2020

Promoting Healthy Strategies to Reduce Obesity

Jarae Swanstrom

COUN 6785: Social Change in Action:

Prevention, Consultation, and Advocacy

Social Change Portfolio

Jarae Swanstrom

Contents

Below are the titles for each section of the Social Change Portfolio. To navigate directly to a particular section, hold down <ctrl> and click on the desired section below.

Please do not modify the content section, nor remove the hyperlinks.

[Please note that in brackets throughout this template you will see instructions about information to include in each section. Please delete the instructions that are found in brackets, including this message, and replace the bracketed instructions with the relevant content for each section].

OVERVIEW

Keywords: Obesity Prevention in Sandpoint Idaho

Promoting Healthy Strategies to Reduce Obesity

Goal Statement: This social change portfolio promotes community awareness and encourages individual behavior modifications, seeking to improve the obesity epidemic in Sandpoint, Idaho.

Significant Findings: Sandpoint, Idaho, is seeing an increase in individuals with obesity. Last year alone, obesity was ranked third as the most significant health problem in Bonner County, and diet and exercise were among the influencing factors (Bonner General Health, 2019). Obesity increases an individual's risk of developing other physiological and mental health conditions and decreases quality of living (CDC, n.d.). One significant risk factor for obesity is living in poverty. Individuals living in poverty are less likely to have affordable options for nutritious foods and physical activity (CDC, n.d.). More specifically, low-income women are at increased risk of becoming obese. Paring the Transtheoretical model of behavior change with behavior modification interventions shows positive results in obesity prevention.

Objectives/Strategies/Interventions/Next Steps: There are many strategies to promote obesity prevention within the community. First, focus prevention efforts on promoting positive coping and problem-solving skills in individuals. Second, collaborate with schools to provide nutritious meals and increase physical activity among students. Third, work with community organizations to identify affordable and wholesome food and physical activity options. Fourth, focus on the family environment with diet and exercise modifications. Finally, use evidence-based programs such as behavioral coaching to promote lifestyle modifications and weight reduction (Social Programs that Work, 2019).

INTRODUCTION

Promoting Healthy Strategies to Reduce Obesity

Sandpoint is a rural community in Northern Idaho with a population of 9,000 in the city limits and 46,000 within the county. Sandpoint is the largest town and the primary source for all services within Bonner County. There is an abundance of outdoor activities to enjoy with the largest and deepest lake in Idaho and many mountains nearby. Even though Sandpoint residents have many options to stay physically active and maintain a healthy weight, a continual rise in obesity within the community and across America has become a trend (County Health Rankings & Roadmaps, 2018). Likewise, the lack of affordable healthy food options has influenced obesity trends in Bonner County. Over the past 20 years, we have seen an increase in information and campaigns to encourage healthy body weights and lifestyles. However, Americans are considered to be heavier and more sedentary than ever. There is still a disconnect. The information is there, but it does not reach those who need it most, rural communities and communities with higher poverty rates.

PART 1: SCOPE AND CONSEQUENCES

Promoting Healthy Strategies to Reduce Obesity

Since 1975 the obesity rate has nearly tripled, with 650 million adults and 38 million children classified as obese (WHO, n.d.). As of 2018, almost half (42%) of the U.S. population is considered to be obese with a body mass index (BMI) of 30.0 or higher (CDC, n.d.). Idaho, particularly Sandpoint, sees an increase in obesity, with 26% of its adult residents falling in the obese category, and this trend is on the rise (County Health Rankings & Roadmaps, 2018). Idaho

also has a significant amount (62%) of residents who are categorized as overweight with a BMI of 25.0 and higher (CDC, 2012). An unbalanced diet and sedentary lifestyles play a significant role in the obesity rates in Bonner County and throughout Idaho. On a daily average, only 33% of residents reported consuming the daily recommendation for fruit, while only 28% reported consuming the daily recommendation for vegetables (CDC, 2012). Additionally, only half of Idaho adults meet the recommended physical activity guidelines of 300 minutes of moderate-intensity aerobic activity or 150 minutes of vigorous-intensity aerobic exercise (CDC, 2012).

Idaho is ranked 36 for childhood obesity, with 12.7% of adolescents classifying as obese (State of Childhood Obesity, n.d.). While the current number of obese adolescents in Idaho is somewhat low, the diet and exercise habits are placing them at risk to become obese adults. 71% of children did not meet the daily recommendation of fruits in their diet per day, while 89% of children failed to meet the daily recommendation of vegetables per day (CDC, 2012). These numbers indicate that Bonner County children are forgoing a whole food diet for a more convenient, highly processed diet full of sugar. Additionally, only 28% of Idaho children are meeting the recommendation of at least 60 minutes of physical activity per day (CDC, 2012). Only 24% of children participated in a physical education class in an average school week (CDC, 2012). Screen time is another primary culprit in the obesity epidemic of children. Rideout and Robb (2019) found that children between eight and twelve years old spend an average of five hours, and teens spend an average of seven and a half hours on a device per day, not including time spent on a device for homework.

The Bonner County Community Health Needs Assessment (2019) indicated that obesity was ranked third as the most significant health problem, right under mental health and access to care. It was determined that behaviors that made the most significant impact on the overall health

of Bonner County residents were alcohol abuse (56%), drug abuse (54%), eating unhealthy foods (53%), not exercising (42%), and overeating (35%) (Bonner General Health, 2019). Of the residents surveyed, 58% believed themselves to have very good overall health (Bonner General Health, 2019). However, when seeking health care services, 35% have joint pain or back pain, 31% have overweight or obesity-related challenges, and 16% have high blood pressure (Bonner General Health, 2019). The above difficulties residents seek health services for are linked to diet, exercise, and weight, indicating a disconnect between one's view towards overall health and a healthy lifestyle. Nonetheless, residents understand that affordable health screenings, mental health services, wellness services, more nutritious food options, and recreational facilities are all needed to improve overall health (Bonner General Health, 2019).

Obesity is a multifaceted issue influenced by genetics (family history, ethnicity), community factors (home, childcare, schools, healthcare), and individual behaviors (exercise, diet, inactivity, medication use) (CDC, n.d.). Moreover, obesity is a factor among the leading causes of death in the U.S. and the world and is associated with a decline in mental health and quality of living (CDC, n.d.). Obesity has many consequences that affect the individual and the community. Individuals with obesity are at a higher risk of developing high blood pressure, high cholesterol, type 2 diabetes, cancer, and sleep problems (CDC, n.d.). Daily movements become challenging, and muscle and joint pain are likely (CDC, n.d.). Moreover, obesity increases an individual's likelihood of developing mental health conditions, such as depression and anxiety (CDC, n.d.). At the community level, obesity and its associated diseases account for most healthcare costs through prevention, diagnostic, treatment, and indirect cost through the loss of productivity at work (CDC, n.d.). It is estimated that the cost of treating obesity-related

conditions in the United States is 147 billion dollars, with a loss of productivity costing between three to six billion dollars per year (CDC, n.d.).

Americans have changed the way they eat over the last 50 years, with diets focused heavily on processed foods and dining out (CDC, n.d.). Convenient foods are higher in sugar, fat, and calories than whole foods and foods prepared at home (CDC, n.d.). Likewise, people in low income and rural communities have less access to affordable and quality food options (CDC, n.d.). Bonner County has a high rate of children living in poverty (County Health Rankings & Roadmaps, 2018). The quality food options Sandpoint does have are difficult for many in the community to afford. Additionally, sedentary lifestyles due to the rise in screen time, longer commute times, and limited areas to engage in physical activity contribute to the obesity epidemic (CDC, n.d.). Sandpoint sees an increased amount of screen time during the winter months due to the long and cold winters making it less appealing and more difficult for outdoor physical activities.

This social change portfolio promotes community awareness and encourages individual behavior modifications, seeking to improve the obesity epidemic in Sandpoint, Idaho.

PART 2: SOCIAL-ECOLOGICAL MODEL

Promoting Healthy Strategies to Reduce Obesity

In Bonner County, prevention efforts need to reduce obesity-related risk factors while promoting protective factors (SAMHSA, n.d.). Risk factors associated with obesity fall into two categories, those that can be prevented or changed, and those that are inherited and cannot be altered (NIH, n.d.). Fixed risk factors of obesity include age, family history, genetics, race, ethnicity, and sex (NIH, n.d.). For example, obesity is more prevalent in blacks and Hispanics

than other ethnicities in America, and of those ethnicities, females are at a higher risk (NIH, n.d.).

There are several malleable risk factors for obesity that one could modify to revert or prevent obesity. A sedentary lifestyle due to prolonged sitting and an unhealthy diet filled with too much sugar and bad fats increases an individual's risk of becoming obese (NIH, n.d.). Not getting enough sleep at night and having a lot of stress have been linked to higher BMIs and disruption in hormones such as cortisol that controls energy balance (NIH, n.d.). Additionally, an inability to cope with negative emotions, low self-esteem, depression, and trauma are risk factors associated with obesity (NEDC, n.d.). Protective factors at the individual level could include a positive body image, high self-esteem, emotional well-being, and good problem solving and coping skills (NEDC, n.d.). At the peer level, the social circle an individual chooses to hang around can influence emotional well-being, diet, and exercise habits. A protective factor could include a strong support network and relationships that emphasize body positivity and healthy lifestyles (NEDC, n.d.).

At the family level, having a lower socioeconomic status where healthy food options and recreational activities are not affordable is linked to obesity risk (NIH, n.d). A protective factor could include parental involvement, promoting family bonding through meal preparation, and physical activities (NEDC, n.d.). The quality of food choices in the school system, such as highly processed, high sugar items, and the decrease in physical activity requirements become obesity risk factors in children at the school level. Likewise, bullying or teasing can influence negative body image issues and emotional eating (NEDC, n.d.). Protective factors could include government regulations on the quality of foods at schools, emphasis on physical activity and

movement during the day, after school activities to promote healthy lifestyles and strong social skills among students.

A community factor for obesity is the amount of chemical exposure in an individual's environment. Chemical exposure disrupts hormones and increases fatty acid deposits in the body (NIH, n.d.). Additionally, living in an unsafe or rural neighborhood increases one's risk for obesity due to the limited availability of healthy food options and safe and available physical activity options (NIH, n.d.). A protective factor at the community level could include community gardens and affordable meal and physical activity options. Finally, cultural factors such as meal times and family traditional foods are a risk factor for obesity. A protective factor that addresses culture could be educational resources or classes on making traditional foods healthier.

PART 3: THEORIES OF PREVENTION

Promoting Healthy Strategies to Reduce Obesity

The transtheoretical model of behavior change (TTM) is a prevention theory developed to recognize how individuals change to diminish addictive behaviors (Hage & Romano, 2013). In the TTM, it is believed that individuals make a change based on going through six different stages: precontemplation (no desire to make change), contemplation (thinking about making a change within six months), preparation (taking steps to incorporate change in the next month), action (actively engaging in behavior modifications), maintenance (maintaining behavior change and focusing on relapse prevention), and termination (free from temptation) (Hage & Romano, 2013). Individuals with obesity typically eat more calories than their body needs and do not have enough physical activity in their daily routine (Tkalcic & Pokrajac-Bulain, 2006). These diet and exercise habits are difficult for individuals to change and can be seen as addictive behaviors. The

developers of the TTM realized that people do not fall on a continuum and, therefore, will not always be at the same level of readiness for change (Hage & Romano, 2013). This is why the TTM effectively combats obesity; it can predict where someone is in their behavioral change journey and adjust treatment techniques to meet individualized needs (Tkalcic & Pokrajac-Bulain, 2006). An individual in the precontemplation stage will not be provided intervention strategies designed to help someone work through the action stage and vice versa, ultimately strengthening adherence to the prevention program (Hage & Romano, 2013).

Tkalcic and Pokrajac-Bulain (2006) found validity in using TTM for behavior change in weight reduction of obese individuals. The study used three dimensions of the TTM: stages of change, self-efficacy and decisional balance, and the process of change (Tkalcic & Pokrajac-Bulain, 2006). Results indicated that the common factor in determining which stage of change an individual is in is based on weight change's pros and cons (Tkalcic & Pokrajac-Bulain, 2006). An individual in the precontemplation stage of change for obesity reduction will typically present more cons to changing behaviors than pros. In contrast, an individual in the action stage will typically display more pros (Tkalcic & Pokrajac-Bulain, 2006). Knowing this of the precontemplation stage, a clinician could focus intervention strategies on increasing pros to weight reduction, shifting the individual towards the next phases (Tkalcic & Pokrajac-Bulain, 2006).

Social Programs that Work (2018) provided an evidence-based program for treating obesity with behavioral coaching. The behavioral coaching program is a two-year program designed to provide weight management to obese individuals (Social Programs that work, 2018). The focus is on reducing caloric intake, increasing participants' physical activity, and delivering either in-person or remote support through phone calls (Social Programs that work, 2018). Of the

415 participants who completed the two-year program, 19.5% with in-person support and 18.3% with remote support lost at least 10% of their body weight (Social Programs that work, 2018). This indicated that remote support was just as successful as the in-person support (Social Programs that work, 2018).

PART 4: DIVERSITY AND ETHICAL CONSIDERATIONS

Promoting Healthy Strategies to Reduce Obesity

Some 36% of American women are obese, and another 28% are considered overweight (Gough, Lippert, & Martin, 2018). Obesity is more prominently seen in women with low socioeconomic status (Weber Buchholz, Huffman, & McKenna, 2012). The rise in obesity trends among women and specifically low-income women is due to multiple factors. Low-income women tend to have limited resources, not enough money to pay for health foods, and limited access to quality health care (Buchholz, Huffman, & McKenna, 2012). Moreover, childrearing responsibilities are associated with obesity and are influenced by socioeconomic status (Gough et al., 2018). Mothers tend to prioritize their children's well-being over their own limiting time for nutritious meals and consistent exercise (Gough et al., 2018). Gough et al. (2018) indicated the number of children a woman cares for is negatively associated with the amount of time spent on daily exercise. Additionally, women in poverty prioritize their children's nutritional needs ahead of their own when food resources and income are limited by skipping meals or consuming calorie-dense meals (Gough et al., 2018). Finally, gym memberships and exercise equipment are costly and often not obtainable for low-income women; a reason higher incomes are positively associated with exercise frequency (Gough et al., 2018).

Promoting healthy strategies to reduce obesity in low-income women needs specific considerations. First, due to a limited income, priority should be placed on providing strategies that will help clients learn how to effectively use their income and other resources such as government assistance to purchase healthy foods (Buchholz et al., 2012). Second, emphasis should be placed on the individual as well as the family environment (dietary needs and desires of everyone consuming meals) and support network (minimal support is a roadblock to weight loss) when working with low-income women with obesity (Buchholz et al., 2012). Finally, assessing the strength in committing to behavior changes is particularly crucial for low-income obese women (Buchholz et al., 2012). The number of overwhelming responsibilities these women have will influence their ability to commit to lifestyle changes and, therefore, should be prioritized when determining readiness to change (Buchholz et al., 2012).

When developing a prevention program for obesity is critical to identify and address some core ethical considerations. Standard A.1.a. of the American Counseling Association (ACA) Code of Ethics (2014) recognizes the responsibility counselors have to respect and promote clients' well-being. Additionally, standard A.4.b indicates that counselors should refrain from imposing personal beliefs and values onto clients (ACA, 2014). When developing a prevention program, it is vital to consider the well-being of clients and ensure that, at no point, the counselor's personal beliefs are conveyed to clients.

Obtaining informed consent is an ethical consideration crucial to ensuring clients' self-respect and independent participation (Hage & Romano, 2013). Informed consent can be challenging to secure in prevention programs due to treating large groups or individuals who are not currently seeking services (Hage & Romano, 2013). Regardless informed consent should be obtained at the individual or group level before any treatment. Confidentiality is another ethical

consideration that is challenging with a prevention program due to multiple individuals seeking interventions in one setting (Hage & Romano, 2013). It can be challenging to ensure confidentiality is maintained throughout when discussing personal topics in group settings. Therefore, it is essential for liability purposes to inform participants of the risks to confidentiality and allow individuals to decide if they would like to participate (Hage & Romano, 2013). When considering stakeholder collaboration, utilizing an inclusive program evaluation would enhance the program's effectiveness through qualitative data collection (Hage & Romano, 2013). The evaluation would spotlight diversity amongst participants through personal interviews that focus on experiences and feedback of the program (Hage & Romano, 2013).

PART 5: ADVOCACY

Promoting Healthy Strategies to Reduce Obesity

So much information plagues the internet regarding obesity prevention, that it often becomes difficult to make concrete decisions about one's health. Moreover, some information deemed trustworthy from sources is not necessarily most beneficial for obesity prevention. Information asymmetries or the variance of information from person to person is strong in the health and wellness industry (Pirog & Good, 2013). Developing advocacy strategies for obesity prevention that adhere to the Multicultural and Social Justice Competencies (MSJCC) and prioritize the client’s well-being is a must.

According to the MSJCC, barriers to obesity prevention can be seen at the institutional (schools, churches, community organizations), the community (societal norms), and the public policy level (local, state, and federal laws) (Ratts et al., 2015). One barrier to obesity seen at the institutional level is the lack of nutritional lunches offered at schools. When compared to

children who regularly bring lunch from home, children who eat school lunches are more likely to be obese, eat two or more fatty meats per day, consume more sugary drinks, are less likely to eat the daily recommendation of fruits and vegetables, and had higher LDL cholesterol (Laino, n.d). Guidelines are set in place by the U.S. Department of Agriculture; however, only 6% of school lunches adhere to those guidelines (Laino, n.d.). The established guidelines have a long way to go if providing children with minimally processed whole foods is essential for obesity prevention.

Moreover, many low-income families rely on school lunches as a low-cost way to feed their children. An advocacy action that would address school lunches' downfall and promote obesity prevention would be through collaboration with the school district. Adding salad bars, partnering with local farmers, and increasing the length of lunchtimes are excellent ways to improve food choices and encourage healthy eating among students (Graves, 2016). The Berkeley Unified School District in California has committed to serve nutritious meals to children by partnering with local vendors, serving organic milk, and banning all processed foods containing hydrogenated oils, high fructose corn syrup, refined sugars and flours, dyes, nitrates, additives, and chemicals (Cather, n.d.). The Baltimore Public School System in Maryland was the first school to adopt "meatless Mondays" to benefit the environment and the children's health (Cather, n.d.). Additionally, the Baltimore Public School System serves local produce and milk and uses a 33-acre farm to teach children how to grow food (Cather, n.d.). Bonner county is filled with local produce and livestock farmers that adopting a farm to table school lunch program would be easily accessible. In France, the French Ministry of National Education requires children to sit at the lunch table for 30 minutes to eat a full and balanced meal including vegetables, a warm main dish, cheese, and fruit as a dessert (Cather, n.d.).

Social norms at the community level highly influence the obesity epidemic. Social and cultural norms are based on a set of combined values seen in personal experiences and even laws (Dietary Guidelines 2015-2020, n.d.). Preferences for certain types of foods, acceptable body image, and values towards physical activity and health are social norms seen with obesity (Dietary Guidelines 2015-2020, n.d.). An advocacy strategy for working on obesity prevention at the community level would be to explore how social and cultural norms positively and negatively influence weight loss goals (Ratts et al., 2015). By exploring social and cultural norms, clients would work to eliminate the thoughts preventing growth and development and begin to develop new beliefs towards diet, exercise, and body image, ultimately promoting positive behavior modifications.

A barrier to obesity prevention at the public policy level is seen in limited health care options for obese clients. Access to quality healthcare is an issue in Bonner County and across America (OAC, n.d.). There are established treatment options for obesity management currently in place; however, health insurance companies make it nearly impossible for people to get the treatments covered (OAC, n.d.). This leaves many individuals feeling lost and defeated, which only further exacerbates the emotional burdens placed on being obese. Obesity should be classified as a chronic disease diagnosed by health care providers and should be billable through insurance companies (OAC, n.d.). An intervention to target this issue at the public policy level would be to remove the biases and stigmas associated with obesity and advocate for insurance companies to cover obesity treatments (OAC, n.d.). At the state level, this could be done by writing letters to the Idaho Department of Insurance, Idaho Medicaid, and state legislators addressing the issue of obesity and urging them to add obesity treatments as a billable option for insurance. With access to quality health care, individuals would be better equipped to combat

obesity, suffer fewer comorbidities, live healthier lifestyles, and reduce the amount of money insurance companies spend on obesity (OAC, n.d.).

REFERENCES

American Counseling Association (ACA). (2014). 2014 ACA code of ethics [White Paper]. Retrieved from https://www.counseling.org/resources/aca-code-of-ethics.pdf

Bonner General Health (2019). *Community health needs assessment.* Retrieved October 16, 2020 from https://www.bonnergeneral.org/wp-content/uploads/2020/03/2019-CHNA-Final-Report.pdf

Cather, A. (n.d.). *Sixteen school lunch programs making a difference*. Retrieved September 15, 2020 from https://foodtank.com/news/2016/02/sixteen-school-lunch-programs-making-a-difference/

Centers for Disease Control (n.d.). *Overweight & obesity.* Retrieved September 7, 2020 from https://www.cdc.gov/obesity/adult/defining.html

Centers for Disease Control (2012). *Overweight and obesity – Idaho.* Retrieved September 25, 2020 from https://www.cdc.gov/obesity/stateprograms/fundedstates/pdf/idaho-state-profile.pdf

County Health Rankings & Roadmaps (2018). *How healthy is your community?* Robert Wood Johnson Foundation. Retrieved from https://www.countyhealthrankings.org/

Dietary Guidelines 2015-2020 (n.d.) *Everyone has a role in supporting healthy eating patterns.* Retrieved October 12, 2020 from https://health.gov/our-work/food-nutrition/2015-2020-dietary-guidelines/guidelines/chapter-3/social-ecological-model/

Hage, S. & Romano, J.L. (2013). Best practices in prevention. In R. K. Conyne & A. M. Horne (Eds.). *Prevention practice kit: Action guides for mental health professionals*. SAGE.

Gough, M., Lippert, A., & Martin, M. (2018). The role of time use behaviors in the risk of obesity among low-income mothers. *Women's Health Issues. 29*(1), 23-30. Retrieved from Walden Library databases.

Graves, G. (2016). *Getting a better school lunch.* Retrieved October 12, 2020 from https://www.nrdc.org/stories/getting-better-school-lunch

Laino, C. (n.d). *School lunches linked to kids' obesity.* Retrieved October 12, 2020 from https://www.webmd.com/children/news/20100315/school-lunches-linked-to-kids-obesity#1

National Eating Disorders Collaboration (n.d.). *Risk & protective factors.* Retrieved September 15, 2020 from https://www.nedc.com.au/eating-disorders/eating-disorders-explained/risk-and-protective-factors/

National Institutes Health (n.d.). *Overweight and obesity.* Retrieved September 14, 2020 from https://www.nhlbi.nih.gov/health-topics/overweight-and-obesity

Obesity Action Coalition (OAC) (n.d.). *Understanding access to care.* Retrieved October 12, 2020 from https://www.obesityaction.org/action-through-advocacy/access-to-care/understanding-access-to-care/

Pirog, M. A., & Good, E. M. (2013). Public policy and mental health: Avenues for prevention. In R. K. Conyne & A. M. Horne (Eds.). *Prevention practice kit: Action guides for mental health professionals* (pp. 1-79). SAGE.

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, K., & Rafferty McCullough, J. (2015). *Multicultural and social justice counseling competencies*. Retrieved October 12, 2020

from https://www.counseling.org/docs/default-source/competencies/multicultural-and-social-justice-counseling-competencies.pdf?sfvrsn=20

Rideout, V. & Robb, M. B. (2019). The common sense census: Media use by tweens and teens. *Common Sense Media*. Retrieved September 25, 2020 from https://www.commonsensemedia.org/sites/default/files/uploads/research/2019-census-8-to-18-full-report-updated.pdf

Social Programs that Work (2018). *Evidence summary for obesity treatment through behavioral coaching.* Retrieved from https://evidencebasedprograms.org/

State of Childhood Obesity (n.d.). *Obesity rates for youth ages 10 to 17.* Retrieved September 25, 2020 from https://stateofchildhoodobesity.org/children1017/

Substance Abuse and Mental Health Services Administration (n.d.) *Risk and protective factors*. Retrieved from https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf

Tkalcic, M. & Pokrajac-Bulain, A. (2006). Biopsychosocial aspects of obesity in Croatia: Transtheoretical model of behavior change. *Romanian Association for Cognitive Science*. Retrieved from Walden Library databases.

Buchholz, S. W., Huffman, D., & McKenna, J. C. (2012). Overweight and obese low-income women: Restorative health behaviors under overwhelming conditions. *Health Care for Women International. 33*, 182-197. doi: 10.1080/07399332.2011.630115

World Health Organization (n.d.). *Overweight and obesity.* Retrieved September 25, 2020 from https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight

SCHOLARWORKS CONTRIBUTOR AGREEMENT

[Please read the information below and if desired, sign, date, and provide email address in the highlighted section at the end].

ScholarWorks Publication Consideration

ScholarWorks makes the intellectual output of the Walden University community publicly available to the wider world. By highlighting the scholarly and professional activities of our students and faculty, ScholarWorks' rich repository encourages new ideas, preserves past knowledge, and fosters new connections to improve human and social conditions.

If you would like your portfolio from your Counseling 6785 course to be considered for submission to ScholarWorks, please review the ScholarWorks Contributor Agreement below and agree to the terms and conditions.

Acceptance of the policies and terms of the ScholarWorks Contributor agreement

- will not impact your grade
- will not guarantee publication

ScholarWorks Contributor Agreement

To administer this repository and preserve the contents for future use, *ScholarWorks* requires certain permissions from you, the contributor. By making a submission to *ScholarWorks*, you are accepting the terms of this license. However, you do not give up the copyright to your work. You do not give up the right to submit the work to publishers or other repositories.

By including an email contact below, you hereby grant Walden a limited license to review the Submission for the purposes of review of scholarly content; to distribute the Submission to the public on the Website; to make and retain copies of the Submission; and to archive the Submission in a publicly accessible collection.

You agree to defend, indemnify and hold Walden harmless from and against any and all claims, suits or proceedings, demands, losses, damages, liabilities and costs and expenses (including, without limitation, reasonable attorney's fees) arising out of or resulting from the actual or alleged infringement of any patent, trademark, copyright, trade secret or any other intellectual property right in connection with any Submission.Walden will not be required to treat any Submission as confidential.For more information, see the Contributor FAQ.

By executing this Agreement, you represent and agree that:

- You are the author or of the submitted work or you have been authorized by the copyright holder, and the submission is original work.
- You hold the copyright to this document and you agree to permit this document to be posted, and made available to the public in any format in perpetuity.
- The submission contains no libelous or other unlawful matter and makes no improper invasion of the privacy of any other person.
- The submission will be maintained in an open access online digital environment via the *ScholarWorks* portal. Because works on *ScholarWorks* are openly available online to anyone with internet access, you do not hold Walden University responsible for third party use of the submission.

ScholarWorks (the Website) is owned and maintained by Walden University, LLC (Walden). All content that you upload to this Website (a Submission) will be available to the public. You represent and warrant that you have the right to upload any such Submission and make it available to the public.

I have read the Scholarworks agreement above, and I agree to have my COUN 6785 portfolio document considered for inclusion in Scholarworks; I also grant my permission for representatives from Walden University to submit this work on my behalf.

By signing again below, I agree to allow my email contact information below to be included in the published document, so that others may contact me about this work.

SIGNATURE: Jarae Swanstrom
DATE: 9 November 2020
DIRECT EMAIL ADDRESS: jarae.swanstrom@waldenu.edu