programs with AA females, one of which would be collaborating with AA women to alter traditional family recipes and soul food to be healthier while retaining flavor and cost-effectiveness (Young, 2018). This may be done in a community outreach concurrent with information about health as it relates to obesity (Young, 2018). Another preventative mechanism that may be employed is including faith-based interventions through collaborating with local churches that have a predominant AA presence. Research has shown that AA females and their family's rates of obesity are sustainably decreased when efforts are made to collaborate with local churches and faith-based programs to support and encourage weight loss (Derose et al., 2019). Such programs may include sermons about the importance of health, prayer walks, brochures about obesity, and faith-based health classes, as well as other interventions that church leaders feel would best serve their community with regards to obesity (Derose et al., 2019). Finally, a third intervention that would be helpful in preventative measures with decreasing rates of AA female obesity would be to address systemic discrimination and oppression within Thurston County. Stress-related to racism, oppression, and discrimination is strongly linked to obesity (Scott, Gil-Rivas, & Cachelin, 2019). Addressing systemic racism, oppression, and discrimination through continuously monitoring, adjusting, and analyzing local resources for racism, bias, and oppression, as well as giving voice to AA females to discuss their lived experience is imperative to have any lasting preventative effect (Scott, Gil-Rivas, & Cachelin, 2019).

When implementing preventative interventions for specific diverse populations within the community, practitioners should take into account core ethical considerations. Socially justice and culturally relevant preventative practice are most effective and culturally appropriate when practitioners collaborate with stakeholders (Vera & Kenny, 2013). As it relates to creating a culturally appropriate preventative program, it is important in Thurston County to collaborate with African American (AA) females as they are

statistically the most directly impacted population to experience rates of obesity (Lincoln, Abdou, & Lloyd, 2014) meaning that this group is one of the main stakeholders in preventing obesity (Vera & Kenny, 2013). Before engaging in any advocacy efforts, including preventative measures to address obesity in the AA community, clinicians must seek to gain general consent from members of the AA community per American Counseling Association (ACA) standard A.7.b. (ACA, 2014). Any participants in preventative collaboration, program association, and so forth must be informed of potential risks, benefits, and aspects of intervention and advocacy that may impact them so that said individuals may make proper informed consent to participate in preventative measures (Vera & Kenny, 2013). Practitioners must make certain to disclose all pertinent information to able adults before informed consent may be given (Vera & Kenny, 2013). Lastly, it is important that when conducting any activity with individuals, clinicians maintain confidentiality (ACA, 2014). Individual personal information and identities must remain confidential unless individual consents to the release of their personal information (Vera & Kenny, 2013). Without collaboration with stakeholders, particularly diverse populations served, informed consent, and maintaining confidentiality, it is more likely that even a well-meaning preventative program will have increased potential to be ineffective and possibly perpetuate aggression against the very population they intend to serve (Vera & Kenny, 2013).

PART 5: ADVOCACY

Obesity in Thurston County Washington

To address obesity in Thurston County, the author contends that it is important to advocate for adults with obesity by identifying barriers and actions to take on institutional, community, and public policy levels. Competent practitioners advocate through identifying and taking action to address any barriers that negatively impact the growth and development of those they serve (ACA, 2014).

When advocating for adults with obesity potential barriers that may need addressing at institutional levels include inequalities through lack of support and increased stigma in churches, community organizations, and businesses that negatively impact the mental health and efforts of prevention and treatment as it relates to obesity (Pearl & Lebowitz, 2014). Studies note, for instance, that in some institutions, such as businesses, employees can be less attentive and helpful to individuals that are considered obese or overweight, thus increasing internalized and externalized stigma (Puhl & Suh, 2015). Increased stigma results in decreased effectiveness of prevention and treatment of obesity (Puhl & Suh, 2015). One advocacy action practitioners may take to address this inequality, as advised by the Multicultural and Social Justice Counseling Competencies (MSJCC) is to collaborate with social institutions to address issues of power, privilege, and oppression as it impacts adults with obesity to remove barriers that promote privilege (MSJCC, 2013). This may include body positivity training, discussion of implicit bias, and creating support and information groups as body positivity and implicit bias training has been shown to decrease stigma as it relates to obesity (Pearl & Lebowitz, 2014).

At a community level, clinicians need to address social norms, values, and regulations that are embedded in society that are oppressive to adults with obesity (MSJCC, 2013). To address norms that disempower adults with obesity, clinicians may employ social advocacy to address community norms and values that are shown to hinder the growth of adults with obesity in their health goals (MSJCC, 2013) such as the belief that individuals who are obese are less capable (Liu, Lee, McLeod, & Choung, 2019). Addressing community social norms and values can decrease stigma and increase public awareness and understanding about obesity and its impact on the community, thus increasing the likelihood of community involvement in preventative and treatment measures (Pirog & Good, 2013).

Finally, public policy may be a barrier to adults with obesity in Thurston County through laws and policies that impede access to preventative aides as well as a lack of protective laws, such as anti-

discrimination laws as it relates to obesity (MSJCC, 2013). To address this barrier, a counselor would need to initiate discussions, conduct research, and engage in social actions to understand how laws and policies at local, state, and federal levels impact adults with obesity (MSJCC, 2013). Furthermore, practitioners can assist with creating laws and policies that promote social justice for adults with obesity, potentially through collaboration with those most affected (MSJCC, 2013). This may include working with lawmakers, members of the community, and local health practitioners to create laws that increase access to healthy foods, gyms, and medical services, as well as other preventative and treatment programs for populations most impacted by adult obesity in Thurston County-based off of research, as access to healthy foods and preventative measures, is identified as a predominant predictor of obesity (Reed et al., 2016).

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