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Carman Sue Gill

Casey Barrio Minton

Jane Myers

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ARTICLES

Poor, Rural Women: Spirituality, Religion, and Wellness Across the Life Span

Carman Sue Gill, Casey Barrio Minton, and Jane Myers

Researchers have suggested strategies in the spiritual domain for improving wellness. This study explored relationships among spirituality, religiosity, and wellness for poor, rural women in early adulthood, early–middle adulthood, and middle–later adulthood. Implications for evidence-based strategies to improve wellness for poor, rural women across the life span are provided.

Keywords: women, spirituality, religion, wellness, life span

Poor, rural women face many documented challenges to mental health and holistic wellness (Gill, Myers, & Barrio Minton, 2010; Myers & Gill, 2004). The challenges affect these women on social (Fuller-Rowell, Evans, & Ong, 2012) economic (Sano & Richards, 2011), familial, and individual levels (Brown, Copeland, Costello, Erkanli, & Worthman, 2009), resulting in a cycle of poverty that is difficult to break (Myers & Gill, 2004). Nationwide, 40.8% of all female-headed rural households are in poverty (U.S. Department of Agriculture [USDA], 2011a). The higher prevalence of depression within rural communities is well documented (Probst, Laditka, Moore, Harun, & Powell, 2005) and constitutes a major public health concern for women in particular (Simmons, Braun, Charnigo, Havens, & Wright, 2008). Yet, as a population, poor, rural women remain understudied and hence their physical and mental health needs remain largely unmet (Dye & Wilcox, 2006).

For many of these women, spirituality and religion represent coping methods linked to holistic wellness (Moorhead, Gill, Barrio Minton, & Myers, 2012). Understanding the role of spirituality and religiosity for rural women in poverty was the first step by researchers in identifying strength-based methods for promoting holistic wellness in this underserved population. However, differential experiences of spiritual and religious coping utilized by poor, rural women across the life span have yet to be addressed. Because spirituality and religiosity have been identified as significant contributors to wellness for poor, rural women as a whole (Gill et al., 2010), understanding the

Carman Sue Gill, Department of Counseling, Argosy University, Washington, DC; Casey Barrio Minton, Department of Counseling and Higher Education, University of North Texas; Jane Myers, Department of Counseling and Educational Development, University of North Carolina at Greensboro. Carman Sue Gill is now at Department of Counselor Education, Florida Atlantic University. Casey Barrio Minton is now at Department of Educational Psychology and Counseling, University of Tennessee, Knoxville. Correspondence concerning this article should be addressed to Carman Sue Gill, Department of Counselor Education, Florida Atlantic University, 777 Glades Road, Building 47, Room 459, Boca Raton, FL 33431 (e-mail: gillc@fau.edu).

specific contributors to wellness across the life span can assist counselors in addressing the particular needs of this client group more effectively.

Wellness has been proposed as the cornerstone of the counseling profession, underscoring the need for counselors to implement evidence-based interventions to improve holistic wellness (Myers & Sweeney, 2008). In our study, relationships among spirituality, religiosity, and wellness for poor, rural women at various ages were addressed. We examined differences among women in early adulthood, early–middle adulthood, and middle–later adulthood to identify potential coping methods for women at different ages. Understanding how these constructs affect holistic wellness has the potential to assist counselors working to improve wellness for poor, rural women.

POOR, RURAL WOMEN

Poverty is more prevalent in rural settings than in urban settings and is experienced at higher rates by female-headed households, a trend that has continued since the first official measurements of poverty in America in the 1960s (USDA, 2011b). Although poverty is defined both quantitatively through poverty rate tables and qualitatively by the USDA, which states that the poor include "any individual with income less than that deemed sufficient to purchase basic needs of food, shelter, clothing, and other essential goods and services" (USDA, 2011a, p. 1), rurality is often more difficult to define. For example, the USDA (2011b) used the terms *rural* and *nonmetropolitan* synonymously and defined nonmetropolitan as any area outside a metropolitan area of 50,000 residents or more.

Frequently underserved by both medical and mental health providers, poor, rural women face overwhelming challenges to wellness (Myers & Gill, 2004). Obstacles such as low income, lower educational expectations, higher school dropout rates, frequent early and high-risk pregnancies, family violence, poor nutrition, chronic underemployment or unemployment, lack of health insurance, substandard housing, and unsafe environments occur in concert with low self-esteem, lack of career goals, chronic stress, depression, anxiety, and negative coping behaviors, and exist in a cycle of poverty from which it is difficult to escape. Moreover, because of geographic and financial factors, women living in poverty in rural areas are frequently unable to access the services needed to meet basic needs. Myers and Gill (2004) portrayed a model of the Cycle of Poverty and Compromised Wellness, adapted from the World Health Organization, to deepen the understanding of the challenges to wellness these women face.

Poor, rural women have high rates of mental health symptoms, particularly stress, anxiety, and depression, which are often related to child care, lack of suitable mental health providers, transportation difficulties, social and geographical isolation, lack of health insurance, economic instability, and traditional beliefs about the roles of women (Myers & Gill, 2004; Simmons et al., 2008). Unfortunately, coping methods used by this population are frequently negative and include tobacco and alcohol abuse, particularly among younger women (American Psychological Association, 2000).

Hardy and Hazelrigg (1993) cited studies documenting the increasing feminization of poverty, particularly among households with older adults. Older adult women living in poverty are likely to be the head of their household or

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live alone, experience declining health, and have limited economic resources in comparison with their male counterparts (Gerrior, Crocoll, Hayhoe, & Wysocki, 2008). Together, these factors contribute to the high risk of depression and mental disorders experienced by this population (Gerrior et al., 2008). As a result, counselors encouraging wellness must assist these women in developing positive coping methods, such as those found in spirituality and religion.

SPIRITUALITY

Cashwell and Young (2011) observed that spirituality is difficult to define, given that it is both universal and highly personal. Numerous authors from faith traditions as well as the psychological sciences have attempted to define spirituality, in many cases as the foundation for the assessment of multidimensional spiritual concepts such as spiritual wellness. For example, Myers (1990) defined spiritual wellness as "a continuing search for meaning and purpose in life; an appreciation for depth of life, the expanse of the universe, and natural forces which operate; a personal belief system" (p. 11). Myers and Sweeney (2005a) defined spirituality as "an awareness of a being or force that transcends the material aspects of life and gives a deep sense of wholeness or connectedness to the universe" (p. 20).

Westgate (1996) conceptualized spiritual wellness in terms of four major themes: meaning and purpose in life, intrinsic values, transcendence, and community of shared values. She noted that meaning and purpose in life were recognized by most existentialists and counseling theorists as central to spiritual wellness and strongly associated with self-actualization. Having "an intrinsically held value system that forms the basis of one's behavior" (p. 29) contributes to a sense of well-being, and persons who consider themselves part of a larger plan and find wonder in the universe realize transcendence. A spiritual community provides individuals with a method for expressing spiritual values and mutual support of spirituality, and a platform for service to other community members and the larger community. Westgate's model builds on existing literature that underscores the pervasive, positive effect of spiritual beliefs and practices, particularly with regard to coping behaviors. As a result, this model was used for our study.

Lindgren and Coursey (1995) reviewed studies on spirituality and coping and concluded that spirituality buffers stressful life events. In addition, spirituality has been found to be positively correlated with physical health and wellness (Myers & Sweeney, 2008). For a variety of disenfranchised groups, components of spirituality have been identified as helpful in coping with major life challenges, whereas specific components of spirituality, such as meaning and purpose, unifying interconnectedness, and private religious practices, have been shown to be effective means of coping for poor, rural women (Gill et al., 2010). Although there is no distinction made in some of these studies, scholars have argued the importance of discriminating between the separate concepts of spirituality and religiosity (Cashwell & Young, 2011).

A study by Gill et al. (2010) confirmed that spirituality and religiosity contribute positively to wellness for poor, rural women, and other studies have linked religious and spiritual development to aging (Dalby, 2006). Tornstam (2011) coined the term *gerotranscendence*, suggesting that as people grow older, their spiritual and religious con-

nections increase, and a review of the literature conducted by Dalby (2006) supports this theory. Howell (2001) theorized that for women in general, midlife is characterized by a powerful spiritual awakening. Furthermore, the Gerontological Competencies for Counselors and Human Development Professionals (Myers & Sweeney, 1990) lists respect for spiritual needs of older individuals in the first competency. However, few studies involving early adulthood in women, age, and spirituality or religion have been conducted and, to date, no studies focusing on life-span differences in spirituality, religion, and wellness for poor, rural women have been documented.

RELIGIOSITY

Like spirituality, religiosity is difficult to define (Fetzer Institute/National Institute on Aging, 1999); however, most theorists agree that religiosity differs from spirituality, describing the external or outward expression of the inward spiritual system (Westgate, 1996). Multifaceted models of religiosity, such as Glock's (1972) Five-Dimensional Model, have been proposed to explain the components of religiosity and how they function to help individuals cope with life challenges.

To better understand religiosity, the Fetzer Institute, in collaboration with the National Institute on Aging, established a working group that examined aspects of religiosity and developed a comprehensive model to explain this construct (Fetzer Institute/National Institute on Aging, 1999). The working group stated that religiosity cannot be studied as a one-dimensional variable; instead, the group posited 12 components of religiosity that must be examined individually: daily spiritual experiences, meaning, values, beliefs, private religious practices, organizational religiousness, religious support, religious coping, forgiveness, religious history, commitment, and religious preferences (Fetzer Institute/National Institute on Aging, 1999). The working group defined each component in detail and operationalized the components through an assessment measure, which has been used extensively in research on religiosity and well-being.

WELLNESS

Myers, Sweeney, and Witmer (2000) defined *wellness* as "a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community" (p. 252). On the basis of previous research from disciplines such as psychology, medicine, health promotion, and anthropology, and the writings of Alfred Adler, Myers et al. (2000) presented a holistic model of wellness and prevention over the life span that consists of six life tasks: spirituality, self-direction, work, leisure, friendship, and love. This theoretical model was subsequently revised based on empirical data, resulting in a new model defined as the Indivisible Self: An Evidence-Based Model of Wellness (IS-Wel; Myers & Sweeney, 2005a).

The IS-Wel model was defined through structural equation modeling and includes a single higher order Wellness factor, five second-order factors of the self (i.e., Creative, Coping, Social, Essential, and Physical), and 17 third-order factors grouped within the second-order factors. Unlike other wellness models, both the theoretical Wheel of Wellness and the IS-Wel are grounded in counseling theory as opposed to physical

health sciences and include a broad range of psychological and physiological factors that contribute to holistic wellness. In both models, one's wellness in any area (e.g., friendship) has an influence on all other aspects of holistic wellness, and vice versa. This structurally sound, highly reliable model of wellness was used as the basis for our study.

Differences in wellness by age and gender have been identified empirically (Dew & Newton, 2005). In a study of West Point cadets, Myers and Bechtel (2004) found that women experienced lower wellness scores for the self-direction subtasks of sense of worth, stress management, and nutrition. Degges-White and Myers (2006) found that psychological factors, such as subjective age, were predictors of both life satisfaction and wellness for midlife women. Given these differences for women and wellness across the life span, it is important to determine how spirituality and religion assist poor, rural women at various ages.

PURPOSE OF THE STUDY

We conducted this study in an effort to better understand the unique interplay among age, spirituality, religiosity, and wellness in a sample of poor, rural women. We addressed the following research questions:

Research Question 1: Do poor, rural women who are in early adulthood, early–middle adulthood, and middle–later adulthood differ significantly in their self-reports of spirituality, religiosity, and wellness?

Research Question 2: Is chronological age correlated with spirituality, religiosity, or wellness for poor, rural women?

Research Question 3: To what extent do spirituality and religiosity predict wellness for poor, rural women in early adulthood, early–middle adulthood, and middle–later adulthood?

METHOD

Participants and Procedure

Upon receiving institutional review board approval from the third author's university, we recruited a diverse group of participants by visiting agencies such as the Salvation Army, a local community college, and nutrition centers. Participants were 158 women who ranged in age from 18 to 90 years (M = 33.05, SD = 18.60), met criteria for poverty or near poverty, and lived in nonmetropolitan areas in North Carolina. Participants were in early adulthood (ages 18–29, 60.1%), early–middle adulthood (ages 30–49, 23.4%), or middle–later adulthood (ages 50 and higher, 16.5%). Women in our study identified as Caucasian (58.9%), African American (17.1%), American Indian (5.7%), Hispanic/Latina (2.5%), and Asian or Pacific Islander (2.5%); 13.3% identified as "other" or opted not to report their ethnicity. Most participants held a high school diploma (57.0%), although 7.6% did not graduate from high school; 24.0% had a trade, technical, or associates degree; and 5.7% had a bachelor's degree. Two individuals (1.2%) reported advanced degrees; 4.4% opted not to report their educational attainment. Participants' estimated pretax income was less than $9,500 (47.5%), $9,501–$15,750 (24.7%), $15,751–$18,500

(5.7%), and $18,501 to $35,500 (17.1%); 5.1% of participants indicated that they met poverty standards but did not indicate an income. (Percentages do not total 100 because of rounding.) Only one third (35.3%) of participants reported currently receiving government subsidies. Because we utilized a modified snowball sampling procedures in which participants were invited to participate by staff at social service agencies, we could not determine a response rate.

Instruments

Instruments included the Spirituality Assessment Scale (SAS; Howden, 1992), the Fetzer Brief Multidimensional Measure of Religiousness/Spirituality Scale (BMMRS; Fetzer Institute/National Institute on Aging, 1999), the Five-Factor Wellness Inventory (5F-Wel; Myers & Sweeney, 2005b), and a researcher-constructed demographic questionnaire.

SAS. Consistent with Westgate's (1996) Spiritual Wellness Model, the SAS (Howden, 1992) includes 28 questions measuring the four factor-derived elements of spirituality: Purpose and Meaning, Transcendence, Unifying Interconnected, and Inner Resources. Participants mark their responses on a 6-point Likert scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Total scores range from 28 to 168, and Howden (1992) interpreted scores between 140 and 160 to represent strong, positive spirituality; scores ranging from 84 to 112 to represent fair or mixed spirituality; and scores under 56 to indicate spiritual distress. Howden reported evidence of convergent and divergent validity via correlations with SAS scores, reports of religiousness, and attendance at religious events. In our study, we observed coefficient alpha reliabilities of .82 (Purpose and Meaning), .72 (Transcendence), .82 (Unifying Interconnectedness, and .88 (Inner Resources).

BMMRS. The Fetzer Institute/National Institute on Aging (1999) developed the 40-item BMMRS to measure 12 dimensions of religiosity. Items are answered using a variety of Likert-type response scales, with lower scores indicating higher degrees of religiosity. In our study, we used six scales—Daily Spiritual Experiences, Forgiveness, Private Religious Practices, Religious/Spiritual Coping, Religious Support, and Organizational Religiousness—and we obtained internal consistency reliabilities of .91, .53, .80, .69, .55, and .78, respectively. The total internal consistency reliability for all six scales was .93.

5F-Wel. Myers and Sweeney (2005b) developed the 73-item 5F-Wel via structural equation modeling (Hattie, Myers, & Sweeney, 2004), which was designed to assess each factor in the evidence-based IS-Wel (Myers & Sweeney, 2005a). Participants respond to each item using a 4-point Likert scale, wherein responses range from 1 (*strongly disagree*) to 4 (*strongly agree*). Scale responses are summed and then computed onto a scale ranging from 25 to 100 for each of five second-order factors (i.e., Essential Self, Creative Self, Physical Self, Coping Self, and Social Self) and one first-order Total Wellness score. In our study, we observed an internal consistency reliability of .94 for the total scale, and alpha coefficients of .83, .85, .86, .78, and .83 for Essential Self, Creative Self, Physical Self, Coping Self, and Social Self, respectively.

Data Analysis

All data were analyzed using SPSS 14.0. We used a one-way analysis of variance (ANOVA) to assess Research Question 1, Pearson product–moment correlations to

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assess Research Question 2, and a series of three multiple regression analyses to assess Research Question 3. An alpha level of .05 was established to determine statistical significance, and effect sizes are reported where appropriate.

RESULTS

Research Question 1

Although we found no statistically or practically significant differences in spirituality among poor, rural women in early, early–middle, and middle–later adulthood, $F(2, 155) = 2.23$, $p = .11$, $\eta^2 = .03$, ANOVAs assessing between-groups differences for religiosity, $F(2, 155) = 9.78$, $p < .001$, $\eta^2 = .11$, and wellness, $F(2, 155) = 6.86$, $p = .001$, $\eta^2 = .08$, were significant. The effect sizes of $\eta^2 = .08$ and $\eta^2 = .11$ indicate a small, yet noticeable effect of age group on religiosity and wellness. Means, standard deviations, *F* values, *p* values, and measures of effect size are presented in Table 1. Follow-up Bonferroni *t* tests indicated that the early adulthood group reported lower religiosity than the early–middle adulthood group ($p = .02$) and the middle–later adulthood group ($p < .01$). Similarly, the early adulthood group ($p = .001$) and the early–middle adulthood group ($p = .03$) reported lower levels of wellness compared with the middle–later adulthood group.

Research Question 2

Research Question 2 was designed to assess relationships among chronological age, spirituality, religiosity, and wellness in this sample of poor, rural women. Chronological age and spirituality were correlated slightly ($r = .18$, $p = .03$), whereas age and religiosity ($r = .34$, $p < .001$) and wellness ($r = .29$, $p < .001$) were correlated to a moderate degree.

Research Question 3

Research Question 3 was designed to assess the degree to which spirituality and religiosity predicted wellness for each of three groups of poor, rural women involved in this study, and we employed simultaneous multiple regressions using forced entry for this analysis. Spirituality and religiosity emerged as strong predictors for women in all

TABLE 1

One-Way Analysis of Variance for Spirituality, Religiosity, and Wellness by Age Category

Variable	*M*	*SD*	*F*(2, 155)	*p*	η^2
Spirituality			2.23	.11	.03
Early adulthood	131.36	18.69			
Early–middle adulthood	135.82	19.46			
Middle–later adulthood	139.44	16.74			
Religiosity			9.78	<.001	.11
Early adulthood	73.39	21.83			
Early–middle adulthood	62.33	17.95			
Middle–later adulthood	55.32	17.94			
Wellness			6.86	.001	.08
Early adulthood	77.17	7.77			
Early–middle adulthood	78.43	9.77			
Middle–later adulthood	84.59	8.65			

Note. Early adulthood age range is 18 to 29 years, $n = 95$; early–middle adulthood age range is 30 to 49 years, $n = 37$; middle–later adulthood age range is 50+ years, $n = 26$. Lower religiosity scores indicate higher degrees of religiosity.

groups; however, predictive power was stronger for the early adulthood group, $F(2, 92) = 33.56$, $p < .001$, $R^2 = .42$, adjusted $R^2 = .41$, than for the early–middle adulthood, $F(2, 36) = 8.26$, $p = .001$, $R^2 = .33$, adjusted $R^2 = .29$, and middle–later adulthood, $F(2, 25) = 5.87$, $p < .01$, $R^2 = .34$, adjusted $R^2 = .28$, groups. Table 2 includes beta weights, p values, and structure coefficients for the analyses. The examination of beta weights and structure coefficients indicates that spirituality accounted for nearly all of the predicted variance in wellness for each of the three age groups. However, religiosity also contributed to a portion of the explained variance, and the strength of religiosity as a contributor to wellness was stronger for women in early middle adulthood ($\beta = .24$, $p = .26$, $r_s^2 = .80$) compared with those in early adulthood ($\beta = .07$, $p = .50$, $r_s^2 = .43$) and middle–later adulthood ($\beta = .13$, $p = .49$, $r_s^2 = .38$).

DISCUSSION

The purpose of this study was to better understand the unique interplay among age, spirituality, religiosity, and wellness in a sample of poor, rural women. In this sample, cross sections of poor, rural women reported an increase in spirituality, religiosity, and wellness as they aged. They also reported spirituality and religiosity as contributors to wellness across the life span. This seems consistent with the literature regarding middle–late adult women and informs the literature for poor, rural women in early adulthood. Further comparison, however, revealed differences among the age groups.

When compared by age, differences were found among means for religion and wellness, but not for spirituality, which appeared to vary little across the life span. Poor, rural women in early adulthood reported being less religious and less well than those in middle–later adulthood; religiosity, wellness, and age were correlated to a moderate degree. This finding suggests that women may become more well as they age, and there is a link between religion and wellness for these women. Given this information, counselors may use interventions based in religiosity, such as prayer, meditation, and the reading of sacred materials, to improve coping for these women, and these interventions may be particularly salient for women in early adulthood, in which early intervention is crucial. It is important to note that, when working in the spiritual and religious domains, counselors should be aware of the spiritual

TABLE 2

Multiple Regressions Predicting Wellness From Spirituality and Religiosity

Variable	R^2	Adjusted R^2	β	p	r_s^2
Early adulthood ($n = 95$)	.42	.41		<.001	
Spirituality			.61	<.001	.99
Religiosity			.07	.500	.43
Early–middle adulthood ($n = 37$)	.33	.29		.001	
Spirituality			.38	.080	.92
Religiosity			.24	.260	.80
Middle–later adulthood ($n = 26$)	.34	.28		<.010	
Spirituality			.51	.010	.95
Religiosity			.13	.490	.38

Note. Early adulthood, $F(2, 92) = 33.56$; early–middle adulthood, $F(2, 36) = 8.26$; middle–later adulthood, $F(2, 25) = 5.87$.

competencies outlined by the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC; 2009) and follow these for ethical practice with clients.

Although women in early adulthood reported the lowest levels of religiosity and wellness, the regression results indicated that spirituality and religiosity were strong predictors of wellness for this group. Spirituality in particular was a very strong predictor of the variance in wellness, indicating that, as with religion, interventions aimed at improving spirituality will also improve holistic wellness. With these clients, counselors should consider interventions aimed at meaning in life, identifying inner resources, and developing connections with others and the divine to promote wellness.

Across the life span of these women, spirituality and religiosity varied in interesting ways as predictors of wellness. For example, early–middle adulthood women relied much more heavily on religion as a contributor to wellness than did early adulthood and middle–later adulthood women, for whom spirituality was a stronger predictor. For early–middle adulthood women, interventions aimed at improving religious coping, religious support, and private religious practices could be most effective in improving wellness. Connections with religious organizations may provide an avenue for overall improvements.

Although women in early–middle adulthood relied more on religion for coping, middle–later adulthood women reported higher levels of religiosity and spirituality, as well as much higher overall levels of wellness when compared with the other two groups. This could indicate that middle–later adulthood women develop more well-rounded, mature methods for coping with the challenges they face throughout the life span, which may be consistent with Fowler's (1981) proposed stages of faith development. For these women, spirituality strongly predicted wellness, leaving the counselor with multiple interventions that may be salient for working with this underserved population. When considering the use of appropriate interventions, counselors should be mindful of the culture and worldview unique to poor, rural women and modify techniques to incorporate their individual religious and spiritual belief systems (ASERVIC, 2009).

Limitations

There are several potential limitations inherent to this study that suggest caution in the interpretation of the results. Grouping the women by age presented a challenge, given that many more young women completed the survey, resulting in unequal group sizes and fewer women over 50. Thus, the middle–later group included those ages 50–90, a large group of women who are very diverse in their own challenges and life experiences. Future researchers may investigate these variables in a sample specific to older adults. Also, the sample was obtained from various locations across the state of North Carolina. Although all these women met the criteria for the study, poverty conditions can vary by geographic area and country. Additionally, women's challenges and responses will vary, so counselors should be aware of this potential threat to generalizability when using the results.

In addition, there are limitations related to the use of quantitative instruments. Spirituality and religiosity were defined and measured using specific criteria, and many individuals and cultures perceive these terms differently. Counselors should always investigate clients' personal beliefs regarding spirituality and religion, as well as take into

account that a certain amount of error will occur in measurement given that no scale is 100% reliable. In our study, several of the religiosity scales had moderate to low reliability.

Implications

The results of our study indicated that early adulthood poor, rural women experienced significantly lower levels of wellness than women in the other groups. However, there is lack of literature and research aimed at understanding the needs of these women and how these needs can be best addressed. We now understand the importance of intervention at an early age and we know that younger, poor, rural women report lower levels of religion, which can be a strong coping method for this group. As a result, counselor education programs must continue to integrate spirituality and religion into their curriculum, specifically through the use of the ASERVIC (2009) competencies. Preparing counselors to effectively address these areas with their clients will be key to improving wellness for poor, rural women. Furthermore, these competencies are crucial for guiding counselors in the use of the types of interventions that will improve wellness for this population.

It is important to note that for all of these women, spirituality was a strong predictor of wellness. Whereas, given our study's results, early adulthood and middle–later adulthood women rely on spirituality more heavily for coping than do early–middle adulthood women, interventions in the spiritual domain will be helpful for all of these women. When working in the spiritual domain, counselors can focus on identifying the areas in which these women find meaning in life and encouraging growth in those areas. Counselors can confidently discuss inherent values that these women have and encourage connectedness. They can assist these women in understanding the temporal nature of suffering and identifying instances and times when transcendence has been effective for them. As a result of this study, we now have evidence that spirituality and religion can improve wellness for poor, rural women.

Further research is needed to identify additional contributors to wellness and develop evidenced-based counseling interventions for poor, rural women. Qualitative studies aimed at providing a greater understanding of what spirituality and religion mean for poor, rural women in differing developmental life stages would assist counselors in customizing interventions specifically for this population. Additionally, because early intervention is crucial in breaking the cycle of poverty and because poor, rural women in early adulthood experience lower levels of wellness, it is imperative that further research studies focus on identifying the needs of these women so that appropriate interventions tailored to their needs may be created and implemented.

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