

Poor, Rural and Female: Under-Studied, Under-Counseled, More At-Risk

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Abstract:

The feminization of poverty has been well documented, and the relationship between the experiences of poverty and negative mental health outcomes has been identified. These consequences remain largely unexamined for women living in rural areas that comprise a population both at risk and underserved by mental health professionals. The dynamics of poverty for these women and the relationship between poverty lifestyles and physical and mental well-being is explored. A model for assessment and mental health interventions is presented. Implications for mental health counseling and for research are considered.

Article:

Poverty and its consequences are associated with pervasive and negative outcomes for individuals throughout their lifespan as well as across generations and are a particular concern for women (DeLeon, Wakefield, Schultz, Williams, & VandenBos, 1989; Gatz & Fiske, 2003). Among more than one billion persons living in poverty worldwide, most living in developing countries (Fourth World Conference on Women [FWCW], 2001), 2% are women living in the United States. In this country, 18,445,000 women, or 13% of all women, are poor, and it is estimated that at least half that number live near the poverty level in circumstances defined as low socioeconomic status (SES; U.S. Census Bureau, 2000). Geographic location is a factor associated with poverty, and several epidemiological studies have established that higher rates of poverty exist in rural areas, where 30% of U.S. women reside (American Psychological Association, 2000; Human & Wasem, 1991). Thus, although overall, approximately one in five women is poor or near poor, the proportion of low SES women in rural areas is even higher.

The gender gap in poverty has not remained constant but has continued to widen in recent decades, resulting in a redefinition of poverty as primarily a women's issue, graphically described as "the feminization of poverty" (Fitzpatrick & Gomez, 1997). Moreover, a cycle of poverty has been identified, in which the factors contributing to and the consequences of being poor become self-perpetuating and lifelong (World Health Organization, 2001). The "cycle of poverty and mental disorders" describes these factors and the complex interplay of the experience of poverty, economic impact of poverty, and increased incidence of mental and behavior disorders (WHO). Most studies underlying this model have examined urban poverty: few studies of poverty in rural areas have been conducted (Amato & Zuo, 1992). As a consequence, mental health professionals know a lot about poverty in general and the gender differential in poverty but know little about rural, poor women, who constitute one third of the total female population. There is also less known about within-group differences, though several studies have suggested that minority women living in rural areas are most likely to experience poverty and its associated negative consequences (DeLeon et al., 1989; APA, 2000).

The results of multiple studies suggest that poverty has broad, negative consequences for psychological well-being and quality of life across the lifespan (Amato Zuo, 1992; Reutter, Neufield, & Harrison, 2001). Although early intervention has been emphasized as a means of addressing the myriad of problems related to poverty (Harris, 1990, within the counseling literature, intervention programs based on holistic models and grounded in research are lacking. Moreover, as noted in a recent APA report concerning the needs of rural women, "there is a dearth of research concerning the behavioral health needs of this substantial, but frequently unnoticed population" (APA, 2000, p. 1). While current models of poverty display a variety of interacting factors and

outcomes, they emphasize pathological outcomes and fail to incorporate the inherent strengths possessed by women. Such strengths represent important resources that mental health counselors may draw upon to help meet the needs of this population (Myers, Sweeney, & Witmer, 2000; Palmo, Rosh, & Weikel, 2001). In the absence of information to help understand their needs, mental health counselors are ill-prepared to help women, especially those living in rural areas, to cope with and break the cycle of poverty.

In this article, poverty is defined and the cycle of poverty and mental disorders is described. A new model explaining the cycle of poverty and compromised wellness is presented which incorporates research defining the feminization of poverty, specifically for women living, in rural areas. Implications for mental health counselors are explored and the need for further research is emphasized.

POVERTY AND RURAL POVERTY

Determining the exact incidence and prevalence of poverty is difficult due to the complexity of interacting factors that define poverty lifestyles. Both financial and social factors need to be incorporated into any definition, and subgroup characteristics must be considered when exploring poverty statistics. Moreover, the impact of interacting factors is associated with different mental health challenges across the life span.

Definition of Poverty and Near Poverty

The U.S. Department of Health and Human Services (2001) defined the Federal Poverty Level (FPL) based on the total annual combined household income for every member over 15. The 2001 guidelines range from a maximum of \$8,500 for a family of one to \$29,730 for a family unit of eight. Although "poverty" thus has a legal definition, there is no such definition for "near" poverty or low SES. In fact, there is no universally accepted standard for defining low SES (Kiefe et al., 2001). A variety of indices are included in attempts to describe persons whose incomes place them above the FPL yet whose standard of living does not allow them to function fully independently. These indices include such factors as income level, educational attainment, reliance on public assistance for free or reduced-fee lunches, and access to health care (e.g., Women and Infant Care programs).

Incidence of Poverty and Rural Poverty

Positive stereotypes of an idyllic rural lifestyle have proven to be a myth for the one fourth of Americans who live in rural areas (Human & Wasem, 1991). Rural residents constitute one third of those who are poor and almost one third of persons over age 65 (29%). They have a higher dependency ratio, more chronic diseases, and higher rates of infant mortality and accidental injuries. The rural population as a whole is older, less educated, and more ethnically homogeneous than urban populations. Only 8.3% are Black and 2.5% are Hispanic, compared to 11.8% and 7.5%, respectively, in metropolitan areas. The population of rural poor includes only 14% Whites, while 44% are Blacks and 36% are Hispanics; however, 80% of families headed by Black women are poor (DeLeon et al., 1989). Overall, among female-headed rural households, almost half have incomes below the FPL, over two thirds of families with children under age 6 and 60% of families with children under age 18 fall below the FPL. Among older adults, 30% of rural residents, but only 15% of their urban counterparts, are poor.

Lifespan Consequences of Poverty and Rural Poverty

Krause (1999) hypothesized that poverty early in life has an accelerating course over the lifespan, such that women in poverty may be increasingly stress prone and subject to negative mental health outcomes. Although persons born into poverty are at risk for a lifetime of low income, socio-economic challenges, health concerns, and mental health issues such as depression (DeLeon et al., 1989; Gatz & Fiske, 2003), poverty may begin at any point in the lifespan. Vartanian and McNamara (2002) conducted a longitudinal study of 1,921 women aged 40-59 and examined factors affecting their economic well being at ages 66-70 and 71-85. They found that relative affluence resulting from factors such as education, mid-life careers, and marital status did not necessarily prevent poverty in later life. This outcome seems especially true for women residing in rural areas as a consequence of the farm crisis, which has increased both financial and psychological suffering in rural areas for over two decades (Hutner & Windle, 1991). The consequences of loss of farms have been so significant that

a reactive syndrome has been defined including symptoms of anxiety, depression, personal maladjustment, and "rampant interpersonal relationship maladjustment [with] noticeable absences of personality disorder and character disorder" (Hargrove & Breazeale, 1993, p. 3). Importantly, the concomitants of rural poverty are not static but have been changing consistently in a negative direction (Hargrove & Breazeale, 1993; Hutner & Windle, 1991). Unsafe or deteriorating housing, deteriorating schools, inadequate water supplies, transportation difficulties, fewer health care resources, and increasing isolation from goods and services are some of the major changes noted by multiple authors, who simultaneously note that rural residents, especially older persons, experience the same or greater needs than their urban counterparts (Chalifoux, Neese, Buckwalter, Liltwak, & Abraham, 1996). Not surprisingly, mental health needs are significant and largely unmet by mental health providers in rural settings (Human & Wassem, 1991; Sears, Danda, & Evans, 1999), in part due to a 50% reduction in federal health and mental health resources since the early 1980s (DeLeon et al., 1989).

The Cycle of Poverty

Persons born into poverty families or families defined as low socioeconomic often perpetuate what has come to be called the cycle of poverty (Shlonsky, 1984; WHO, 2001). These families are at greater risk for repeating the behaviors that result in low income such as low educational expectations (Haynie & Gorman, 1999), early pregnancies (APA, 2000), and lack of career goals (Wilson & Peterson, 1993). Shlonsky challenged the idea that the cycle of poverty across generations results from the transmission of poverty from parents to their children, citing instead the pervasive influence of education, occupation, welfare, and housing. Other authors have underscored the complex, multidimensional nature of poverty (e. g., Fitzpatrick & Gomez, 1997; FWCW 2001), suggesting the need for models which assist in conceptualizing and understanding poverty and which provide a structure for addressing the myriad of associated issues. One such model, the "Vicious Cycle of Poverty and Mental Disorders" (WHO, 2001), has been presented as a framework for understanding relationships among the experience of poverty and mental health outcomes.

THE VICIOUS CYCLE OF POVERTY AND MENTAL DISORDERS

The Vicious Cycle of Poverty and Mental Disorders (WHO, 2001) was developed as a public health model to explain how life circumstances related to poverty lifestyles result in negative mental health outcomes, which then create more poverty. Physical, mental, and social health are viewed as inextricably intertwined and form the foundation of the model. Poverty, mental and behavioral disorders, and the economic impact of these two constellations of factors comprise three key elements that interact cyclically to reinforce and perpetuate poverty lifestyles.

In the Vicious Cycle of Poverty and Mental Disorders, the *experience* of poverty includes economic deprivation, low education, and unemployment (WHO, 2001). These three factors are interactive, and it is impossible to separate which comes first. Persons with lower educational attainment often are chronically unemployed or underemployed (Haynie & Gorman, 1999), and economic deprivation is a constant factor that influences virtually all aspects of their lives. These factors alone are self-perpetuating; however, individual pathology represents a complex and co-morbid issue that both results from and contributes to poverty lifestyles (Chalifoux et al., 1996).

The *mental health consequences* of poverty include a higher prevalence of mental disorders, lack of self-care, and more severe mental health symptoms and outcomes (WHO, 2001). For example, it has been estimated that 41 % of poor, rural women self-report significant depression (Sears et al., 1999), and there seems to be a greater incidence of substance abuse in rural areas (Cellucci & Vik, 2001). It is not known how many of these women experienced depression or mental illness and then became poor as a result of their inability to function effectively in work and social roles: however, regardless of which came first (i.e., poverty or mental distress), in the absence of early intervention, these problems perpetuate over the lifespan and may become worse in later life (Gonyea, 1994). Older persons are both more likely to reside in rural areas and are at higher risk for life stresses and mental disorders than their urban counterparts and younger urban dwellers. [They] are poorer, more likely to be female and white, affected by chronic medical conditions, and at greater risk for low quality of life" (Chalifoux et al., 1996, p. 2). Inadequate self-care, influenced both by poor health-seeking behaviors and poor

treatment adherence, combined with lack of access to needed care (Glied, McCormack, & Neufeld, 2003), results in chronic mental health challenges (Harris, 1996); and chronically mentally ill individuals in rural settings are even less likely to receive needed services (Murray & Keller, 1991).

Three major indicators of the economic impact of poverty are increased health care expenditures, job loss, and reduced productivity. Poor nutrition and poor health are common concomitants of poverty lifestyles (Reutter et al., 2001), as are increased morbidity and mortality due to illness and disability (Adler, Espel, Castellazzo, & Ickovics, 2000). Welfare programs are particularly targeted at low-income pregnant women and mothers, as poor nutrition and lack of health care during pregnancy are strongly correlated with health problems throughout the lifespan (Reutter et al., 2001; U.S. Department of Commerce, 1995), while few programs are available to meet the needs of poor women in mid-life and later (Hardy & Hazelrigg, 1993; Vartanian & McNamara, 2002). Increased physical and mental illness among those who are poor results in an inability to sustain gainful employment over time (WHO, 2001).

The three components of the cycle of poverty and mental disorders represent serious public health concerns, both individually and collectively. The focus of the WHO model is on economics, and the need for public policy reform and community-based care of persons with mental illness and co-morbid dual or multiple diagnoses is emphasized. However, when viewed from a developmental, wellness-oriented (Myers, Sweeney, & Witmer, 2001), or positive psychology perspective (Diener & Seligman, 2002), it is necessary to broaden the assessment and influence of poverty to incorporate more psychosocial factors and a holistic perspective. In effect, a different model explaining the interaction of factors related to poverty is needed as a basis for designing mental health counseling interventions. Further, how those factors specifically affect women, for whom the consequences of poverty are especially serious, needs to be considered.

THE CYCLE OF POVERTY AND COMPROMISED WELLNESS: A NEW MODEL

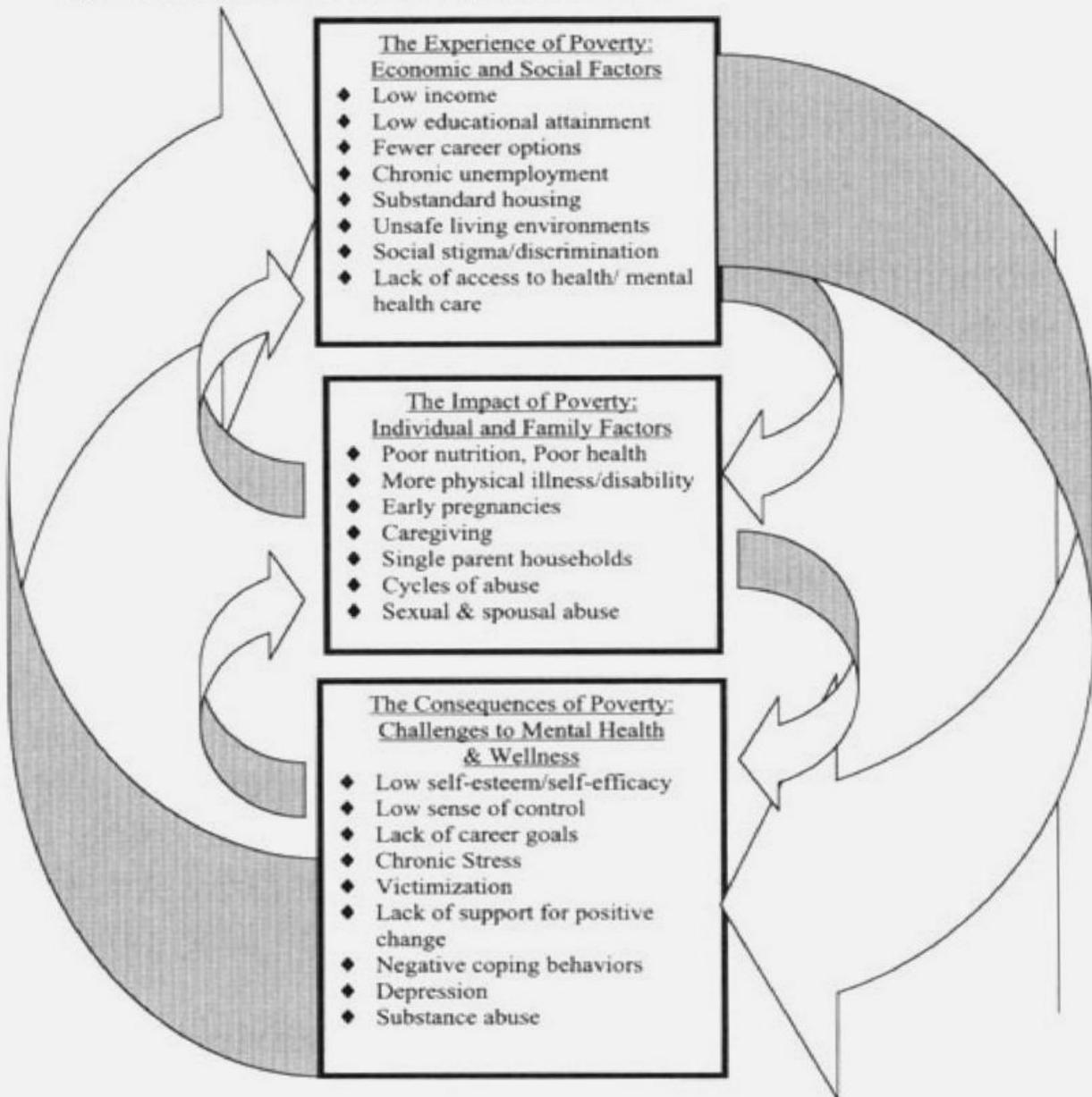
Poverty may be "particularly acute for women living in rural households" (FWCW, 2001, p.1), especially minority women, who are over represented among those living in poverty but are traditionally ignored in the literature (Saris & Johnston-Robledo, 2000). To better conceptualize and address the challenges faced by these women, we propose a new model. The Cycle of Poverty and Compromised Wellness (see Figure). This model emphasizes a strength-based approach to understanding and intervening in three areas: the experience of poverty, the impact of poverty, and the mental health consequences of poverty.

The Experience of Poverty for Rural Women: Economic and Social Factors

As shown in the Figure, the experience of poverty for rural women includes a variety of economic and social factors. Economic factors, which are cyclical and self-perpetuating, include low income, low education attainment, participation in primarily entry-level jobs, and chronic unemployment. Poor, rural women, especially those who are younger, receive little encouragement for continued levels of education even when they perform at higher levels academically (Wilson & Peterson, 1993). As a result of early termination of education, they have fewer qualifications and choose predominantly low-order personal and social service type jobs, which have few if any benefits, including health care insurance (FWCW, 2001).

Lacking economic independence, poor, rural women are dependent on others for both financial and emotional support and are more vulnerable to maltreatment (Fitzpatrick & Gomez, 1997). Women living in poverty are more likely to live in poor or substandard housing and in unsafe neighborhoods (APA, 2000); thus they are more likely to be victims of crime and violence than are other women (Amato & Zuo, 1992; Pan, Neidig, & O'Leary, 1994). Rural violent crime rates are increasing (Hargrove, & Breazeale, 1993), as underscored by high rates of homicide experienced by rural, poor Native American women (APA).

Figure 1. The Cycle of Poverty and Compromised Wellness



Adapted from the Cycle of Poverty and Mental Disorders, World Health Organization, 2001

Social factors including stigmas and stereotypes also affect the web of women living in poverty, beginning with the stigma of poverty itself, which contributes to fewer career options, frequent unemployment, and reduced job opportunities. These outcomes are compounded by the effects of gender role stereotypes prevalent in poverty environments as well as in rural areas (Haynie & Gorman, 1999; Scattolon & Stoppard, 1999). Rural, poor women experience social stigma and discrimination in employment (Adler et al. 2000; Amato & Zuo, 1992) as well as discrimination from health care and other service providers (Murray & Keller, 1991). Discrimination is a particularly salient issue for minority women who also experience problems associated with institutionalized racism. Stigma from multiple sources is associated with lower self-esteem (Belgrave, Chase-Vaughan, Gray, Addison, & Cherry, 2000), initial sexual intercourse at younger ages, and early pregnancy (Kalil & Kunz, 1999).

Accessing both health care and mental health services constitutes a significant challenge for poor, rural women, who often seek mental health care from primary care providers (Sears et al., 1999). Rural areas report a 75% health care profession shortage, and 60% of rural areas are designated mental health shortage areas (APA, 2000). Geography, inclement weather, lack of public transportation, and the need for improved communications in rural areas contribute heavily to the difficulties women face in accessing both health care and mental health services (Murray & Keller, 1991). High rates of underservice by mental health providers in rural areas are related to factors such as inadequate training for working in these settings (Hargrove & Breazeale, 1993), value systems that are radically different from those predominant in rural areas (Human & Wasem, 1991), discrimination in the reimbursement policies of Medicare and private insurance companies (DeLeon et al., 1989), and high rates of professional isolation in rural areas (Murray & Keller). These factors are compounded by a lack of awareness regarding mental health services (APA), the stigma associated with mental illness in rural areas (Scattolon & Stoppard, 1999), and the increased likelihood of dual relationships creating reluctance to enter into helping relationships on the part of clients, both individuals and families, as well as mental health professionals in rural communities (Lewis, 2001; Schank & Skovholt, 1997).

The Impact of Poverty for Rural Women: Individual and Family Factors

Individual and family factors comprise the second major constellation of issues to be considered in understanding rural poverty among women. The list shown in the Figure should not be considered to be exhaustive: rather, several major risk factors are identified. At the individual level, poor nutrition, poor health, and increased incidence of disability are prevalent; and early pregnancies and single parent households are common. Family dynamics encountered frequently in rural, poor families that affect women include a high incidence of family illness and caregiving, and repetitive family violence best characterized by cycles of abuse.

For rural women, poverty increases the risk of poor nutrition and consequent poor health. Higher rates of smoking, related to low socioeconomic status, place these women at risk for cardiovascular disease and cancer, with African American women at particular risk (Kiefe et al., 2001). Lack of exercise and poor dietary habits result in greater incidence of overweight and obesity, increased incidence of type 2 diabetes (Robbins, Vaccarino, Zhang, & Kasl, 2001), and increased risk for metabolic and cardiovascular disease (Adler et al., 2000). For African American women, the risk of Type II diabetes is more strongly correlated with both income and body size than for White women (Robbins et al.). In addition, the stress of balancing family and work roles as well as financial difficulties may contribute to weight gain and obesity (Reutter et al., 2001). The negative consequences of poor nutrition and poor health have lifelong physical effects due to a greater incidence of multiple chronic disabling conditions.

Low SES and poverty are linked directly to early pregnancy and childrearing (Corcoran, Franklin, & Bennett, 2000) that both complicate and perpetuate the poverty cycle (Harris, 1996). Limited education regarding the reproductive system and lack of access to adequate health care experienced by young, rural women contribute to the likelihood of early pregnancy (Ward, 2000). In fact, increased numbers of births to young, single women have been linked directly to lower socioeconomic status (Kalil & Kunz, 1999). Higher rates of early pregnancies in rural areas, in particular teen parenting accompanied by early school dropout, result in an increased prevalence of women as head of households and as single parents (Gonyea, 1994). In general, single parent households are more common among low-income families (Wilson & Peterson, 1993), with almost one third of rural female head of households living in poverty (APA, 2000).

Early pregnancies are of particular concern for young, minority women who experience poverty (Merrick, 1995); in fact, Kalil and Kunz (1999) reported that being a minority group member is a positive predictor of early, nonmarital pregnancy. Fenzen and Butler (1997) reported that the birth rate to unmarried rural, Black women has risen rapidly since 1980, and in 1994 surpassed that of their urban counterparts. In addition, although the rates of nonmarital pregnancy for Black women historically have been higher than those of White women, only recently have the rates of early nonmarital pregnancy reported by young, unmarried Hispanic women exceeded those of young, Black women (Kalil & Kunz).

Extended kin networks are common in rural areas, and as in urban areas, women remain the traditional family caregivers throughout the lifespan (Myers, 2003). Women of all ages provide care for relatives and others, thus complicating their risk factors for physical and mental health concerns as well as increased poverty. On the one hand, they may need to curtail outside employment in order to provide family care; on the other they remain subject to the same chronic health concerns for which they are care providers. Myers described the typical caregiver as late middle age (i.e., 55-60), white, and herself an individual with multiple health challenges. The U.S. Department of Agriculture (2000) reported that older persons living in rural areas were most likely to be poor women, living alone, and reporting a high incidence of chronic health problems such as arthritis and hypertension (Rogers, 2000). These same women are likely recipients of care from younger relatives. They also are likely themselves to be caregivers, even primary caregivers or surrogate parents, especially for grandchildren whose mothers are young and unmarried (Hayslip & Patrick, 2003).

Violence is a common occurrence in the lives of rural women (Boyd, 2003). Logan, Walker, Cole, Ratliff, and Leukefeld (2003), in one of the only empirical studies comparing violence in urban and rural areas, found that rural women reported lower levels of education, income, and social support than their urban counterparts and higher rates of physical abuse, more incidences of childhood physical and sexual abuse, abuse instances earlier in intimate relationships, and worse physical and mental health. Cycles of abuse within families often co-exist with cycles of poverty (Saris & Johnston-Robledo, 2000), as socioeconomic factors have been directly linked to husband-on-wife physical abuse (Pan et al., 1994). A female head of household whose income is below the poverty line is five times more likely to be a victim of violence (APA, 2000). As a result, children of impoverished families are more likely than are their higher socioeconomic status peers to experience systems in which abuse occurs. The incidence of abuse is even greater for rural, poor Native American women for whom the third leading cause of death is homicide and suicide (APA). In addition, family violence in rural communities is far less likely to be reported due to the lack of anonymity in small communities and the social stigma associated with violence. Violence and abuse experiences are both precursors to and concomitants of mental and behavioral disorders (WHO, 2001).

The Consequences of Poverty for Rural Women: Challenges to Mental Health and Wellness

In the Cycle of Poverty and Mental Disorders, poverty is presented as a factor both leading to and resulting from serious mental pathology (WHO, 2001). From a developmental, wellness perspective, pathology can be re-conceptualized as resulting from developmental challenges (Ivey, Ivey, Myers, & Sweeney, 2004; Myers et al., 2000) and can be examined from a continuum of mental health rather than mental illness issues (Palmo et al., 2001). Viewed from a wellness paradigm rather than an illness paradigm, while the objective circumstances of poverty lifestyles do not change, the potential for prevention of serious, negative mental health consequences through early interventions and strengths-based assessments and counseling (Myers et al., 2001) emerges as a clear possibility. Hence, in the new Cycle of Poverty and Compromised Wellness, the consequences of poverty are conceptualized in terms of low self-esteem (Reutter et al., 2001), lack of empowerment or low sense of control (FCFW, 2001), lack of career goals (Wilson & Peterson, 1993), chronic stress (Adler et al., 2000; Sears et al., 1999), victimization (Boyd, 2003), lack of support for positive change (Fitzpatrick & Gomez, 1997), and negative coping behaviors such as depression (Craft, Johnson, & Ortega, 1998) and substance abuse (Cellucci & Vik, 2001).

Poor, rural women often experience low self-esteem, low perceptions of self-efficacy or ability to set and achieve life goals, a lack of feelings of empowerment, and an external locus of control (FCFW, 2001; Reutter et al., 2001). Perceived control is associated with emotional well-being, successful coping with stress, better physical health, and better mental health over the lifespan as well as psychological hardiness; having an internal locus of control has been associated with lower levels of anxiety and depression and higher levels of self-esteem and life satisfaction (Daniels & Guppy, 1994). Further, higher levels of perceived self-control predict healthier behavior (Birkimer, Johnston, & Berry, 1993), including weight control (Walcott-McQuigg, Sullivan, Dan, & Logan, 1995) and career choice (Luzzo & Jenkins-Smith, 1996).

Wilson and Peterson (1993) explored educational and occupational attainment of women in poor, rural families and found that female adolescents are more likely to consider their career expectations secondary both to male career expectations and to family planning. Further, these women are more likely to choose to remain in a rural area than move to escape poverty. Limited career goals contribute to early pregnancies, factors which also contribute to high rates of chronic stress and chronic depression. Multiple, interacting sources of stress result from occupational and family responsibilities, a lack of social support, and daily economic struggles (Maguire, 1997; Reutter et al., 2001). Chronic levels of high stress have been associated with decreased sleep and increased body weight, contributing to chronic health problems, feelings of hopelessness, and social isolation (Adler et al., 2000; Scattolon & Stoppard, 1999). In addition, women from low socioeconomic groups, including African Americans, have an increased incidence of eating disorders (Dittrich, 2001).

Lindgren and Coursey (1995) noted that social support has "a stress-buffering effect" (p. 93); thus any factor that reduces perceived support may act to increase perceptions of stress. Moreover, the perpetuation of poverty for women has been linked to a lack of social support (Fitzpatrick & Gomez, 1997). Because persons in rural environments who are poor tend to perceive assistance, whether from the government or society, as negative (Amato & Zuo, 1992), accepting needed help can further feelings of inadequacy and failure, which in a cyclical manner, can contribute to social isolation. Related to these issues is the fact that women in rural areas lack a strong network of support for positive change. As a consequence, they frequently resort to negative coping behaviors as a response to the perceived unchangeable circumstances of their lives, notably substance abuse and depression. In short, these women experience high rates of depression and anxiety, low self-esteem, decreased social support, and high amounts of stress (Adler et al., 2000; APA, 2000), all of which are associated with a continuation of the cycle of poverty and compromised wellness.

IMPLICATIONS FOR MENTAL HEALTH COUNSELORS

In the Cycle of Poverty and Compromised Wellness, economic and social factors help to explain the experience of poverty, and individual and family factors provide a foundation for understanding the individual and systemic impact of poverty lifestyles. These interacting factors have been found in multiple studies to be associated with negative mental health and wellness outcomes among poor women living in rural areas; however, it is important to note that specific causal factors or paths have not been identified. The lifelong association between these factors has been well-established, underscoring the need for early intervention to break the cycle of poverty. Mental health counselors are uniquely positioned to provide needed interventions based on a preventive, developmental, and wellness philosophy. The focus of effective interventions must include assessment, individual, group, and family counseling, and advocacy for change.

To interrupt and reverse the cycle of poverty, poor, rural females need to be empowered to change in positive directions. The first step in this process is a strength-based assessment. Mental health counselors need to view these women from a strength-based holistic wellness perspective that is oriented towards identifying positive behaviors, affect, and cognitions that can be enhanced and that can form the foundation for positive change. For example, a woman who is a caregiver can be helped to view her multiple roles as evidence of her flexibility and ability to multi-task successfully, and/or her skills in recognizing and providing for the needs of others. Assessment of support networks is also important, given the critical role of social support, or lack of support, in the poverty cycle. Multigenerational supports, friendship networks, and formal or institutional services may be included in the network. Holistic assessments may be informal, using holistic models as a basis for clinical assessment interviews, or they can be formal, using available assessment instruments (Myers et al., 2000). The model presented here can also serve as a basis for assessment, as it provides a checklist of factors to consider in conceptualizing the circumstances and needs of individual clients and groups of clients.

Once assessments have been completed, plans can be made for individual, group, and/or family counseling. The goal of individual and group counseling efforts is to empower clients for positive change. Thus, issues of self-esteem, self-efficacy, and personal control need to be an important part of counseling goals. When present, depression, anxiety, and related concerns need to be treated. In addition, strategies for building positive support, such as group and peer counseling and career mentoring, need to be a priority. Successful role models and

mentors are needed to help women develop a new vision of who they can become, and these models can be co-constructed through group counseling interventions. Ideally, role models will be women in similar life circumstances who have coped successfully with the challenges associated with rural poverty.

One strategy for change is to help clients develop a personal wellness plan based on a multi-factor model of wellness (Myers et al., 2000; Hartwig & Myers, 2003). Having clients choose the area in which interventions begin contributes to a sense of empowerment. Because the dimensions of wellness models are overlapping and interacting, change in one area contributes to and creates positive change in other areas as well. For example, helping a woman develop and adhere to a plan for increased physical activity will not only improve her physical health and help reduce health risks, but also the increased activity will help her develop a greater sense of perceived control over her ability to alter her life in positive ways. Continued counseling to encourage the change process will help to ensure positive outcomes.

The systemic problems associated with poverty lifestyles imply a strong need for family counseling. At the same time, the needs of rural families and the extent of dysfunction may be overwhelming. As with most family interventions, it is difficult to get all members of the family to participate, thus changing family patterns is hard as well. What seems to be important is a conceptual focus on the family as the context for change, with systems theories as the foundation for creating effective interventions. If poor, rural women are to be helped to change, they will need to develop an understanding of family dynamics and be helped to make a choice to not perpetuate dysfunctional family patterns in their own lives. Again, empowerment to choose their behaviors and lifestyles must be a priority; however, policies are needed to provide a contextual foundation that makes such choices possible.

Economic and social policy in the United States does not adequately reflect the unique needs of rural, poor, women. Mental health professionals are urged to become advocates for these women, who remain essentially voiceless at this time. Opportunities for advocacy include letters to policy, and decision-makers and statements at public hearings and community meeting. Opportunities for advocacy are internal to the profession as well as external. Saris and Johnston-Robledo (2000) pointed out the dearth of studies and literature within the mental health field concerning the need of rural, poor women. Research—qualitative, quantitative, single case studies, and especially outcome studies to determine effective interventions—is needed to inform clinical practice and to serve as a basis for advocacy. The Cycle of Poverty and Compromised Wellness model provides a starting point for designing needed studies. When available, professional organizations can disseminate the results of research as a basis for challenging economic and social policy to benefit poor, rural women.

A number of barriers to mental health service in rural areas have been identified, and mental health counselors themselves comprise one of these barriers. We need to become aware of the difficulties that poor, rural women face and become knowledgeable about what to expect as the result of poverty. Because of the myriad of problems associated with poverty lifestyles, mental health counselors working with this population need to function as members of an interdisciplinary team to identify and address the social and economic experiences as well as the individual and familial outcomes associated with poverty lifestyles. Skills in strength-based assessments and holistic, wellness interventions are needed. Lack of knowledge often acts to prohibit effective services, while the counselor's own biases and stereotypes, if unexamined, may further reduce both the level and quality of mental health care. Mental health counselors are encouraged to examine their attitudes, beliefs, and behaviors concerning rural and poverty individuals, and women in either or both of these circumstances, and seek mentoring and supervised experiences to help them develop expertise in working with these populations.

CONCLUSION

The Cycle of Poverty and Compromised Wellness model was presented as a conceptual framework for understanding the mental health needs of rural, poor women. Three components of the model include the experience of poverty as reflected in economic and social factors, the impact of poverty associated with individual and familial factors, and the consequences of poverty in terms of challenges to mental health and wellness. This model is cyclical, thus the lifelong impact of poverty on holistic functioning is evident.

In the absence of intervention especially early intervention, the potential for interrupting the cycle is limited. Mental health counselors operating from a preventive, wellness orientation can provide effective strength-based assessments and interventions that have the potential to help young women choose alternate lifestyles and can act as advocates to change contextual factors that function to maintain poverty lifestyles. Research is needed using the proposed model to determine the most effective strategies for achieving positive change and to test the model for inclusiveness and usefulness with both urban and rural women of all ethnic backgrounds.

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