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RESEARCH

The Wellness and Self-Care Experiences of Single Mothers in Poverty: Strategies for Mental Health Counselors

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Poverty impacts holistic health and wellness, yet little research in counseling has been conducted exploring the holistic wellness and self-care of marginalized groups. Self-care and wellness are important components of overall mental health, and integrating strategies for self-care and wellness can support mental health counseling practice. A transcendental phenomenological design was used to explore and describe the wellness and self-care experiences of 10 single mothers in poverty. Data were collected using individual, face-to-face, semi-structured interviews, conducted for 45 to 60 minutes each. Major themes that emerged from the data include (a) barriers to wellness and self-care, (b) supports with wellness and self-care, (c) single mothers' awareness of wellness and self-care, and (d) personal strengths of single mothers in poverty. Implications for clinical mental health counselors include utilizing strengths-based approaches, wellness, and advocacy interventions for single mothers in poverty.

The relationship between diminished physical and psychological health and poverty experiences is well documented (Weissman, Pratt, Miller, & Parker, 2015; World Health Organization [WHO], 2017). Poverty and decreased mental health are correlated, making the needs of this marginalized population important for clinical mental health counselors to understand (Weissman et al., 2015; WHO, 2017). Rates of depression, anxiety, post-traumatic stress disorder, and substance abuse are higher for persons experiencing poverty, indicating the need for mental health counselors to be prepared to effectively serve this population (Broussard, 2010; Broussard, Alfred, & Thompson, 2012; WHO, 2017).

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In 2016, approximately 40.6 million people experienced poverty in the United States (Semega, Fontenot, & Kollar, 2017). Poverty is an intersectional issue and impacts marginalized groups at higher rates. Age, racial and ethnic identity, gender, sexual identity, ability status, educational attainment, residence, region, and nativity are all factors related to poverty experiences (Semega et al., 2017). In 2016, the poverty rate was 12.2% for men and 14.8% for women (Semega et al., 2017). In households headed by a single adult, the female heads of household experienced double the rate of poverty (28.2%) of the male heads of household (14.9%; Moodley, 2014; Semega et al., 2017). Further, there were 4,200,000 households headed by single mothers in 2016, compared to 404,000 households headed by single fathers (Kramer, Myhra, Zuiker, & Bauer, 2016).

Additionally, single mothers are more likely to use federal assistance such as Medicaid and food stamps and are more likely to report food scarcity than single fathers (Young, Cunningham, & Buist, 2005; Zilanawana, 2016). Single mothers are twice as likely to experience poorer mental health compared to partnered mothers, single fathers, and women in any other group (Beeber, Perreira, & Schwartz, 2008; Broussard, 2010; Broussard et al., 2012; Kramer et al., 2016; Young et al., 2005; Zilanawala, 2016). Single mothers are also more likely to experience depression, anxiety, and substance use disorders compared to partnered mothers their age (Beeber et al., 2008; Broussard, 2010; Kramer et al., 2016; Young et al., 2005). Thus, single motherhood coupled with poverty increases the risk of mental, physical, and social health concerns for such women (Broussard et al., 2012; Weissman et al., 2015; Young et al., 2005; Zilanawala, 2016). It is evident that single mothers face unique social, emotional, and economic challenges. These intersecting risk factors associated with poverty, single motherhood, and mental health needs are paramount issues for mental health counselors to consider.

WELLNESS AND SELF-CARE

Wellness and self-care are cornerstones of effective counseling practice (Granello, 2000, 2012; Kaplan, Tarvydas, & Gladding, 2013). Wellness is "a way of life oriented toward optimal health and well-being, in which mind, body, and spirit are integrated by the individual to live life more fully within the human and natural community" (Myers & Sweeney, 2004, p. 252). Clinical mental health counselors should consider the integration of wellness-supporting practice in their work with clients from a variety of backgrounds, but especially those clients with multiple minority status or those diagnosed with mental health disorders (Granello, 2000; Myers & Gill, 2004; Myers & Sweeney, 2008). Due to the significant and overlapping physical and mental health concerns for single mothers, it is critical to better understand how these women experience wellness and self-care. Wellness is often a protective factor for stress and other mental health concerns (Myers & Sweeney, 2004, 2008). Integrating wellness practices in mental health counseling can be a powerful

tool for client recovery (Granello, 2012; Myers & Sweeney, 2008). Researchers have demonstrated that applying a wellness approach to counseling has a positive impact on the holistic health of clients (Granello, 2012; Myers & Sweeney, 2008; Myers, Sweeney, & Witmer, 2000). Wellness practices can assist in both prevention and remediation of mental health concerns, including depression, anxiety, stress management, and social isolation (Granello, 2012; Myers & Sweeney, 2008; Myers et al., 2000).

The present study utilizes the Indivisible Self model, or IS-WEL (Myers & Sweeney, 2004), as a framework to conceptualize the holistic wellness of single mothers experiencing poverty. The domains within this wellness model include Coping Self (i.e., realistic beliefs, stress management, self-worth, and leisure), Social Self (i.e., friendship and love), Physical Self (i.e., exercise and nutrition), Essential Self (i.e., spirituality, self-care, gender identity, and cultural identity), and Creative Self (i.e., thinking, emotions, control, positive humor, and work). This wellness model is the only empirically validated model of wellness and is grounded in philosophy of holism and the indivisibility of the self (Myers & Sweeney, 2004, 2008), frequently integrated into a variety of counseling settings.

PURPOSE OF STUDY

Little research exists exploring how single mothers in poverty experience self-care and wellness (Broussard, 2010; Broussard et al., 2012; Mendias, Clark, Guevara, & Svcek, 2011). This gap perpetuates a deficit model of health and further marginalizes this population. Conceptualizing health through a wellness lens allows mental health counselors to better understand and address the unique needs of this group in a robust way (Myers & Sweeney, 2008). The present study addresses the following research question: "What are the lived experiences of wellness and self-care for single mothers experiencing poverty?"

METHOD

Tradition and Paradigm

We utilized a transcendental phenomenological tradition to explore the unique perceptions, experiences, circumstances, and worldview of our participants (Moustakas, 1994). Phenomenology is a method for sharing participant voice, which is critically important for this marginalized group (Amankwaa, 2016; Wilson, 2015). The intersectional feminist paradigm was implemented to better understand the experiences of single mothers through the lens of gender and other intersecting identities factors such as age, race, ethnicity, and social class (Crenshaw, 1991; Olsen, 2011). According to intersectional feminism, intersecting identities (such as gender, race, and social class) influence how individuals experience power, privilege, oppression, and discrimination (Crenshaw, 1991; Olsen, 2011). Intersectional feminism is a vehicle to address complex issues that impact women by illuminating issues related to gendered social justice, including political, economic, and social processes that consti-

tute inequality (Crenshaw, 1991; Olsen, 2011). Further, an intersectional feminist paradigm coupled with the transcendental phenomenological tradition provided the researchers an opportunity to amplify participant voice and gain a rich understanding of participants' worldview (Amankwaa, 2016; Moustakas, 1994; Olsen, 2011; Ponterotto, 2010; Wilson, 2015), while considering the intersections of their identities and experiences.

Sampling and Inclusion Criteria

The researchers interviewed 10 participants who met inclusion criteria (i.e., single mothers, ages 18 and older, who were currently experiencing poverty). Phenomenological research typically includes five to 25 participants (Hays & Singh, 2012; Polkinghorne, 1989). This sample size ($N = 10$) is appropriate due to the richness and thickness of the participant data shared and analyzed. The data collected captured the essence of participant experience as it relates to the phenomena explored within this study. We sought to address transferability, or the ability to transfer results from this study into other settings and populations, through the use of thick description of the phenomena (Amankwaa, 2016; Hays & Singh, 2012; Wilson, 2015). With 10 participants we were able to capture the lived experiences of this minoritized population and highlight the essence of participant lived experiences via the phenomenological method (Moustakas, 1994).

Participants were selected using a snowball sampling method, which involves using participants' relationships with others to identify additional cases that meet the study inclusion criteria (Hays & Singh, 2012). This is an appropriate strategy for accessing vulnerable groups of people (Hays & Singh, 2012). To engage in snowball sampling, the lead researcher began with one participant, a single mother experiencing poverty who was receiving childcare services at a local nonprofit. Then the lead researcher asked the participant if she knew other women who might also meet inclusion criteria. This process was repeated throughout data collection until 10 participants were contacted and included in the study.

Participants

A diverse sample of single mothers participated in this study ($N = 10$), including women of different ages, racial and ethnic identities, employment statuses, numbers of children, and lengths of time in poverty. Participants identified as Black or African American ($n = 5$), White ($n = 4$), and Hispanic ($n = 1$). Participants' ages ranged from 19 to 26 ($M = 20.5$ years, $SD = 2.72$). Participants in this study identified as single ($n = 8$) or in a relationship ($n = 2$). Participants who identified as "in a relationship" were included in the present study because their partners did not live in the home or provide any financial support to the participants or their children. Participants in this study indicated having one ($n = 7$) or two children ($n = 3$). The ages of the children ranged from 1 to 7 years ($M = 2.5$ years, $SD = 1.97$). Participants' time in poverty ranged from 7 months to 26 years ($M = 3$ years, $SD = 7.47$).

Research Team, Researcher Roles, and Researcher Bias

A research team addressed and managed subjectivity and biases throughout the research process, in a strategy used for trustworthiness in qualitative research (Hays & Singh, 2012). The research team was composed of three members total, the lead researcher and two additional members. The lead researcher was involved in all parts of the research process, to include constructing the protocol, recruiting and interviewing all participants, coding transcripts, creating the codebook, and writing the research report. The lead researcher identifies as a White woman who is child-free and does not identify as living in poverty; she has lived experiences as a child of a single mother. The second and third researchers were involved in coding transcripts (five each) and the creation of the codebook. The inclusion of these researchers in the process helped address any individual researcher biases or stereotypes and added triangulation of the researcher. The second researcher identifies as a White man who does not identify as being in poverty or have lived experiences with a single mother. The third researcher identifies as a White woman who does not identify as being in poverty or have lived experiences of single motherhood.

The research team attended regular research meetings and participated in the research procedures such as bracketing, coding interviews, and creating a codebook. The researchers engaged in bracketing throughout the entire research sequence through memoing, reflexive journaling, and research team meetings, appropriate methods in a phenomenological inquiry. As the researchers represent a component of data analysis (i.e., researcher as instrument; Hays & Singh, 2012), a discussion of research team biases and assumptions is critical. The research team assumed that single mothers in poverty experience significant barriers (i.e., financial, occupational, educational, health, social), which impairs their ability to engage in self-care. The researchers also assumed that single mothers in poverty experience stigma, oppression, and marginalization based on their intersecting identities such as gender, racial and ethnic identity, parenting status, and social class.

Data Sources

The present study was reviewed and approved by the researcher's institutional review board prior to participant recruitment and data collection. Participants consented to participate in this study by voluntarily signing an informed consent document.

Demographic questionnaire. The demographic sheet was given to all participants during the initial interview and included questions about age, gender, racial/ethnic identity, relationship status, number of children and children's ages, employment status (e.g., full-time, part-time, student, or unemployed), length of time in that employment status, and length of time in poverty (e.g., year and months). The demographic sheet served to describe the sample in the study and was created to ensure researchers had a robust understanding of participants' identities, in comportment with intersectional feminism (Crenshaw, 1991).

Semi-structured interview. The interviews were conducted face-to-face and audio-recorded for transcription purposes and lasted approximately 45 to 60 minutes. Each question in the protocol was open-ended, which allowed participants to provide a richer description of their experience with the phenomena. Probing questions were used throughout the interview to gather a deeper understanding of participant experience (Hays & Singh, 2012). Sample interview questions included "Tell me about your experiences as a single mother," "What self-care practices do you do, if any?" and "How do you describe your personal wellness?"

Data Analysis

To begin the data analysis process, the lead researcher transcribed all participant interviews verbatim. Each transcript was coded twice to build consensus; initial coding was done by the lead researcher and a member of the research team (Hays & Singh, 2012). The team coded salient words, phrases, and sentences that connected to the phenomenon of interest (Moustakas, 1994). The research team identified non-repetitive and nonoverlapping statements in each transcript, a process congruent with the phenomenological tradition called *horizontalization* (Moustakas, 1994).

Consensus coding. When individual coding was completed, the research team met to begin consensus coding the data. The use of multiple researchers is particularly important in the consensus coding process and involves the researchers arriving at a shared definition of each code and cocreating knowledge about the phenomena studied (Hays & Singh, 2012). Each code was discussed with the research team to reach agreement (Hays & Singh, 2012). This was accomplished through structured consensus meetings; notes were recorded by a member of the research team in comportment with consensus coding (Hays & Singh, 2012). Significant statements and phrases that connected to the phenomenon were identified and removed from each transcript to develop *meaning units* in this consensus coding processes. These significant statements captured the meaning of the phenomena being explored and assisted the researcher in constructing themes that described the phenomena (Moustakas, 1994), in comportment with transcendental phenomenology.

Codebook construction. The researchers revised the codebook throughout the data analysis process, congruent with qualitative strategies of simultaneous data collection and analysis (Hays & Singh, 2012). The research team engaged in the process of *constant comparison* to construct a strong codebook (Hays & Singh, 2012). New codes were added to the codebook when existing codes did not fit the data (Hays & Singh, 2012). The research team made decisions about collapsing codes into larger categories that described the phenomena (Hays & Singh, 2012). Finally, all draft codebooks were examined for parallel findings before finalizing the codes (Hays & Singh, 2012).

Trustworthiness

We addressed trustworthiness using the following criteria: credibility, transferability, dependability, confirmability, authenticity, coherence, sampling

adequacy, ethical validation, substantive validation, and creativity (Amankwaa, 2016; Hays & Singh, 2012; Levitt, Motulsky, Wertz, Morrow, & Ponterotto, 2016). To meet these criteria, several strategies of trustworthiness were utilized: (a) an auditor and an audit trail containing reflective journals to provide physical evidence of systematic research procedures such as bracketing, data collection and analysis (Hays & Singh, 2012; Levitt et al., 2016; Moustakas, 1994), transcripts, and demographic sheets; (b) prolonged engagement with the participants; (c) triangulation through the use of a research team; (d) member checking, whereby participants reviewed their individual transcript; (e) a thick description of participant experience, including pertinent quotations from participants.

FINDINGS

The following themes emerged from the participant data: (a) barriers to wellness and self-care, (b) supports with wellness and self-care, (c) single mothers' awareness of wellness and self-care, and (d) personal strengths of single mothers in poverty. Participant quotations used below are associated with pseudonyms.

Barriers to Wellness and Self-Care

Participants identified six barriers to their wellness and self-care: (1) emotional barriers to wellness and self-care, (2) balancing roles and responsibilities, (3) lack of self-care, (4) lack of support, (5) lack of resources, and (6) systemic oppression. Several participants (n = 6) described their experiences as single mothers as emotionally stressful in a variety of ways. Cora explained:

> It is honestly, it is kind of very challenging. Like, I tell my friends that don't have kids really wait because it is … she is the joy of my life, I couldn't imagine it without her, but definitely could have waited because it's hard.

Furthermore, participants (n = 2) expressed feelings of guilt if they were to practice self-care, which ultimately prevented them from engaging in wellness-enhancing activities. Willow shared:

> Parents who do take the time to practice self-care are seen as selfish, but I don't think that they are. I don't think that people who haven't been children of single mothers or who are single parents, I don't think they understand that something is being neglected … I mean, I feel guilty even when I choose to do my homework instead of taking her to the park or something like that. I know I would feel guilty if I would take that time for myself.

Other barriers to wellness expressed by participants include self-consciousness (n = 1), reluctance to reach out to others for support (n = 5), and perceived judgment from family (n = 3). Cora explained the challenges in reaching out to others:

> I have a pride issue that I am trying to get over. I am a very private person, but I'm starting to get over that because it took a toll on me, so. I was freaking myself out trying to do stuff. I just have an issue. I just feel like that's my baby, you know, I don't want to ask anybody, that's my decision, that's my thing.

Participants noted challenges in balancing their responsibilities as mother, worker, and student (n = 8). Tracee expressed her duty as a role model:

> As a mom you are a model. As a parent in general because that's the person my kids are around me all the time ... I'm the adult and the fact that they are girls, I am the person they see, the person that is supposed to show them how to be. So, now I am learning, especially being the only person now that their dad is out of the picture, that I am the only person they have to look up to. They do have their family and their teachers and stuff, but I am the regular.

Participants expressed that their child was a priority over their own needs (n = 5). Cora explained a need for balance in her role as a parent as it relates to her health:

> I am learning though to start caring for myself better because I was lacking on eating and stuff. I just I am so wrapped up into in caring for her and it finally took a toll on me. I lost a lot of weight because it's just hard to care for her and try to go to school. It is, it's hard.

Furthermore, participants expressed the importance of protecting their children from the hardships they experience as a single parent (n = 3). Stephanie shared the importance of protecting her child:

> I can't be stressed out around her because kids her age are like sponges. They know how you're feeling and, and I know now, my feelings are her feelings, basically. So, I can't so, I can't be sad or depressed around her because I know she can tell, she'll see it and like I said, I don't want her to go through it. I would have to go somewhere else and cry about and then go about my day.

Participants (n = 5) expressed that they do not practice self-care and that if they do, it is very minimal: that is, taking care of basic needs such as sleeping and eating. Willow stated that she does not engage in any self-care beyond her basic needs: "Self-care? Nothing because sleep is something you have to get, so yeah. I mean, I don't have naps or anything. Just, yeah. I just get regular sleep. Like, I take care of myself the bare minimum: sleep, shower, eat." This quotation illustrates that participants consider self-care to be above and beyond basic needs such as hygiene, sleep, and nutrition.

Most participants (n = 8) shared how lack of support from their family, from friends, and from their child's father impacted their wellness. Charlotte explained: "I got pregnant when I was around 16 and then after, my family, some of my family started disappearing and didn't want nothing to do with me

and that's still to this day." Most participants cited a lack of resources such as time, money, and childcare ($n = 8$). Some participants ($n = 5$) identified money as a barrier to their wellness and self-care as a single mother. Tracee explained how money interferes with her ability to engage in activities for her wellness: "As far as treating myself, I don't really get to do that a lot because of my financial situation." Participants ($n = 3$) identified childcare as a challenge as a single mother. Child concerns related to quality care, trust, and affordability were expressed as lack of support from the participants in this study as it related to their barriers to wellness.

Participants ($n = 2$) noted systemic oppression and the difficulties in navigating an oppressive system. Angela shared her experiences with receiving government assistance:

> Being a single mom, it's like frowned upon, like getting government assistance because everyone thinks if you get it that's where you're going to stay forever and you're never going to get away from it, so. Like, I feel like, it's kind of hard to want to get that assistance because society is going to look down on you but um, I definitely think that part is definitely one of the hardest parts.

This quotation illustrates the challenges single mothers experience in receiving government assistance to help care for their children.

Supports for Wellness and Self-Care

Participants within this study cited four supports for their wellness and self-care: strategies for mental health, physical health, social health, and spirituality. Many participants noted taking time for self as helpful in supporting their wellness ($n = 6$). Additionally, participants cited creativity and working with their hands (e.g., cooking, doing hair) as supports for their wellness ($n = 5$). Journaling and music ($n = 6$) were other supports for mental wellness mentioned by several participants in this study.

Some participants ($n = 5$) cited basic hygiene as a support for physical wellness. This included activities such as bathing daily and grooming or styling their hair. Additionally, participants shared the importance of maintaining their appearance, such as having their hair or nails done ($n = 4$). Physical exercise was also included in many participants' experiences with physical wellness, such as going to the gym, working out at home, and doing yoga ($n = 6$). Moreover, participants noted the importance of consuming a healthy diet to support their physical well-being. Participants cited supportive relationships as important to wellness. Willow's quotation highlights this finding:

> Even though I am a single parent I have people who help me like [community agency], which is absolutely wonderful and then I have my parents who are great about everything and then her dad and her dad's parents. And it's just that, I am privileged with how much support I do have compared to other single mothers, but it's just like their time is so limited, and I don't want to overuse the support I do have, so.

Participants expressed how their children, family, friends, and coworkers supported their wellness. Support from other single mothers was specifically cited by participants (n = 3). Angela expressed this theme: "I have one very close friend who, she's in the same situation that I am in, single mom, but now she's found someone, but she knows a lot about what I am going through." Additionally, participants (n = 2) cited spirituality as a support for their wellness. Tracee shared the importance of spirituality for her personal wellness:

> Spirituality. That's the first thing. Definitely my focus on God and trusting in Him if I'm having a stressful day … I know that if I am smart about it then God will take care of it, so, spiritual wellness is really big for me.

Single Mothers' Awareness of Wellness and Self-Care

Many participants in this study discussed how their mood, energy levels, nutritional choices, and engagement with others are connected to their wellness. Participants (n = 6) expressed that their mood indicates whether or not they are well or unwell. Symptoms of both depression and anxiety were identified by participants when they were unwell. Additionally, participants (n = 2) cited their energy levels as indicators of their wellness; this was expressed as low energy and a lack of motivation. Participants cited their nutritional choices as they relate to their wellness (n = 3). Cora explained: "My vitamin D levels are very low and my kidney and liver function were messed up and that was all from not eating."

Participants (n = 2) expressed the tendency to connect with others as an indicator of their wellness, as explained by Willow:

> When I feel good I want to talk to people, I can like feel emotions for other people, I am more empathetic when I am well. Um, and let's see. I just have a more very positive attitude when I [am] well. My attitude is relatively positive all the time um, but I am definitely more optimistic when I am well.

All participants indicated that their personal wellness influences their children and other family members in a variety of ways (n = 10). Lea explained how her personal wellness influences her family: "I would say that I try not to let it influence my family, but I know that on days when I'm like having a rough day I am sure I'm like harder on him and not as fun to be around for my son or anyone else." This quotation illustrates that the personal wellness or unwellness of single mothers has both negative and positive effects on their children.

Personal Strengths in Single Motherhood

Many participants in this study noted such personal strengths as self-awareness, self-esteem, autonomy, resiliency, positive experiences in single motherhood, and intentionality with wellness and self-care practices (n = 7). Participants (n = 3) expressed their ability to notice what their needs are and how to respond to those needs to enhance their wellness; this theme was defined as *self-awareness*. Participants (n = 1) cited *autonomy* as a strength

as a single mother. Additionally, participants (n = 1) noted *self-esteem*, *resiliency* (n = 2), *positive experiences as a single mother* (n = 3), and *intentionality with wellness and self-care* (n = 4). Personal characteristics as sources of strength were described as maintaining a positive attitude, perseverance, and patience. This theme was illustrated by Angela's statement:

> My strengths are that whenever I know it's time it's time to get it together, I can, like I know exactly what I need to and I can get it done quickly. Like one of my big things whenever I notice myself coming down, like to pick me up is to, um, listen to music or read a really good book and I always have at least one new book on hand in case. So, I think that's something that I know really good about myself to get myself back up on my two feet.

DISCUSSION

The findings of this study indicate that single mothers in poverty have varied yet similar experiences with wellness and self-care. These experiences can be utilized by mental health counselors who work with this unique marginalized group. Many of the themes expressed by participants are congruent with existing literature, such as lack of self-care, mental health concerns (e.g., depression, anxiety, substance use), lack of nutrition, poor physical health, and social stigma and discrimination (Broussard, 2010; Broussard et al., 2012; Kramer et al., 2016; Mendias et al., 2011; Myers & Gill, 2004). The strongest connection to previous research includes emotional barriers, lack of social support, stigma, and lack of resources (e.g., time and money; Broussard et al., 2012; Dejean, McGeorge, & Carlson, 2012; Hochschild, 1989; Myers & Gill, 2004; Vickery, 1977; Zilanawala, 2016). This indicates that single mothers in poverty may have a lack of self-care practices due to their responsibilities as a single mother, suggesting that single mothers may view self-care as a privilege for single mothers and not necessarily accessible in their daily life. Clinical mental health counselors could work directly with clients to bolster their ability to integrate these practices in the daily lives of these women.

The findings of the present study show an array of wellness supports for single mothers in poverty, including mental wellness supports, physical wellness supports, social wellness supports, and spirituality. Previous studies support these findings; family, friends, community, and spirituality have been indicated in supporting the wellness of single mothers (Broussard et al., 2012; Moodley, 2014). However, the present study is unique because it indicates the individual wellness supports and coping of participants, including leisure time, journaling, and music (i.e., mental wellness supports), hygiene, exercise, and nutrition (i.e., physical wellness), child, family, friends, other single mothers, community (i.e., social wellness supports), and spirituality, which may be particularly useful to single mothers who experience poverty.

A specific finding of this study is that single mothers receive support from other single mothers. Women who do not have established social networks within their family, friends, or community may find support outside of those

systems within the single-mother community. This is an item clinical counselors could consider when working with this population. It may be useful to connect single mothers to one another via group counseling or other support groups in the area. Participants reported being aware of their wellness and their needs as a strength, which has not been previously presented in the literature. This is congruent with empowerment approaches in counseling, meaning that mental health counselors can leverage existing client strengths to assist in treatment planning and recovery (Granello, 2012; Myers & Sweeney, 2008).

Finally, the personal strength of intentionality with wellness and self-care is unique to the present study. These findings in this study highlight the need for awareness and advocacy for single mothers. Mental health counselors should be aware of the barriers that exist for marginalized women as depicted in Figure 1. Mental health counselors must be aware of how these barriers impact the wellness and self-care of these women and advocate to eliminate the oppressive systems that continue to marginalize women, single mothers, women in poverty, and all intersections of those groups. Additionally, counselors should emphasize the personal strengths (autonomy, self-awareness, self-esteem, resiliency, and intentionally) of this group and connect this to overall wellness promotion.

IMPLICATIONS

Single mothers experiencing poverty have a clear need for self-care and wellness that is unique; mental health counselors occupy a unique space in the treatment of these women and therefore could provide a critically important service in alleviating this deficit. Due to the complex mental health needs of single mothers experiencing poverty, mental health counselors may be on the front lines at helping this population integrate wellness into their experiences. Increasing wellness can be a protective or supportive factor in mental health recovery (Granello, 2000, 2012; Myers & Gill, 2004; Myers & Sweeney, 2008); helping single mothers understand and integrate self-care and wellness can be a useful treatment tool for mental health counselors.

Clinical mental health counselors should work to understand this group's needs on the micro, meso, and macro levels to support their overall wellness (Bronfenbrenner, 1979; Ratts, Toporek, & Lewis, 2010). Mental health counselors should be aware of the unique barriers expressed by these women (e.g., time, money, childcare, emotional distress, guilt) and how these barriers could be navigated to increase wellness. Some examples of this include assisting these women in applying for federal assistance programming to alleviate issues related to transportation and childcare and connecting them to additional community resources such as specialized support groups, youth programming for children, and mental health case management.

Some practical applications for counseling single mothers and increasing their overall wellness could include integrating empowerment skills consistent within feminist therapy approaches (Clark, Neukrug, & Long, 2017; Foss-

Kelly, Generali, & Kress, 2017) and various advocacy interventions (Ratts et al., 2010; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). Because time is a significant barrier for the participants within this study, it is important for mental health counselors to consider conducting services within the home and the community; this strategy may accommodate single mothers with transportation or childcare concerns. Psychoeducation about wellness and self-care is also an important intervention for mental health counselors to integrate in their work with single mothers in poverty. It was clear that many of these women did know how, when, or what to do for self-care. Mental health counselors can work in session to help clients understand self-care and wellness practices that are accessible to their clients. Due to financial barriers, mental health counselors and clients should explore self-care strategies that are cost-free and accessible.

Another concrete strategy mental health counselors could use is collaborating with clients in creating an individualized wellness plan (Granello, 2012). This could include specific self-care interventions. Examples may include sharing information with clients about free activities such as walking in the park, attending local events, and engaging in leisure activities such as listening to music, reading, journaling, or meditation. Other interventions at the micro level could include strengths-based interventions such as exploring clients' personal strengths and how they can use their strengths to enhance their wellness and support their overall mental health. A component of this wellness plan could be helping clients use self-care practices to self-soothe when symptomology of presenting concerns arises (e.g., using meditation or yoga poses to manage anxiety or panicked feelings; Granello, 2012; Myers & Sweeney, 2008).

On the meso level, mental health counselors should explore any existing supports in their clients' lives and assist them in integrating such supports to enhance their wellness. Advocacy interventions at this level could include

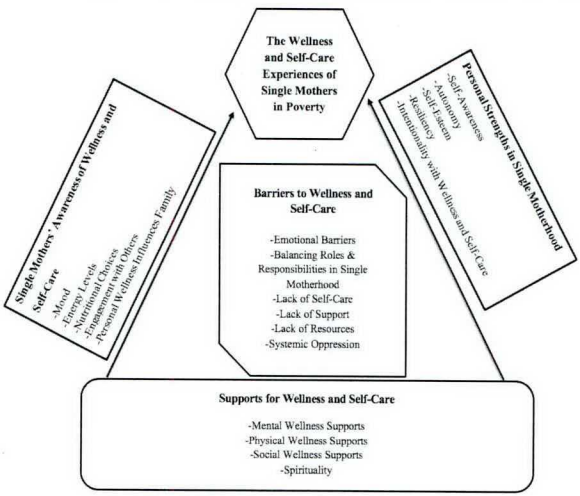

Figure 1. The self-care and wellness experiences of single mothers in poverty: Codes and subcodes.

establishing positive support systems (e.g., by strengthening interactions within existing networks such as family, friends, and coworkers). Moreover, mental health counselors should work with clients by identifying new opportunities to increase interactions with new people (e.g., within their communities and workplaces or in specialized support groups for single mothers). This could include starting a counseling group for single mothers experiencing poverty. Interventions at the macro level should include advocating at the local, state, and national levels to increase the visibility of barriers and strengths of this population to reduce stigma and increase access (Ratts et al., 2010). Mental health counselors should advocate to effect policy and promote equitable access to resources such as quality and affordable healthcare, daycare facilities, transportation assistance, and case management services. This calls for mental health counselors to go beyond their offices and advocate with and for clients to promote overall wellness.

FUTURE RESEARCH DIRECTIONS

Future research should evaluate the efficacy of current wellness models with marginalized populations. No empirical research exists exploring the use of existing wellness models with marginalized groups. Without such research, mental health counselors may not be practicing in comportment with current ethical and multicultural standards (American Counseling Association, 2014; Ratts et al., 2016). Quantitative methods could include a pretest/posttest method to measure clients' wellness levels before and after integrating wellness interventions in mental health counseling. A predictive design could also be conducted to investigate the relationship between income and wellness in a sample of single mothers. Additionally, a hierarchical linear regression could be conducted to determine the strength of the relationship between income; wellness; and demographic factors including, age, racial and ethnic identity, and number of children. These research directions could add evidence for mental health counselors to better understand the experiences of marginalized populations and how to best serve them in clinical practice.

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