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On Seeking Help: Social Reactions Experienced by Sexual Violence Survivors in the Indian Diaspora

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Abstract
Sexual violence trauma counseling should be informed by the intersections of a survivor's identity. This research focused on the social reactions experienced by survivors of sexual violence from the Indian diaspora. This study used quantitative survey research methods and correlational analysis as well as descriptive statistics to understand the social reactions that survivors received from informal supports and formal supports. Significant results, implications for counselors, and future research recommendations are discussed.

Survivors of sexual violence face many barriers to disclosure and support seeking. Societal messages, legal systems, and lack of access to resources have long suppressed disclosure of and support seeking after experiences of sexual violence (McPhail, 2015), though recent social media movements and documentaries have attempted to change the narratives around sexual violence (PettyJohn et al., 2018). While the United States (US) has seen these changes in the dominant culture, little notice has been given to survivors from marginalized populations.

Individuals in marginalized populations negotiate dominant narratives with their own cultural lenses. The socialization and narratives of these survivors are a combination of dominant and cultural narratives (Rosetto & Tollison, 2017). One such population, members of the Indian diaspora, represents an immigrant culture that holds onto much of its ethno-cultural values (Kuiren, 2005), leading to the unique interaction between the stigma of sexual violence and support seeking.

Sexual Violence Within the Indian Diaspora

Data show that sexual violence in the Indian diaspora is heavily underreported (Niaz, 2003). Lack of disclosure is driven by stigma and a fear of victim-blaming. Survivors in the Indian diaspora can be subjected to further violence through honor killings, rape, and dowry-related crimes upon disclosure (Niaz, 2003). This prevalence of sexual violence and the consequent underreporting is reflective of the values of the society, influenced by the intersection of the cultures of their country of origin and the dominant culture (Rosetto & Tollison, 2017).

Sharma, Unnikrishnan, and Sharma (2015) compare the literature and resources in India to that of the US, asserting that India needs to learn more from the US in

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addressing sexual violence and accurately reporting the incidence of assault. They claim that, with the introduction of the Rape, Abuse, and Incest National Network (RAINN) and over 650 other organizations dedicated to survivors of sexual violence, the United States has decreased the incidence of sexual violence by 60 percent since 1993 (Sharma, et al., 2015). This increase in resources also helps first-responders such as emergency rooms or police to connect survivors with further resources (Ullman & Filipas, 2001).

Rosetto and Tollison (2017) discuss that family and sociocultural level messages influence each other and suggest understanding all cultures influencing an individual to reduce negative consequences. These authors also apply script theory to name that distinguishing sexual violence and support resources are defined by these messages (Rosetto & Tollison, 2017). Support seeking is determined by the problem definition and resource availability (Whittaker & Garbarino, 1983). Thus, these messages have implications for support seeking.

Support Seeking

A survivor's choice of when and from whom to seek support relies on the availability of and access to resources. Survivors of sexual violence will often seek help directly after or within the first few weeks after their experience (Orchowski & Gidyz, 2012). A few of the respondents wait more than a month to a year to disclose, which might mean access to their supports is a factor in disclosure (Osgood & Lee, 1993). Consequently, support seeking from formal mental health resources or informal supporters is informed by availability. Survivors' reflections on the support they sought show that people often access the informal supports of people they encounter normally (Orchowski & Gidyz, 2012). This is reflective of the dominant culture. To understand the Indian diaspora, one must also understand the cultural perspectives on support seeking and sexual violence.

Cultural Perspectives

Few studies have looked at sexual violence survivors within the Indian diaspora. Some studies have broadly looked at intimate partner violence within the South Asian diaspora and these have focused on messages survivors receive. Other studies on survivors in the United States might have had a few participants from the Indian diaspora, but those participants are more broadly categorized within "Asian-American." Understanding of cultural perspectives, therefore, is informed by research general support seeking for the Indian diaspora.

Some trends have been observed regarding what influences Indian-Americans to seek support or stay silent. Indian-Americans, like many other immigrant communities, are less likely to endorse that issues are caused by physical distress, personality, or family issues (Sabina, et. al., 2012; Yeh, et al., 2004). They are also less likely to seek mental health support (Yeh et. al., 2004). Survey research on Asian-

Americans, which includes Indian-Americans, reports the lowest rates of professional help-seeking of all the ethnic populations in the United States (Garland et. al, 2005; Ho, et al., 2007). This phenomenon is connected to parents and family being strained through the use of this service (Yeh et al., 2004).

Informal Support. Indian-Americans are often not knowledgeable about professional supports (Robertson et. al., 2015; Gill, 2004), and therefore may use informal supports. Previous literature on support seeking for Indian-Americans has been focused primarily on a stigma towards mental health resources (Miller et. al., 2011). There have been a few investigations into other forms of support seeking (John & Montgomery, 2012; Kumar & Nevid, 2010; Shoemaker, 2016).

Shoemaker (2016) observed that, in the case of finances and health, members of the Indian diaspora sought support from their parents, and also noted that these same participants, when seeking support for relationships, would seek support from siblings and friends. These are consistent with many of the behaviors within the dominant society in America (Orchowski & Gidyz, 2012). One main distinction between the Indian diaspora and the dominant population is that Indian-diaspora tended towards seeking support from those more culturally similar to them (Shoemaker, 2016).

Formal Support. Studies report conflicting evidence regarding the perceptions of mental health help-seeking. Some studies show that some Asian-American populations relate mental health issues with shame, and others reflected that more traditionally Asian families will be more likely to seek support (Daley, 2005; Lau & Takeuchi, 2001; Lowinger, 2009). It is not certain how much of this research addresses Indian diaspora in particular, but a few different studies explore Indian-American support seeking behavior.

Indian-Americans have a stigma towards seeking professional supports, instead of relaying that they would rather leave issues and concern in the confidence of their family units (Shoemaker, 2016). Both Shoemaker (2016) and Kumar and Nevid (2010) found that an exception to this was when it came to physiological concerns. Indian-Americans are more likely to seek support if there is a physical symptom, such as a stomachache or bodily trauma. Results from this attitude have been echoed in several other quantitative inquiries (Constantine et al., 2005; Miller, et al., 2011; Panganamala & Plummer, 1998). It takes a significant disturbance to bring Indian-Americans in to seek professional support, which might result in members of this community seeking support from informal sources.

Types of Reactions Experienced by Survivors

The reactions experienced by survivors can either add to their trauma or create a healing environment for the survivor (Bolger et al., 2000). Research into

social reactions has observed both negative and positive reactions upon disclosure of sexual violence (Orchowski & Gidyz, 2013; Relyea & Ullman, 2015; Ullman & Filipas, 2001). Negative reactions include victim-blaming, stigma, controlling responses, egocentric responses, and distracting responses. Positive reactions, on the other hand, include emotional support and provision or discussion of tangible aid (Relyea & Ullman, 2015).

Negative Reactions

Former studies stated that survivors were often questioned about their part in their experience of sexual violence (Orchowski & Gidyz, 2013; UlIman & Filipas, 2001). This blame is associated with negative coping and self-blame. Many survivors who self-blame also socially withdraw (Relyea & Ullman, 2015). Stigmatizing responses also reinforce that the survivor is the problem in the scenario, rather than acknowledging that a crime was perpetrated upon them or the negative aspects of society. Stigmatizing responses another example of the pervasiveness of rape culture and patriarchal narratives (Johnson & Johnson, 2017; McPhail, 2015).

Controlling responses impact the power and agency of the survivor. Unlike tangible support, which provides the survivor with resources and support, controlling responses take over the survivor's narrative and enforce messages about the survivor's experience. Egocentric responses focus on the supports experience rather than that of the survivor. Distracting responses validate that sexual violence occurred, but take away from the survivor's opportunity to disclose their story (Relyea & Ullman, 2015).

Positive Reactions

Bolger at al. (2000) found that the survivor incurs an emotional cost when they seek support, and if it is not substantiated by benefits, this can be harmful to the survivor. Therefore, emotional support is one type of positive support. Another positive reaction is the provision of tangible aid, which might be in the form of a referral, discovering coping skills, legal support, etc. (Relyea & Ullman, 2015).

Purpose of Research

This research addresses the gap in research about sexual violence survivors in the Indian diaspora. Specifically, this research looks at the social reactions experienced by survivors and relates these reactions with the supports that survivors' access. The questions are two-fold: "What are the social reactions experienced by sexual violence survivors in the Indian Diaspora?" and "What types of social reactions do survivors experience according to the source of support?"

The first hypothesis is in accordance with much of the scholarship around sexual violence in the both India and the United States; it is hypothesized that survivors will experience fewer positive reactions from their sources of support, regardless of the number of supports. According to the

patriarchal narratives in Indian culture and Sharma et al. (2015), research into differences in experiences of sexual violence, the hypothesis was that family will espouse more Indian values, which would lead to more overall negative and fewer overall positive reactions from family. However, given the reduction of sexual violence reported in recent years (Sharma et al., 2015), it was also hypothesized that other supports, including friends and mental health providers, will provide more overall positive reactions.

Theoretical Framework

Cultural ideas of power explain how survivors might view their experiences. Critical to understanding this link between culture and perceptions of sexual violence is the concept of power. Feminist theory sees sexual violence as driven by power rather than sex (McPhail, 2015), which supports that cultures may view power differently, thereby studying sex and sexual violence differently. Understanding immigrant cultures in the United States requires an inquiry into the positive and negative messages embedded in the culture of origin, the dominant culture, and the process in how these cultures interact (Adam & Schewe, 2007; Ayyub, 2000; Gill, 2004; Kurien, 2005).

Methods

The data analyzed and reported in this article are part of a larger study understanding the relationships between acculturation, support seeking behavior, and social reactions. Prior to beginning the study, the researcher sought approval from the respective review board. The study was approved and conducted in spring 2019. Participants were recruited online and completed an online survey with all of the respective measures.

Participants

Eighty-six participants were recruited in the study. Out of these, 55 people ultimately completed the measures to understand social reactions. Participants were self-identified women of Indian origin that had experienced sexual violence. These participants ranged in age from 21 to 48 years old and represented various areas of the United States though the majority of respondents (30.9%) were located in the New England area.

Measures

The researcher disseminated the survey online and conducted recruitment through social media and email distribution lists. Respondents were asked to complete an informed consent, demographics form which included an area to identify experiences of sexual violence, acculturation measure, support checklist, and the Social Reactions Questionnaire (SRQ; Relyea & Ullman, 2015).

Sexual Violence Checklist

Demographics included a sexual violence checklist in which the respondents to identify the types of sexual violence they

have experienced. Respondents were able to identify multiple responses out of seven total items. The participants shared that 96.4% of them had experienced cat-calling or eve-teasing, 60% reported sexual harassment in the workplace or school, 87.3% reported sexual assault, 32.7% reported rape, and 23.6% reported non-consensual sex, and 5.5% reported "other."

Support Seeking Checklist

The support seeking checklist consisted of 14 informal and formal supports that have been supported by literature regarding sexual violence (Murugan, 2018; Orchowski & Gidycz, 2012, 2015; Orchowski, Untied, & Gidycz, 2013; Relyea & Ullman, 2015; Sabina, et al., 2012; Ullman, 2000; Ullman & Filipas, 2001). These included mother, father, sibling, friend, grandparent, professor/teacher, school counselor, mental health professional, family friend, cousin, and online community. The prompts for this instrument required a dichotomous response of "Yes" or "No." Participants were able to declare whom they sought for support regarding their experience of sexual violence and were also able to label the support's gender if they were inclined.

Social Reactions Questionnaire

The Social Reactions Questionnaire ([SRQ] Relyea & Ullman, 2015) is a 48-question measure that observes the social reactions that people experience when disclosing about their history. This was provided only to people that responded affirmatively to any disclosure during the checklist. Participants were asked to respond according to when they have disclosed experiences of sexual violence. Participants were then asked about separate reactions, including "reassured you are a good person" and "encouraged you to seek counseling." They then were asked to rate the frequency of how often they receive these reactions based on 0 (never) to 4 (always).

The SRQ contains three general scales for observing reactions. These are broken down into Turning Against, Unsupportive Acknowledgement, and Positive Reactions. The former two, turning against and unsupportive acknowledgement, can also be coded as Negative Reactions. Thus, coding for this study separated the scales into two: Negative Reactions and Positive Reactions. Within these categories are seven more specific scales: victim blame, treat differently/stigma, taking control, distraction, egocentric reactions, tangible aid, and emotional support (Relyea & Ullman, 2015).

The developers of the SRQ performed psychometric testing on a racially diverse population. Factor analysis using Cronbach's alpha returned subscale alpha's of greater than .77: .93 for emotional support/relief, .86 for treat differently, .80 for distraction/discourage talking, .83 for taking control, .84 for tangible aid/information support, .80 for victim blame, and .77 for egocentric reactions.

Further, test-retest correlations of the measure were significant using Pearson R

with a p-value of less than .001. The SRQ is a measure that has been used in studying populations with experiences of sexual violence in the past. A limit to the SRQ is that when normed and tested, Asian participants were broadly defined (Ullman, 2000). As Asian cultures are very diverse, it is possible that Indian-Americans were not represented in the analysis of the measure.

To interpret the SRQ with the population, the researcher added some of the qualitative questions asked when the developers worked on understanding the SRQ's psychometric properties (Ullman, 2000). The participants were asked three questions. These were "In the time since your experience, what has been the most helpful thing someone has said or done?," "In the time since your experience, what have you wished a particular person had said or done to help you with your experience that they did not do?," and "What coping skills have you used during this process?"

Results

The Social Reactions Questionnaire (SRQ) data showed the overall social reactions received by the populations. Descriptive statistics (Table 1) reflect the types of reactions experienced by survivors. These statistics are followed by overall reactions as they correlate with support sought.

Hypothesis 1: Overall Reactions

Analysis of data involved correlational analysis on the amount of supports and overall negative and positive reactions. Pearson correlation returned a significant positive relationship, ($r(55)=.381$, $p=.004$), between the number of supports used and overall positive reactions. The use of just informal supports did not correlate with overall positive reactions. Univariate ANOVA also showed that informal and formal supports did correlate with overall positive reactions, ($F(1,54)=7.073$, $p=.01$), despite the number of overall supports. Further analysis was completed to compare reactions between the informal support groups and across informal and formal supports.

Hypothesis 2: Family Reactions

Family support included parents and siblings. Extended family were included on the survey, however, no participants answered affirmatively for support sought from grandparents or cousins. Participants did share that parents and siblings were sought for support.

Parents

The analysis looked at differences in parental reactions versus others and differences in reactions between mothers and fathers. Parents provided less emotional support and more tangible aid, stigma, control, and distraction responses. Overall, more negative reactions were received from parents, though much of these findings were not significant. There were some differences between reaction from mothers (n=15) and fathers (n=7) as mothers provided more

distracting reactions, (F(1,53)=5.464, p=.023).

Sibling

Eighteen participants shared that they sought support from their siblings (n=18). Overall, the siblings provided significantly more tangible aid, (F(1,53)=6.930, p=.011), a positive reaction, and more egocentric reactions, (F(1,53)=5.643,p=.021), a negative reaction. Non-significant differences also include more unsupportive acknowledgement, and also less blame, stigma, and control reactions.

Hypothesis 3: Friend and Clinical Mental Health Provider Reactions

Outside of family, friends (n=39) were another source of informal support. Friends showed significantly more emotional support, (F(1,53)=15.522, p<.000), and tangible aid, (F(1,53)=7.006, p=.01), than other informal supports. Overall, friends showed significantly more overall positive reactions, (F(1,53)=15.234,p=.00).

Formal supports sought for support were clinical mental health providers (n=15). Most data from the analysis of formal supports to informal supports turned up insignificant results. However, clinical mental health providers did provide significantly more tangible aid, (F(1,53)-9.903, p=.003), than informal supports.

Discussion

The results of the analysis supported hypotheses two and three, and refuted hypothesis one. The results showed two main data: an increase in support correlates with overall positive reactions and the presence of informal and formal support correlate with increased overall positive responses. To the former point, an increase in support might relate with overall positive reactions for a few reasons. First, there may be factors that made the survivor feel safe to discuss their experience with multiple supports. This might imply societal values that place more understanding of a survivor's experience and less stigma and other negative factors overall.

Friends and clinical mental health providers provided the most positive reactions. Friends will have experienced the attention to sexual violence within the "#MeToo," "#TimesUp," and other movements. It is possible that recent waves of social media have increased the visibility of potential providers of support who might have more positive reactions to activism (PettyJohn et al., 2018). When combined with clinical mental health providers, who are trained in provision of tangible aid (Ullman & Filipas, 2001), this would support positive reactions to a survivor's disclosure.

Implications

This study holds some implications for clinical counseling. Most of the survivors shared that they sought friends for

support and more respondents named a sibling as support than clinical mental health providers. Friends are often not involved in clinical counseling due to legal and ethical guidelines. However, counselors can assess for peer supports and bring this discussion to counseling.

The sibling support provides some insight into family counseling for survivors of sexual violence in this population. Family counselors that work with this population may want to adopt a structural family counseling approach. Family counselors can use family mapping to mark the subsystems of the family and solidify the sibling subsystem to provide support to the survivor. Counselors can hold sibling-only sessions and position the family in session to strengthen the alliance.

Further implications of this data analysis are focused on the counselor's role in the community. Counselors in training are taught to think of multicultural aspects of counseling within their counseling relationships in their office. Given the rate of sexual violence and the relative lack of work with clinical mental health providers, these implications focus on community-based work.

Community in Counseling

Results showed that the total number of supports significantly related to the overall positive reactions. This could imply that it would be critical for clinical mental health providers to take a more systemic approach to their practice. This would allow clients to discuss their experiences with their informal supports and strategize how to receive more positive reactions overall. Friends, especially, could be resources of emotional support and help to provide continuity outside of the counseling process.

Advocacy and Psychoeducation

This also carries implications for outreach. Clinical mental health providers might increase overall positive reactions by providing psychoeducation in the community. In social organizations, community centers, and cultural festivals, providers can provide helpful and unhelpful reactions to disclosure of sexual violence. This might preemptively provide survivors with more positive reactions from their supports.

Additionally, outreach will provide the community with more knowledge about mental health and the resources available. With a society that mostly keeps concerns within the family (Shoemaker, 2016), this could be an access point so that they understand the tangible benefits of clinical mental health and increase the use of clinical mental health resources. Outreach will also be a way to discuss coping skills, calming techniques, and other relevant strategies for survivors that may not want to disclose, but still could benefit from assistance.

Limitations

The sample size of this study limited the power of each analysis and therefore the generalizability of the study. Additionally,

the participants were concentrated in a certain age range and in regional areas. Most of the respondents (96.6%) were of the millennial generation, and, whether raised in India or the United States, would have grown up with increased access to web-related access to online groups, sources of support, and resources to identify more formal supports. This sampling technique also relied on snowball sampling, which leads to selection bias (Hossain & Veenstra, 2017).

Further, post-hoc power analysis was performed using comparison with the population. Unfortunately, there is no extant data on the prevalence of sexual violence within the Indian diaspora in the US. Therefore, Relyea and Ullman's (2015) recent study on using the SRQ with college-aged populations was used to determine the power of the sample size. G*Power derived from ClinCalc was determined as 86.1% (Kane, 2018). A larger sample size would have provided for more power.

One hundred individuals started this survey, but only 55 (55%) of respondents completed all sections of the survey in its entirety. This is evidence of survey fatigue. Further, the survey materials were not previously normed on South Asian populations, specifically. This limits the interpretations of this study within this population. Finally, these results are limited by the study design. Participants were asked to recall their support-seeking experiences.

Conclusion and Future Directions

This study focused on survivors within the Indian diaspora and the results showed that more supports correlates with overall positive reactions and that informal and formal support, in tandem, correlates with overall positive reactions. This research can be used to inform counseling practice and advocacy and outreach for the profession. However, this research is limited by the sample size and the specific population. Future research could expand this study to the entire South Asian diaspora, and other studies can follow up with other immigrant cultures in the United States. Cultural messages about sexual violence and support seeking may create variability in these results. Further, the nuances of support seeking after experiences of sexual violence are not reported in quantitative data. Future research should expand understanding of the population through the qualitative methodology.

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Table 1.

Descriptive Statistics for SRQ (N=55)

	N	Minimum	Maximum	Mean	SD
Emotional support	55	0	3.47	1.99	0.82
Tangible aid	55	0	4	1.32	0.83
blame	55	0	3	0.94	0.90
stigma	55	0	2.33	0.80	0.76
control	55	0	2.43	0.81	0.70
ego	55	0	3.5	1.10	0.89
distract	55	0	3	1.16	0.89
Turning against	55	0	2.15	0.86	0.72
Unsupportive acknowledgment	55	0	2.85	1.04	0.68
Positive reaction	55	0	3.35	1.83	0.77
Negative reaction	55	0	2.38	0.95	0.66

The Use of Dialectical Behavioral Therapy (DBT) Techniques Creatively in the Treatment of Perinatal Mood and Anxiety Disorders

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Abstract
Perinatal Mood and Anxiety Disorders (PMADs) is a serious condition impacting up to 21 percent of woman after the birth of a child (Byrnes, 2018). Jane, a 32-year-old female presented for treatment for anxiety, depression and mood disturbance (5th ed.; DSM-5; American Psychiatric Association, 2013) and in need of feeling more connected to her baby and her life. The use of creative techniques including mindfulness, distress tolerance activity, emotion regulation, and interpersonal skills (Linehan, 2015, 2016) were implemented. The use of these skills can be added to the repertoire of practice of a mental health counselor working with clients with PMADs.

Having a baby can be a beautiful experience but it can also come with significant emotional distress. Many women are told that their postpartum struggles are either a normal part of the adjustment to motherhood or "the baby blues." However, it is estimated that 15% to 21% of pregnant and postpartum women meet the diagnostic criteria for a Perinatal Mood and Anxiety Disorders (PMADs) (Byrnes, 2018). PMADs reflect a range of postpartum conditions to include postpartum depression, postpartum anxiety, postpartum obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), and postpartum psychosis (Byrnes, 2018). Research has shown that PMADs impact women of every culture, age, income level and race. While there is no clear cause, some of the risk factors that are highly correlated with PMADs include low socioeconomic status, single parents, geographic location/isolation, and maternal age (Milgrom & Gemmill, 2015).

As a construct, PMADs offer a different and more nuanced lens through which clinicians can understand the various types of postpartum distress. Historically, most of the research on postpartum challenges has focused on postpartum depression (Fairbrother, 2016). This parallels stories that one sees in the media and "pop culture" where much of the reporting of a mom in crisis refers, often inaccurately, to postpartum depression. There are significant diagnostic and treatment differences between postpartum depression, postpartum anxiety, postpartum psychosis, and birth-related PTSD.

PMADs can have a significant impact on maternal behavioral responses and lasting impacts on a child's emotional, cognitive, and behavioral health outcomes (Choi & Sikkema, 2017). Symptoms range in severity and focus but can include significant disruption of daily functioning, maternal suicide and infanticide. Despite these risks and the growing percentage of

women experiencing distress in the postpartum period, many practicing clinicians remain unaware of the unique clinical presentation and treatment needs for this population (Fairbrother, 2016). PMADs are different from traditional mood and anxiety disorders in onset, intensity, treatment, and recovery. There is also a growing body of research that suggests mishandling by the mental health and medical community can exacerbate PMADs symptoms and further traumatize new moms (Ali, 2018).

There are many reasons why timely intervention with PMADs is critical. First and foremost, with PMAD clients there is an increased risk for maternal suicide and infanticide (Ghaedrahmati, 2017). Supporting clients in distress is made more complicated by the fact that many women do not seek treatment because of feelings of shame, fear, and stigma related to perceived maternal failure. Researchers have also found that when practitioners are not trained in the nuances of treating PMADs, their efforts to "help" can cause more harm than good (Ali, 2018). As such, there is a growing call for clinicians to have more focused training and awareness surrounding the treatment of PMADs.

Assessment, Diagnosis, and Treatment of PMADs

Assessment

Clinical assessments are an essential component to effective treatment planning There are three common assessments that can used to measure and track PMADs. The Edinburgh Postnatal Depression Scale (EPDS) is a 10 item self-rating instrument that measures the cognitive and emotional symptoms of postpartum depression (Cox & Holden, 2003; Sumitra et. al., 2016). The Perinatal Scary Thoughts Action Algorithm (PPSC) Suicide Assessment provides 17 follow-up questions to the EPDS to provide additional screening for suicidal ideation and intent when a client has a positive EPDS screen (Kleiman, 2015). Another common self-rating instrument, the Postpartum Distress Measure (PDM), is composed of 10 ratings that can be used to screen for postpartum distress symptoms of depression and anxiety (Allison et al., 2011).

Diagnostic considerations

When a client presents for treatment, counselors are encouraged to work collaboratively with the client to determine presenting problems, identify goals for treatment, and make a plan for effective treatment intervention (Sommers-Flanagan & Sommers-Flanagan, 2017). Women presenting with a range of symptoms in the postpartum period should be screened carefully to ensure accurate diagnosis. As previously noted, the term "PMADs" captures a range of presenting issues to include Postpartum Depression, Postpartum Anxiety, Postpartum OCD, and Postpartum Psychosis. The term "postpartum depression" is often used as a catch-all for a variety of PMAD symptoms ranging from the Baby Blues to Postpartum Psychosis. For the purpose of this paper, Postpartum Depression and Postpartum Anxiety will be highlighted specifically as they are the most diagnosed types of PMADs (Kendig et al., 2017).

Postpartum depression signs and symptoms are often seen as the typical symptoms of depression including: frequent crying, changes in sleep patterns, appetite changes, feeling sad and or hopeless, not enjoying activities usually enjoyed, and confused thinking and/or trouble making decisions (5th ed.; DSM-5; American

Psychiatric Association, 2013). Postpartum depression can also result in stronger emotions such as anger and rage, fear that one is not a good mother, hopelessness, shame, guilt or inadequacy. Recurring thoughts of suicide or death can occur. Postpartum depression can severely impact relationships such as withdrawing from loved ones, difficulty bonding with the baby or having thoughts of harming oneself or the baby. The physical symptoms may include fatigue, restlessness and loss of energy (5th ed.; DSM-5; American Psychiatric Association, 2013).

In assessing for PMADs, it is important to consider a variety of diagnostic rule outs. For example, symptoms such as emotional lability, depressed mood, and anxiety could be indicative of a variety of Mood and Anxiety Disorders. The timing of symptom onset will often help to make this distinction more evident. Other diagnostic considerations include: Major Depressive Disorder with Peripartum Onset, Bipolar Disorder with Peripartum Onset, Postpartum Mood Disturbance, Brief Psychotic Disorder with Peripartum Onset, Adjustment Disorders, Generalized Anxiety Disorder, Obsessive Compulsive Disorder, and Posttraumatic Stress Disorder.

Evidence-Based Treatment of PPD

Evidence-based treatment of PMADs is relatively new in the research. Karen Kleiman, one of the clinicians who has pioneered the treatment of women with PMADs, suggests the use of Winnicott's theory of "therapeutic holding" as a foundation for PMADs work; this refers to a therapist's capacity to respond to postpartum distress in a way that facilitates an immediate and successful therapeutic alliance (Kleiman, 2017). There are a variety of clinical approaches that have shown to be successful in the treatment of PMADs to include cognitive behavioral therapy, narrative therapy, mindfulness-based stress reduction and feminist theory (Milgrom & Gemmill, 2015). Given the relative "newness" of PMADs and the limited research on evidence-based practices, Byrnes (2017, p. 512) notes that developing and testing culturally sensitive interventions for PMADs should be made a priority for women.

It is widely accepted that Dialectical Behavior Therapy (DBT) is an effective therapeutic approach to use in the treatment of depression, anxiety, and PTSD (Forman et al., 2007; Harley et al., 2008; Fassbinder et al., 2016). However, new research is starting to explore the use of DBT in the treatment of perinatal and postpartum depression. Kleiber et al. (2017) conducted one of the first studies to examine the use of DBT skill training in a group of adolescent women with perinatal depression. Group sessions focused on skill training across four DBT modules; Mindfulness, Emotion Regulation, Distress Tolerance, and Interpersonal Effectiveness. Their findings provide support for using DBT as a treatment strategy "credible and acceptable" with many participants reporting a reduction in depressive symptoms. Kleiber et al. (2017) also highlighted the need for further development of these types of treatment programs and noted iterations of the treatment may be administered individually.

A more recent study by Huang et al (2020) explored the use of DBT skills training for a patient who was diagnosed with COVID-19 in China and hospitalized during the late stage of pregnancy through early postpartum. In an effort to manage emotional distress and avoid the use of psychotropic medication, researchers utilized a variety of DBT techniques with

the patient to include mindfulness and relaxation exercises, distress tolerance skills, and interpersonal relationship skills. Results indicate that DBT is an appropriate and helpful intervention to utilize as the patient reported a reduction in symptoms related to depression and anxiety. The authors also highlighted that more research is needed on the role DBT can play in crisis intervention and supporting clients with trauma (Huang et al, 2020). To understand PMAD better and its link to DBT creative techniques, a case example will be utilized to show the steps of the problems, goals, and implementation.

DBT and PMAD

Understanding the primary foundation of DBT and applying it to the case of women diagnosed with PMADs requires a creative lens for clinicians. The DBT approach offers a framework that balances acceptance, change and skills by examining dialectical thinking, communication patterning and a desire for all humans to be accepted. A core tenant of DBT involves validation so it behooves clinicians to have a thorough understanding of how important validation is within the therapeutic alliance. Linehan (1993,1995) indicated that an invalidating environment can result in dysregulation, difficulty with managing emotional responses, and cause a shut down and difficulty communicating needs and wants in an assertive manner. The relationship between counselor and client begins with the primary validation of the individual's present experience and existence. It is critical that the counselor accepts the client and communicates this by taking the client's responses seriously without discounting or trivializing them (Linehan, 1993, 1995, 2015, 2016). This involves hearing the experience of the client and evoking a level of understanding of the emotions in light of the history and overall context of the situation. This validating environment sets the tone to begin working with women with PMADs and is a catalyst to begin the process of integrating specific problem-solving strategies and the skills that guide change.

DBT is a complex treatment process that includes specific protocoled treatment and long-term commitment for individuals typically diagnosed with borderline personality disorder. One element of the DBT model is the implementation of DBT skills modules that include teaching mindfulness, interpersonal effectiveness, distress tolerance and emotional regulation (Linehan, 1993, 1995, 2015, 2016). When working with individuals diagnosed with PMADs, these DBT modules can be utilized in whole or in part based upon the treatment needs of clients. To effectively implement them into treatment, counselors should have a general knowledge of DBT skill areas when creating a treatment plan. These skill areas and Linehan's (2015, 2016) training modules provide step by step guidelines for implementation.

Linehan studied Zen Buddhism and incorporated its mindfulness concepts into DBT Skills training (Linehan, 1993, 2015, 2016). Mindfulness has been defined in many ways but it is considered to be a purposeful focus and does not have to be meditative. Mindfulness discourages attachment to the moment along with accepting the moment without judgement. This helps the client to notice where they are in the moment combined with an examination of where they want to go. This is possible by practicing "what and how skills" developed by Linehan (1993, 2015, 2016). Mindfulness skills are designed to reduce suffering, pain, tension and stress and encourage a focus on the present so that

one's mind does not control the person. While reducing areas of distress, there is an increase in happiness, a sense of control of the mind, a sense of seeing reality as is and accepting it along with facing the world with open eyes of awareness (Linehan, 2015, 2016). Linehan's skills manuals provide a plethora of handouts designed to assist with clients with practicing mindfulness. For the purpose of working with individual's diagnosed with PMADs, the application of the skill of "wise mind", "observe, describe and participate", and "loving kindness" meditation (Duncan & Bardacke, 2010; Linehan, 1993, 2015, 2016) are applicable to the case scenario.

DBT theory posits that humans have the capacity to tolerate crisis and stress and that individuals can learn to endure pain and make meaning out of distress events with the practice of distress tolerance skills (Linehan, 1993, 2015, 2016). The goal of distress tolerance skills is to enable individuals to survive crisis situations (or perceived crisis situations) without exacerbating the crisis, learn what cannot be changed, and free oneself from allowing events to control emotions and behaviors (Linehan, 2016). This includes accepting the reality that suffering happens to everyone yet some find a way to move forward. Linehan (2015, 2016) believed that pain and unacceptance can led to ongoing suffering. When clients understand the normality of pain with acceptance, it can help make it manageable (Linehan, 2015, 2016). It is important that PMADs clients are aware that they do not have to live in a state of crisis. Part of knowing when to implement distress tolerance skills includes understanding what is considered a crisis and knowing when to use a set of specific skills when the need arises. Handouts specific to distress tolerance might include the use of distracting, self-soothing, improving the moment and considering pros and cons when there is an overwhelming sense of crisis and doom (Linehan, 1993, 2015, 2016, Russel & Lincoln, 2015).

Emotions are a part of every human although DBT notes that some individuals will have more intense emotions than others. Thus, the overall goal in emotional regulation is not to eliminate emotions but rather to eliminate suffering. Emotional regulation skills in DBT fall under the focus of change skills and are linked to factors such as the emotion mind (Linehan, 1993, 2015, 2016). The training is geared toward identifying and labeling affect, examining obstacles to changing emotions, seeking reduction of the influence of the emotion mind, increasing positive emotional responses to events and increase purposeful and mindful awareness to current emotions (Linehan, 1993, 2015, 2016). Emotion regulation involves learning how to manage and impact the emotions that an individual has along with how these emotions are both expressed and experienced daily (Goss, 2014). Using DBT it is important to teach clients to identify emotions, the normalcy of emotions in relation to recent circumstances and apply skills to reduce the distress. DBT has an overall goal of assisting a client to be able to experiencing a life worth living. There are times that women will need to consider personal goals of maintaining self-care and cultivating positive emotion moments (Linehan, 1993; 2015, 2016; Haga et al., 2012).

The ability to engage with people on a personal level is critical to effective relationships with others. Part of this includes the ability to connect with others while maintaining appropriate boundaries. There is a need for a healthy balance between alienating others and compromising while effectively meeting personal goals

with healthy boundaries (Linehan, 2015, 2016). DBT's interpersonal effectiveness skill modules are designed to assist clients with being skillful in three primary areas. The first is a need to know how to achieve personal objectives including effectively communicating requests and needs and saying no to unwanted requests. Another interpersonal effectiveness module involves the importance of building relationships and learning how to end destructive relationships (Linehan, 1993, 2015, 2016). A final primary area of interpersonal effectiveness is learning to walk the middle path. This includes learning how to consider validation of others points of view to promote acceptance and change (Linehan, 1993, 2015, 2016; Rathus et al., 2015). These skill areas are beneficial with clarifying relationship goals, personal priorities regarding relationships and learning how to engage in situations where familiar and unfamiliar individuals are engaged in a group context. These skill areas are important because clients with PMADs can exhibit overwhelming depression that impacts personal engagement with family, friends, and specifically an intimate partner (Garthus-Niegel et al., 2018).

The ability to engage with people on a personal level is critical to effective relationships with others. Part of interpersonally relating to others includes the ability to connect with others while maintaining appropriate boundaries. There is a need for a healthy balance between alienating others, compromising and effectively meeting personal goals with healthy boundaries (Linehan, 2015, 2016). These skill areas are beneficial with clarifying relationship goals, personal priorities regarding relationships, and learning how to engage in situations where familiar and unfamiliar individuals are engaged in a group context.

Case Study

To illustrate how DBT might be used in the treatment of PMADs, a hypothetical client, "Jane," will be presented. Jane represents a composite of typical postpartum clients who are presenting with a range of PMAD symptoms with emphasis on anxious and depressive symptoms.

Presenting Symptoms

Jane is a 32-year-old Caucasian female who was referred for treatment by her obstetrician and gynecologist for "feelings of depression, anxiety, and mood disturbance" following the birth of her first child. She is currently 7 weeks postpartum and arrives for her first appointment with her baby. Jane is oriented to name, location and time, well-dressed, and well-spoken as she discusses what brings her to treatment. Jane is set to return to work in 5 weeks and is experiencing feelings she has "never had before." She reports crying frequently during the day, has difficulty sleeping, and increased frustration with her partner. When asked to elaborate, she described being annoyed by "just about everything" and that nothing seems to make her feel better. While she doesn't feel disconnected from her baby, she does report fantasizing about what her life was like before she became a mother and longing to have a "carefree life" once again.

Jane denied any suicidal or homicidal thoughts when asked by her physician. But she did say that she is tired of dealing with this every day and has little hope that things are going to get better. She feels alone in parenthood and is wondering if she made a mistake in becoming a parent. She described her current coping skills as extremely limited. She is resistant to taking medication for symptom management as she

is breastfeeding and "wants to learn how to solve this herself." She reports that she wants to "feel like herself again."

Client History

Jane reports no previous history of significant depression or anxiety. She has always had high expectations for herself and feels like she has been successful in most areas of her life. She was thrilled to start her family with her husband and described an "easy pregnancy and delivery". She noticed she was not feeling herself shortly after the baby was born but wrote it off as "the baby blues" everyone talks about. She does not have family in the area but her mother did come to visit for the week after the baby was born. Her mother told her "having a baby is hard" and that she would be fine in a few weeks. She indicated she did not feel like she could tell her mom how hard it was for out of fear of disappointing her. She says it is hard to ask for help from those around her as people are accustomed to her being on top of things. Aside from her husband, no one knows she is struggling. When asked about spiritual supports, Jane said "she has not felt connected to God for some time" and does not feel like she would find much help at her church.

Assessment & Diagnosis

At the beginning of the intake session, Jane completed The Edinburgh Postnatal Depression Scale (EDPS) with a total score of 16 (out of 30). A score of 10 or higher suggests that minor or major depression may be present further evaluation is warranted (Schaper et.al, 1994**).** In addition to looking at the total score for the EDPS, it is critical the clinicians review Item 10 as it focuses specifically on suicide risk. On item 10 (i.e., "The thought of harming myself has occurred to me") Jane endorsed "Hardly Ever."

Based on the results of the EDPS and her intake interview, Jane meets the diagnostic criteria for Postpartum Depression (F53.0). Postpartum depression signs and symptoms are often seen as the typical symptoms of depression including: frequent crying, disruption in sleep patterns, appetite changes, feeling sad and or hopeless, not enjoying activities usually enjoyed, and confused thinking and/or trouble making decisions (5th ed.; DSM-5; American Psychiatric Association,). Jane agrees that she has been feeling very depressed but acknowledges that anxiety is also present.

Treatment progression and outcomes

The counselor-client relationship is a critical piece for a client like Jane to feel safe and to trust the counselor. Trust creates a space for disclosure of the personal concerns associated with being a new mother and all of the varied concerns that arise for mothers. Having this foundation provides a framework when DSM-5 diagnostic considerations (5th ed.; DSM-5; American Psychiatric Association,2013) are considered for treatment outcomes.

Art-Based Therapy, DBT, and PMAD's

Creativity in the form of art-based activities can play an important role in the treatment of PMADs. Sarid et al. (2017) posit that it is important to find non-stigmatizing, strength-based interventions when providing treatment to women who are experiencing perinatal mood and anxiety disorders. They state, "Art therapy generates a symbolic, therapeutic narrative, engaging the senses through observing, touching, and manipulating art materials,

creating a connection between mind, body, and cognition" (Said et al., 2017, p. 229). This process, in turn, helps women increase coping skills and self-esteem, and decrease overall stress.

There is a small body of literature that supports the claim that art therapy and art-based interventions can support mothers who are experiencing PMADs. Positive outcomes reported include an increase in self-assurance, sense of wellbeing, self-image, and self-esteem (Hogan et al., 2017; Morton & Forsey, 2013; Ponteri, 2001). Research has also found that art making helps new mothers relieve stress (Perry et al., 2008; White et al., 2010) and has a positive effect on mood (Morton & Forsey, 2013).

Perry et al., (2008) report that creative arts can be complementary to conventional therapies when treating PMADs, especially in cases that are not severe. Utilizing art-based interventions to support core DBT principals is an example of this (Clark, 2016; Heckwolf et al., 2014; Franklin, 2010; Kalmanowitz & Ho, 2017; Monti, et al., 2006). Case studies combining DBT and art therapy document the successful outcomes that can occur when combining the two approaches (Huckvale & Learmonth, 2009; Heckwolf et al., 2014).

Clark (2016) has discussed in detail the success of bringing DBT and art therapy together. The author suggests that art activities combined with DBT help to "facilitate mindfulness, the foundational DBT skill, by engaging clients in a novel, process-oriented experience" (Clark, 2016, p. 11). Daler and Schwanbeck (2014) have developed a model called "Creative Mindfulness" which combines expressive arts therapy with DBT. They report that goal of the model is to integrate the effectiveness of DBT with the creative and sensory modes of self-expression and learning of expressive arts therapy (Daler & Schwanbeck, 2014). While integrating DBT with expressive arts, Daler and Schwanbeck (2014), much like Clark (2016), found that utilizing creative techniques helped to engage their clients and promote an openness around exploring new concepts. The following hypothetical case application provides examples of creative interventions, each combined with a DBT tenet, and how they are utilized in the case study of Jane.

Creative DBT Case Application

Mindfulness Activity: Here and Now Meditation and Mandala

Objective: This mindfulness activity will allow Jane to become more grounded, experience living in the "here and now", and help to reduce pain, tension, and stress.

Materials: 8x10 paper, circular objects/stencils for tracing, various drawing tools such as markers, colored pencils, gel pens, and oil pastels. Watercolor and acrylic ink may also be included if the therapist has knowledge of the medium.

Procedure: The therapist led a brief guided meditation that allowed Jane to quiet her mind and experience the present moment. Jane then utilized art materials to draw on the inside of the circle, using shapes and colors that represented her experience in the "here and now".

Processing: Upon completion of the artwork, Jane was encouraged to process the experience and her artwork verbally with the therapist. Questions for Jane to ponder included: Did you notice any shifts in your emotional experience throughout the process? Was it easy to stay in the present or

did your mind tend to wander throughout the exercise? What senses were you aware of as you created your art? Do any symbols or colors seem to stand-out to you in your artwork?

Outcome: Jane was able to reflect on the emotional shifts that occurred during the meditation and art creation. She reported a decrease in anxious feelings and a decrease in the tension in her body. Jane pointed out colors and shapes that represented calmness and relaxation. She reported that she would hang the mandala drawing on her refrigerator as a visual reminder for her to practice mindfulness skills throughout her day.

Distress Tolerance Activity: Self-Care Kit

Objective: This distress tolerance self-care kit contained useful activities to encourage Jane to practice the coping skills of self-soothing, distraction, and acceptance.

Art Materials: Canvas bag with fabric markers, fabric paint, stamps, screen printing supplies, etc. (a box with a lid and a variety of collage, painting, and drawing materials could also be used for this exercise). Examples of items to put in the kit: Crossword puzzles, favorite magazines, basic art supplies, sketchbook/journal, affirmation cards, joke cards/book, favorite book, worry stone, stress ball, putty, coloring pages, gum/candy, favorite essential oil, small photo album, worry beads, CD/MP3 Playlist, teabags, and spiritual literature.

Procedure: Jane used the art materials provided to decorate the canvas bag that would hold the items for her self-care kit. Jane worked together with the therapist to brainstorm materials that would go into the self-care kit.

Processing: Jane shared some of the special items she will be putting in her self-care kit, including essential oil rollers, a stress ball, and mint candies to engage her senses for grounding. She also included a small blank journal and colored pencils for creative journaling, affirmation cards for motivation and self-reflection, and her favorite book to aid in distraction. Jane and the therapist also discussed examples of times when the items in her self-care kit might be especially helpful.

Outcomes: A few weeks after creating the self-care kit, Jane shared that during times she was feeling especially anxious when her baby was fussy, she was able to utilize the essential oil rollers and mint candies, along with relaxed breathing to help her stay calm and grounded. She also reported that when she found herself awake at night, unable to sleep due to her anxiety and depression, she was able to engage in creative journaling to help calm herself, which in turn made it possible for her to go back to bed and fall sleep. Jane reported that successfully utilizing the distress tolerance skills also increased her confidence in her ability to be resilient and manage her emotions.

Emotional Regulation Activity: A Life Worth Living Vision Board

Objective: This emotional regulation activity helped Jane to identify and affirm her values and goals to focus on creating “a life worth living”. The activity also helped Jane to identify obstacles to changing emotions and ways to increase positive emotional events.
Materials: Large paper/poster board, scissors, magazines/collage material, glue sticks, gloss medium, various drawing tools such as markers, colored pencils, and gel pens.

Procedure: Jane utilized the art materials provided to create a vision board around the general theme of "a life worth living". The vision board included images, words, and phrases cut from magazines and motivational quotes that are important to Jane.

Processing: Upon completion of the vision board, Jane processed her artwork verbally with the therapist and later through written word in her journal. Topics discussed included Jane's vision of cultivating "a life worth living", possible action steps towards meeting her goals and positive intentions and affirmations that will help Jane to increase her motivation while moving forward.

Outcome: Jane was able to process obstacles to "a life worth living" and identify which short- and long-term goals she would be able to accomplish to help her manage her expectations. This allowed her to connect her goals with cultivating future positive emotional events. Jane was able to journal about the thoughts and emotions that she experienced when looking at the board for several weeks after she created it. In subsequent sessions, she reported an increase in awareness around the unrealistic expectations she tends to set for herself as a mother and wife. She also shared some of the steps that she had made towards meeting her short-term goals. These included signing up for a weekly yoga class and reaching out to a friend for help in reorganizing certain areas of her home so that she could be more efficient in her day-to-day living, thus decreasing her overall stress.

Interpersonal Effectiveness Activity: Boundary Drawing

Objective: This interpersonal effectiveness activity allowed Jane to explore the importance of healthy boundaries and reflect on how she could implement them in her life.

Materials: 8x10 paper, various drawing tools such as markers, colored pencils, gel pens, and oil pastels.

Procedure: Jane and the therapist discussed the various types of boundaries that are present in relationships (rigid, weak, healthy, etc.). Jane then explored her current boundaries by creating a piece of artwork using the metaphor of a castle/fortress.

Processing: Upon completion of the artwork, Jane was encouraged to process the experience and her artwork verbally with the therapist. Questions for processing included: Who do you let inside your fence/wall? Who do you keep out? What factors do you consider when deciding who to let in and keep out? What actions might you take to create boundaries as you would like them to be? Processing this turned into a wider discussion on needed communications skills such as assertiveness and active listening. A second image was also be created later in the week in her creative journal to allow Jane to explore how she would like her boundaries to be in comparison to the boundaries reflected in her first drawing.

Outcome: Jane was able to increase awareness around boundaries in particular

relationships in her life, specifically focusing on the times when she failed to use her boundaries and assertiveness skills to say no to others who ask her for help or favors when she is feeling overwhelmed. She also discussed the times when she tends to "shut people out" when she becomes overwhelmed and resentful. Through the use of role play in later sessions, Jane was able to practice assertiveness skills so that she would be able to feel more comfortable saying no to requests for favors when she is overwhelmed, stressed, and tired. Jane made progress with creating healthy boundaries during her time in therapy, although she admitted that she sometimes "slipped and would say yes" when she really didn't want to. This led to processing around self-compassion and forgiveness, as well as more practicing of skills via role play.

Overall Treatment Outcomes Compared to the Literature

Jane's experience of decreased anxiety and decreased physical tension during and after mindfulness-based practices and art-based activities correlate with the literature on the topic (Kalmanowitz & Ho, 2017; Park, Lee, & Lee, 2016; Perry et al., 2008; Sarid et al., 2017; White et al., 2010). Her successful use of distress tolerance skills, aided by the self-care kit, and her increased confidence reflect similar outcomes discussed by several authors (Hogan et al., 2017; Morton & Forsey, 2013; Ponteri, 2001; Sarid et al., 2017). Jane's development of self-awareness and self-assurance over time, her willingness to explore new ideas, and her ability to take action steps towards cultivating positive emotional events and increased interpersonal effectiveness are similar to many outcomes described in the literature on the topic (Daler & Schwanbeck, 2014; Hogan et al., 2017; Morton & Forsey, 2013; Ponteri, 2001).

Treatment goals and modalities: Initial goals focus on symptom reduction (e.g., decreased mood, sleep disruption, irritability), education on perinatal mood and anxiety disorders, development of coping skills and a potential referral for medication evaluation. Another goal is to provide DBT skill training with mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness modules. As these are established and implemented with a client, counselors must keep in mind factors that are associated with postpartum depression and how derailment can happen.

Complicating Factors

There are many factors to consider when treating PMADs such as medical complications and barriers to care. Risk factors may include depression and/or anxiety during, prior or after pregnancy, low social supports, difficulties breastfeeding, admission of infant to a neonatal intensive care unit, preterm birth and stressful life events during or after the birth (Rai et al., 2015).

Returning to work can provide obstacles including lack of financial or social support. One in four women return to work within 10 days of delivery. Only 14% have access to paid leave. While the 1993 Family Medical Leave Act provides 12 weeks of unpaid leave, it only covers 60% of the population (American College of Obstetrics & Gynecologists, 2018). Barriers to care exist for women who are immigrants or non-citizens, endure physical and mental disabilities, are homeless or have non-English speaking status. Other patients have concerns that perinatal care providers lack

education about postpartum depression and will be judgmental in their approach (Moore et al., 2018).

Medical factors that emerge during pregnancy and after need evaluation. Complications such as preterm delivery, gestational hypertension and/or diabetes, urinary incontinence and preeclampsia need monitoring. Postpartum thyroid disease can occur in women with no history of it prior to delivery. Many women are challenged by a lack of sleep, breastfeeding challenges, pain, fatigue and lack of sexual desire (Byatt et al., 2012).

Conclusion

Dialectical Behavior Therapy is an evidenced based approach designed to treat individuals with emotional dysregulation. Although women with PPMDs do not have a genetic link to emotional dysregulation, the realities of pregnancy, labor and delivery can bring on a variety of signs and symptoms creating a need for clinical treatment. Various assessments can be utilized to successfully assess for proper diagnosis and treatment planning. As treatment goals are established, the use of creative techniques aligned with DBT can assist with improving PPMDs symptoms in helping a client, such as Jane, improve.

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Counseling Adolescents Aging Out of Foster Care

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Abstract
The high prevalence of youth aging out of the foster care system and the numerous poor outcomes they experience during the transition to emerging adulthood has been well documented. Although addressing the complex needs and concerns of this distinct population can be difficult, mental health counselors maintain the philosophical tenants and training strengths necessary to successfully serve youth aging out of foster care. This article aims to provide counselors with the historical context, developmental framework, and specific challenges needed to better understand this population, as well as suggested counseling implications to address their unique needs by reviewing relevant literature.

The United States has been experiencing a steady increase in the amount of neglected and maltreated children—approximately 4.3 million referrals to the child welfare system involving over 7.8 million children in 2018 alone (Children's Bureau, 2018). Many of these children entered foster care, with the total population of foster youth surpassing 400,000 in 2019. Within this population, more than 25% consisted of adolescents 13 years old or older, with over 20% having entered into foster care as an adolescent. As a result of the high number of older foster youth, the number of adolescents aging out of foster care has grown in the United States (Children's Bureau, 2019). In 2018, estimates reported by the Children's Bureau (2019) stated that approximately 17,844 young adults left foster care through emancipation. Due to the significant challenges within the foster care population, Courtney et al. (2012) highlighted that many foster youths making the transition to adulthood likely needed significant assistance following care termination.

Despite the high prevalence of youth aging out of the foster care system, the counseling literature has yet to discuss this special population with unique needs. As defined by Nsonwu et al. (2015), "Aging out of foster care is the vernacular used to describe the point at which a youth exits the formal home, educational, and financial systems of foster care and becomes independent" (p. 19). When these adolescents reach the age of majority, generally at 18 years old, they are emancipated and expected to live self-sufficiently. This means that it is no longer the state's responsibility to provide care including access to basic resources such as housing, health care services, or supportive services such as counseling (Courtney et al., 2001). The present article will explore adolescents aging out of foster care by providing historical context and a developmental framework while reviewing the relevant literature. The focus of this article will be on the unique challenges of this population and how counselors may support them throughout emerging

adulthood. A case study will then be provided to detail a typical episode of counseling with this population.

Historical and Legislative Considerations

Aging out of the foster care system has only received legislative attention in the past 35 years. The first federal effort to extend financial support for services to aging out foster youth was *The Independent Living Initiative of 1985*. Over a decade later, *The Foster Care Independence Act of 1999* further increased the amount of funding available for the services provided by the previous initiative, doubling the resources from $70 million to $140 million (Fernandes-Alcantara, 2011).The most recent legislation regarding this topic was *The Fostering Connections to Success and Increasing Adoptions Act of 2008*, which required child welfare systems to create a transition plan for youth aged 18 or older, at least 90 days before care termination. These policies came about in response to the presence of numerous poor outcomes for individuals aging out of foster care, which had been well documented, but little was known about appropriate intervention. Boshier and Wademan (2010) stated that, "although the court does have mechanisms for coordinating assistance, it lacks the potency needed to assist our transitioning youth; these youths are deemed too old to fall under the protective arm of our youth legislation, but too young to be appropriately assisted via adult legislation" (p. 294).

Before an individual exits the foster care system, federal legislation requires that sufficient transition planning and care coordination is provided to the youth in foster care through the development of an Independent Living Plan (ILP). Scannapieco et al. (2007) found that foster youths who had aged out of the system felt that there was a lack of respect for them during the emancipation process, primarily due to the caseworker creating the ILP without the input of foster youth. From the perspective of these aged-out foster youths, the caseworkers dictated both their tangible (money, safe housing, transportation, etc.) and intangible essentials (understanding health needs, advocacy, and social supports).

Federal legislation does not currently require behavioral health systems to offer transitional care to youth aging out of foster care. What is more, findings by Shpiegel (2016) suggested that when ILPs were implemented, they often focused too much on measurable outcomes like gaining employment, graduating from high school, and obtaining independent living, and, therefore, minimize the complex emotional needs of the youth. Stott (2012) further explained that the common approach to assisting foster youth transitioning to adulthood focused on skill training and was lacking the relational interactions that fostered the development of emotional and social competencies, as well as self-sufficiency. As stated by Leve et al. (2012), despite documented and sustained mental health needs, this population was generally neglected and underserved in the field of mental health services. Therefore, practitioners ought to be called to action, creating specialized mental health programs designed specifically to address the needs of youths aging out of foster care.

Developmental Framework

Emerging adulthood is a period of major transitions, challenges, and opportunities with the expectations of increased maturity and self-sufficiency. In addition to the typical problems of adolescence (e.g., peer-pressure, self-doubt,

expectations of success, ambiguity, etc.), self-sufficiency demands that an individual accepts responsibility for making major life decisions while working towards physical, emotional, and financial independence (Keller et al., 2007). While the expectation of self-sufficiency at 18 years of age was historically appropriate, emerging adults in contemporary Western society, even those from two-parent homes, delay adult roles until their mid- to late-20s (Nsonwu et al., 2015). Yates and Grey (2012) noted that if these expectations cannot be met by young adults with numerous supports and resources, then it should not be realistically expected from an emerging adult with less of the vital resources needed for a successful transition into adulthood from foster care.

Adding to the obstacles that foster youth experience while aging out, researchers have concluded that adolescent brains are not fully developed until early adulthood (Paus, 2005; Steinberg, 2005). Without the cognitive tools to navigate complex systems, adolescents aging out of foster care would benefit from additional support (Olson et al., 2017). Similarly, Erikson (1950) stated that individuals shift their focus from identity development to issues of love and intimacy as they approach early adulthood. It is imperative that adolescents have the opportunity to explore their identity in a supportive environment, including sexual and ethnic identity because of their link to overall development (Cass, 1979; Phiney, 2006).

Population Challenges

Older adolescents in foster care face unique challenges as they approach the age of emancipation. For example, it is significantly harder for adolescents to be placed into foster families than younger children (Children's Bureau, 2016). Because of this, adolescent foster youth likely spend more time in flux, not knowing when or where they will experience stability. The lack of permanency and stability exposes them to numerous risks factors including toxic relationships and insecure attachments, further abuse, mental/behavioral health concerns, physical health challenges, educational disruptions, financial instability, and unhealthy coping skills. Crawford et al. (2018) added that individuals with placement instability had higher rates of felony adjudication and criminal involvement.

Further, youth aging out of foster care have likely faced additional trials that could make the transition from adolescence to adulthood more difficult. Reilly (2003), for instance, estimated that approximately 37% of aged-out foster youths had at least one experience of being victimized, sexually assaulted, incarcerated, or homeless. Reilly also added that approximately 10-40% of aged-out youths were unemployed or had trouble keeping steady employment; only 34% completed high school; 44% had serious health problems, with more than 50% having difficulties obtaining health coverage; and nearly 25% were involved in the criminal justice system since aging out. Lee et al. (2015) added that foster youth with criminal records had decreased rates of employment and high school graduation and higher rates of adult involvement with the legal system by the time they turned 21. These findings are in opposition to what Gochez-Kerr and Helton (2017) found: that emerging adults with a previous abuse investigation were three times more likely to be robbed and 24 times more likely to be physically assaulted as emerging adults.

Mental Health

Approximately 50% of adolescents in foster care exhibited at least one diagnosable mental health disorder (Pecora et al., 2005; Shpiegel, 2016), while approximately 20% had three or more diagnosable mental illnesses. Furthermore, PTSD prevalence rates were twice as high in youths who had aged out of foster care than in U.S. war veterans (Pecora et al., 2005). According to Leve et al. (2012), foster youths' mental health was their primary area of vulnerability because of the disruptions they had experienced during the early developmental stages of life. The mental health concerns that youths may develop while in the foster care system, in addition to the traumatic experiences that caused their involvement in the foster care system to begin with, could remain unresolved and repressed until more severe mental and/or physical health problems manifested in adulthood (Leve et al., 2009).

Substance Misuse

Greeno et al. (2019) highlighted that although the substance use rates of current foster youth mirrored the national average of non-foster care youth, the rates of former foster youth were alarmingly high in comparison. According to Shpiegel (2016), around 60% of aged-out foster youths reported substance use, while Narendorf and McMillian (2010) noted in their study that 15% of this population met criteria for a substance use disorder. Attitudes towards substances also differed between foster youth and non-foster youth. Siegel et al. (2016) found that non-foster youth were more likely to view drugs and alcohol as being dangerous, had negative views towards substance users, and had more difficulty obtaining drugs than foster care youth. Meyers et al. (2013) added that foster parents in their nationally representative study were less willing to take in a foster youth who had a history of substance use, especially in cases where the substance was not alcohol or marijuana.

Homelessness

Shah et al. (2017) estimated that 25-30% of aging out foster youth experienced unstable housing/living arrangements. Shah et al. also noted that African Americans, youth with criminal involvement, and youth with a disrupted adoption or multiple foster home settings had increased rates of homelessness. Dworsky et al. (2013) demonstrated that between 31% and 46% of youth transitioning out of foster care had an episode of homelessness by the age of 26. Mitigating factors of homelessness in this population were predominately identified as being related to family connectedness (Fowler et al., 2017; Shah et al., 2017).

While homelessness is an acute issue, it can also impact the severity of other challenges that this population experiences. Dworsky et al. (2013) suggested that homeless youths were at a higher risk of physical or sexual victimization, had higher rates of health concerns, and had more difficulties accessing healthcare and other necessary services. Additionally, aged-out homeless youths had higher rates of mental health disorders than their aged-out peers who did not experience homelessness (Dworsky et al., 2013) and were less likely to pursue post-secondary education or have full-time employment (Rosenberg & Kim, 2018).

Sexual Health

In their comprehensive literature review, Winter et al. (2016) found that youth within the child welfare system had higher

rates of sexual risk-taking behaviors, including not using contraception. Stott (2012) found that nearly half of all aged-out foster youth reported never using condoms during vaginal intercourse, while Rebbe et al. (2017) reported that 33% of their sample of aged-out foster youth had been previously diagnosed with a sexually transmitted infection. Additionally, aged-out foster youth had higher rates of pregnancy and repeat pregnancies than youth not involved in the foster system (Winter et al., 2016). Still, aged-out foster youth who were parents demonstrated the desire to be resilient. Even with limited resources, support, and parenting skills, adolescent parents who had aged out of foster care found joy in parenting and desired to break the cycle of abuse and neglect with their own children (Aparicio, 2017).

Protective Factors

There are a variety of protective factors that are considered essential in nurturing resilience in high-risk populations. The most widely accepted protective factor for foster youth has been identified as having supportive and trusting relationships (Davidson-Arad & Navaro-Bitton, 2015; Drapeau, et al., 2007; Kothari et al., 2020; Shpiegel, 2016). While Drapeau et al. (2007) found that having a significant and positive relationship with an adult helped foster youth gain essential skills needed in developing and maintaining trusting relationships, as well as feel a sense of security and acceptance, there was not an agreed-upon specific relationship that provided an increase in foster youth resiliency.

Self-efficacy is another protective factor that fostered resilience in these emerging adults. Drapeau et al. (2007) reported that an influential factor on the path to resilience for foster youths was experiencing achievements through work, school, and/or extracurricular activities. These achievements helped foster youths experience a sense of accomplishment, have a more positive outlook, regain a sense of control, and realize their ability to succeed—all increasing self-esteem. Kothari et al. (2020) also emphasized the importance of focusing on the individual and interpersonal strengths of this population to promote positive mental health, well-being, and resiliency.

Furthermore, Shpiegel (2016) proposed the possibility that the resilience of foster youth may be more directly related to decreased risk factors than to increased protective factors. Although clinicians cannot remove the trauma and adverse experiences that these emerging adults have already experienced prior to being placed in foster care, they can aid in minimizing the risk factors experienced while in care. This can be done through offering timely, appropriate intervention services; establishing rapport and trusting therapeutic relationships; facilitating needed communication to ensure stable, long-term placements; and collaborating with the foster youth to provide Independent Living Programs that focus on both the tangible behavioral outcomes and their deeper emotional needs (Shpiegel, 2016).

Cultural and Gender Considerations

While children of color are over-represented among the foster care population, Watt and Kim (2019) found in their comprehensive study of transitional foster youth that although there have been some racial differences related to variables such as higher education enrollment, employment, and incarceration, there were no clear group advantages in psychosocial

functioning among African American, Hispanic, and White adolescent foster youth. Research conducted by Shpiegel (2016) offered a possible explanation by demonstrating that non-white youth had higher rates of resiliency than White youth, even when controlling for protective factors. Still, Watt and Kim (2019) also reported that American Indian/Alaska Native youth did experience poorer outcomes and had significant disadvantages related to transitioning out of foster care, advocating for continued efforts to reduce these disparities. Regarding gender, Davidson-Arad and Navaro-Bitton (2015) suggested that females were more resilient than males, explaining that it was more socially appropriate for girls to receive help from social resources than boys.

Counseling Implications for Youth Aging-Out of Foster Care

Indeed, the challenges faced by youth who age-out of foster care are vast, but it does not equate to hopelessness. Adolescent youth can be unfathomably resilient, and this strength should bring optimism to those counselors who choose to work with them. This section provides practical guidance to counselors who provide counseling to youth aging-out of foster care by discussing five areas identified in the literature that promote success with this population: prevention and resiliency development, using creative approaches, behavioral treatment, developing communication and life skills, and establishing mentors.

Prevention and Resiliency Development

The counseling process for youth aging out of foster care should begin as early as possible. Prevention is necessary to strengthen youth during the transitions experienced in foster care to build resiliency for future success. Yates and Grey (2012) confirmed this importance in saying, "resilient strivings and successes among emancipated foster youth reveal significant heterogeneity in the adaptive profiles of a population that has too long been discounted as lost or beyond saving" (p. 477). Furthermore, Yates and Grey (2012) suggested that even individuals from the most vulnerable populations can have or gain strength in one or more domains of resiliency and adaptation during the transition to adulthood.

Building resiliency through counseling can happen throughout the time an individual spends in foster care. For example, many youths in foster care enter counseling following periods of maladaptive behaviors. In a case study of African American male adolescents with behavioral issues in foster care, Utsey et al. (2003) demonstrated a reduction in maladaptive behaviors resulting from therapeutic mentoring groups. Additionally, counseling can occur at expected transition points in the foster care process. Lancaster et al. (2017) conducted research exploring the perspectives of clinical mental health counselors who provided post-adoptive family counseling services, noting the importance of using trauma and attachment focused therapy. Whether counseling is implemented to address concerns or as support for a transition, it should be utilized to develop preventative factors that will build resiliency as foster care youth move towards aging-out.

Creative Approaches

Nsonwu et al. (2015) suggested that the use of a holistic, arts-based treatment program has encouraged older youths in foster care to gain increased self-awareness,

improved self-esteem, enhanced cohesion, a sense of belonging, and reduced feelings of isolation. They recommended utilizing a Narrative Therapy approach, where participants can tell their story by creating a timeline and writing a third-person narrative to recognize a trauma history. The premise was that a self-reflective process led to healing by analyzing and changing his/her own story. This, in turn, helped to develop personal identities through the relationship of his/her life experiences to others, while the addition of a Drama Therapy approach helped the older foster youths to tell their stories, examine stressful subjects, and develop possible solutions. Participation in the play not only gave them a voice to be heard but also provided a safe environment in which they could improve their social skills and practice problem-solving. Lougheed and Coholic (2018) also created a creativity-based intervention for youth aging out of foster care in the form of a 10-week arts-based mindfulness group. By incorporating mindfulness into a strengths-based group that allowed participants to explore areas of art including painting, drawing, music, and experiential activities, Lougheed and Coholic sought to offer a promising approach to promote wellness with this population.

Behavioral Treatment

For adolescents with more significant struggles in foster care prior to aging-out, a more extensive treatment strategy may be indicated. Multidimensional Treatment Foster Care (MTFC or MTFC-A) has been widely considered as the most effective and efficient treatment model in producing positive outcomes for foster care adolescents (Leve et al., 2009; Leve et al., 2012). In support of this treatment model, Farmer et al. (2010) demonstrated that MTFC-A had indicated significant enhancements in the symptoms, behaviors, and strengths of their sample at a six-month follow up. Although it was originally designed to reduce delinquency outcomes, MTFC has also been successfully used as a preventative factor, to promote resiliency, and to increase positive social/behavioral skills (Leve et al., 2009).

Communication and Life Skills

Working with an aged-out youth on interpersonal and communication skills, planning for the future with decision-making skills, self-management, and coping skills were a few other key topics noted as being beneficial during an emerging adult's transition (Gomez et al., 2015). Teaching cognitive reframing and emotional regulation skills was also beneficial to emerging adults. According to Johnson and Tottenham (2015), regulatory skills have a moderating influence on emotional processes and often counteract emotional triggers and stressors.

Based on a study done by Smith et al. (2017), a lack of experience or adult support in financial matters led to poor financial decision-making. Smith et al. suggested the use of a prevention-focused Financial Therapy model, which is an integration of various therapeutic aspects, typically framed around the Stages of Readiness to Change (DiClemente & Prochaska, 1998), to help an individual develop the cognitive, behavioral, and emotional aspects of financial decisions. This approach both motivates and educates the adolescent in financial literacy.

Mentoring

Thompson, Greeson, and Brunsink's (2016) comprehensive review of the literature established that natural mentoring

has been beneficial to older youth in foster care. Still, current policies promoted focusing on the development of self-sufficiency over social support development (Curry & Abrams, 2015). The development of the therapeutic mentoring approach stemmed from the consistent finding throughout literature that resilient children typically had some type of caring and supportive non-parental, extra-familial adult in their lives (Osterling & Hines, 2006). Thompson and Greeson (2017) added that simply being involved in a hobby/activity or an organization/club dramatically increased the likelihood of having a natural mentor. Additionally, Greeson and Thompson (2017) developed the Caring Adults 'R' Everywhere (C.A.R.E.) mentoring model that connected aged-out foster youth with natural mentors and provided efficacy support demonstrated through a randomized controlled pilot study.

Advocacy

Advocacy has been a primary function of mental health counseling since the start of the profession. The ACA Advocacy Competencies state that counselors need the necessary skills, knowledge, and behavior to influence the systemic barriers impacting clients by both empowering clients to act for themselves and by acting on their behalf (Toporek & Daniels, 2018). While advocacy initiatives that focus on increasing funding and youth-centered services for the aging out population should be prioritized by counselors, the empowerment of individual youth strengthens clients while equipping them to be agents of change when they reach adulthood. Salazar et al. (2020) recommended that foster care youth engagement should promote agency while amplifying the voices of the youth, and that institutional policymakers should connect with frontline staff to ensure that systemic decisions are influenced by those with first-hand knowledge of the population's experience.

A noteworthy phenomenon that has allowed for foster care youth to engage their communities while developing agency and advocacy skills has been the influx of foster youth boards, councils, and coalitions across the United States (Forenza & Happonen, 2016). Forenza (2018) explained that foster youth who participated in advisory boards developed the ability to critically reflect on their experiences and explore their ability to make change. Havlicek and Samuels (2018) added that the critical examination offered by the advisory board platform allowed for foster youth to normalize, protect, and enhance positive identities within the participants. Advisory board formats varied from setting to setting and ranged from adult-driven designs to youth-led strategies, with a 50/50 youth-adult partnership being the most common (Havlicek et al., 2018); and two primary goals that facilitators maintained for youth participants were to develop their ability to speak out for themselves and to gain respect among key stakeholders (Havlicek et al., 2016).

Case Study

The purpose of this case study was to apply the information gleaned during the synthesized literature review to describe an eclectic mental health counseling approach with a typical client who has recently aged out of foster care. The client, Hannah, is a fictional composite derived from descriptions of the population in the scholarly literature and the authors' clinical experiences. The counselor, Roxanna, in this case study utilizes a common approach to mental health counseling, blending elements

of cognitive behavioral therapy and a person-centered approach.

Hannah aged out of foster care on her 18th birthday and was referred to counseling services at a local homeless shelter where she had been staying approximately one year after becoming an adult. Upon arrival to the shelter, Hannah completed a risk assessment and a needs assessment. The risk assessment helped to evaluate batterer-generated risks (i.e., physical violence, threats, emotional/psychological abuse, financial abuse, manipulation, etc.), life-generated risks (i.e., life circumstances, physical and mental health, impact of abuse, access to resources, etc.), and goals/priorities. The needs assessment helped to determine what were the immediate needs to be addressed or assisted with (i.e., legal aid, social services, access to care, housing, employment, counseling, etc.). Counseling was an identified need in both assessments, and Hannah started counseling services shortly after entering the shelter.

Hannah began counseling with Roxanna, a licensed mental health counselor, shortly after being referred from the shelter. Since Hannah was never given the opportunity to seek consistent counseling services while in foster care, she was never able to fully process and cope with the years of trauma that brought her into foster care or the adversities she experienced while in the system. Additional to her trauma history, Hannah had current mood and substance use concerns. After a thorough assessment with Roxanna, Hannah was diagnosed with Major Depressive Disorder, Alcohol Use Disorder in early remission, and a preliminary diagnosis of Unspecified Trauma- and Stressor-Related Disorder. Following the assessment, Hannah and Roxanna developed a treatment plan that included the goals of addressing her depressive symptoms, maintaining sobriety, and working towards independence.

The first few months of counseling consisted of Roxanna building a strong therapeutic relationship based on the person-centered constructs of unconditional positive regard, empathic understanding, and genuineness. During this time, Hannah was learning coping skills to assist her in managing her depressive symptoms, including cognitive disputes for irrational thoughts and mindfulness. Hannah elected not to seek a psychiatric evaluation, and instead, she focused on implementing her strategies to effectively regulate her mood. Hannah additionally agreed to participate in a counseling support group for women recovering from abuse and trauma, regularly attend recovery meetings, and participate in the mandatory programming provided by the women's shelter where she was staying (i.e., life-skills building activities, substance abuse screenings and educational meetings, support groups, and crisis intervention/safety planning). Hannah continued to actively participate in these services, allowing her to stay in the shelter's transitional housing facility as she worked towards independence.

After experiencing some relief from her depressive symptoms and while maintaining sobriety, Roxanna suggested that Hannah might begin exploring her trauma history in counseling. Hannah agreed and the two began creating a timeline of events, outlining Hannah's life. As Hannah encountered traumatic incidents along the timeline, Roxanna gave Hannah the opportunity to recount the events in a safe, therapeutic environment. If Hannah chose to revisit the memory, Roxanna worked closely with her to implement coping strategies to regulate the emotionality of the experience.

The extended exposure to the memories diminished their emotional impact, while sharing the experience with Roxanna provided a cathartic response. After multiple difficult sessions, Hannah began to build confidence that she was healing from her past. Roxanna provided encouragement throughout the difficult sessions and began to help Hannah transform her self-schema from a victim to a survivor, leading to an increase in Hannah's self-esteem.

After the extensive trauma work, Roxanna and Hannah refocused on establishing Hannah's independence. Hannah had recently found a job as a restaurant server, which allowed Hannah to start generating an income. After a few months of consistent, successful employment, Hannah elected to enroll in college. In counseling, Roxanna began to encourage Hannah to start identifying and developing her social network. Hannah had developed some friendships with women she had met through her support groups and work, with one woman serving as an informal mentor. Roxanna guided Hannah as they discussed which relationships would support Hannah as she continued working towards her recovery and independence. After extended consideration, Hannah decided to move in with a friend who was also in recovery, leaving the shelter's long-term residential housing approximately one year after entering the program. During this time, Hannah had learned how to navigate and access governmental resources, secure and maintain employment, and develop appropriate friendships. Through counseling, she also resolved her major depressive episode, maintained sobriety, and established herself as a survivor of trauma.

Conclusion

The developmental vulnerabilities of emerging adulthood combined with the risk factors inherent in foster care led aged-out foster youth to experience multiple poor outcomes compared to their peers, including those in other high-risk groups (Gomez et al., 2015). With a lifetime prevalence of involvement in the child welfare system having been estimated at 7% of all children and adolescents in the U.S. (Leve et al., 2009), there needs to be a more targeted approach to spotlighting specific policies and practices that address the potential risk factors of foster youths aging out of the system. Because of this, mental health counselors need to be aware of the unique factors of this population to adequately serve them during their transition to adulthood. Likewise, mental health counselors should consider the needs of a diverse range of foster youths in order to strive towards equity among oppressed groups. With a strong understanding of the needs of those individuals aging out of foster care, mental health counselors are in a significant position to make a difference with this population.

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