We are pleased to present Volume 2 of Clinical Updates for Family Therapists: Research and Treatment Approaches for Issues Affecting Today's Families. Since 1999, the AAMFT has produced a new Clinical Update article every two months, to coincide with the publication of Family Therapy Magazine. This volume includes the 18 Clinical Updates that were originally published from 2002 through 2004. (Refer to the back of the book for a list of topics included in Volume 1.) The articles have been reviewed by the authors and revised to include the most up-to-date research and resources.

Clinical Updates are digests of the latest information about a topic, with references for more in-depth study. Clinicians find the Clinical Updates particularly useful when faced with a clinical issue they rarely see. Students of family therapy find them an invaluable primer on the array of issues likely to be presented by clients. My hope is that you will reach for it often, and that it will benefit both you and your clients.

When each Clinical Update was originally published, a companion Consumer Update on the same topic was published in the form of a brochure. The Consumer Update brochures offer a way to inform clients about the topic and learn how family therapy may help them. Further, the Consumer Update brochures serve the clinician as a marketing tool to reach out to potential clients and referral sources, and let them know that the therapist is available to assist with the particular problem discussed in the brochure. The Consumer Update brochures are still available from the AAMFT. We invite you to consider purchasing some of the brochures to market your expertise and your availability to the public.

We extend thanks to the authors of the Clinical Update chapters, both for their authorship of the original article as well as their review and update in preparation for this publication. Your work continues to be a valued resource for the field.

Karen Gautney, M.S.
Deputy Executive Director
American Association for Marriage and Family Therapy
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A CLOSER LOOK: UNDERSTANDING POSTPARTUM MOOD DISORDERS

“My baby had been crying for an hour. I felt nauseous. I had a four-year-old in the next room, a screaming baby and I felt myself unraveling away from my backbone. I started to shake. The quivering came from the deepest part of my soul, a place that you’re only aware of when you’re about to die. I needed to throw up, but I couldn’t get out of bed. I tried to sit up, but my eyes couldn’t see and I was dizzy. I felt scared. I thought I had made a horrible mistake. I didn’t want to take care of this baby.”

In recent years, there has been increasing public awareness and growing concern about the necessity to educate and inform women and their families about their risks for a mood disorder during pregnancy and/or postpartum. Research indicates that women are more vulnerable for developing a mood or anxiety disorder in the months surrounding birth than at any other time in their life (O’Hara, 1999). Fifty percent to 80% of mothers will experience some change in their mental health within the first year after delivery. Approximately 10% to 15% of these women are at risk for postpartum depression with potentially serious consequences for themselves, their families and their newborns—the most devastating being suicide and infanticide.

There is a critical need for early assessment and effective treatment. When ignored, the symptoms of a postpartum depression are far more likely to exacerbate, to become treatment-resistant and cyclical in nature with deleterious repercussions for the developing attachment relationship between mother and child.

Additionally, there is growing evidence that a mother’s ongoing depression may impair a child’s cognitive and social development (Murray, 1997). With proper screening and risk assessment during pregnancy and in the early months of the postpartum period, postpartum mood disorders are very treatable and even preventable.

Marriage and family therapists (MFTs) are frequently called upon to...
help families cope during tenuous periods along the lifecycle. The birth of a baby is a life cycle event of dramatic proportions. A physically and emotionally taxing experience, childbirth involves a renegotiation of family roles in order to create a space for the newest member.

Stress in the postpartum period is a predictable developmental crisis that disturbs the equilibrium of the family system. For some women, a postpartum mood disorder is a maladaptive response to the normal and appropriate feelings of loss that surround the birth of a child.

Shrouded in cultural myths and expectations, new parents tend to revel in the ideals that society promotes about motherhood and childbirth without accounting for the psychological, environmental, and biological stresses that this normally joyful event brings to the family. As a result, new parents often fail to prepare themselves for the enormous emotional changes and physical demands that occur after a baby’s birth, particularly during the first year. This lack of preparation leaves some women much more susceptible to the hormonal and chemical changes that occur during pregnancy and after childbirth.

A woman may believe that mothering is an instinctive phenomenon that requires no outside training or influence, or that the bond with her baby will be immediate and intense. As she comes face to face with the contrast between her expectations and the reality, guilt and fear may interfere with any expression of conflicted feelings.

Because MFTs are privy to so much of a family’s biological and psychological history, they are also in an excellent position to assess a woman’s risk for postpartum depression even before she becomes pregnant. With an understanding of the emotional process and dynamic shifts that occur during the first year after birth, clinicians can help families create psychological supports in advance of the postpartum period, as well as in the early months following delivery, while normalizing this developmental transition for families.

**DIAGNOSIS AND ASSESSMENT**

*What is postpartum depression?*

Postpartum depression is a biological illness caused by changes in brain chemistry that can occur following the birth of a child. During pregnancy, hormonal levels elevate dramatically, particularly progesterone, estrogen, and cortisol, falling rapidly within hours to days after childbirth. In addition, the amount of endorphins produced by the placenta during pregnancy drops significantly after delivery.

Female reproductive hormones assist in maintaining the balance of neurotransmitters that regulate the chemical activity of the brain. A disruption in that activity with a corresponding fluctuation in the normal levels of serotonin, norepinephrine, dopamine, and/or acetylcholine can lead to depression, panic, and even psychosis. Even the thyroid gland can be affected by the enormous chemical shifts associated with pregnancy and childbirth, leaving women more vulnerable to a depressive episode.

The literature on postpartum mood disorders makes a distinction
between postpartum depression and postpartum psychosis. Traditionally, the “baby blues,” was an umbrella term used to describe any postpartum depression regardless of symptoms or severity. However, the blues is now considered a part of normal postpartum adjustment because so many women, as many as four out of five, experience mild changes in their mental health following childbirth. Characterized by tearfulness, irritability, anxiety, and feelings of being overwhelmed, the baby blues usually surface by day three or day four postpartum. These symptoms are transitory, and generally diminish by day 14 without any need for medical and/or psychological intervention. Because, however, some women go on to develop a major postpartum depression, women at risk should be monitored during this initial period. Symptoms that persist or intensify beyond two weeks should be evaluated immediately to determine whether medical and/or psychological support is indicated.

Postpartum psychosis, a potentially life-threatening medical emergency is biochemical in origin. Approximately one to two out of every thousand women who give birth will experience a psychosis. If ignored, postpartum psychosis can prove costly to both mother and child with suicide rates at approximately 5% and the risk of infanticide at 4% (Bennett & Indman, 2002). Notable about psychosis is its abrupt onset anywhere from 3 to 14 days after childbirth. Significant confusion, disorientation, and rapid mood cycling often accompanied by auditory hallucinations and delusional thinking are the predominant features of this illness. Mothers with postpartum psychosis frequently have intrusive and obsessive thoughts about harming their infant and/or themselves. Personal and family histories of women with psychosis indicate a higher incidence of mood disorders, particularly bipolar disorder and schizophrenia.

At least 1 out of 10 women who give birth will develop a major depressive disorder with postpartum onset. Among the characteristic symptoms listed in diagnosis are dysphoric mood accompanied by sleep and appetite changes, psychomotor disturbance, fatigue, excessive guilt, and suicidal ideation. In addition, women with pronounced postpartum depression experience feelings of confusion and disorientation (they describe it as “being in a fog”) that is sometimes accompanied by memory impairment. The singular feature that seems to distinguish postpartum disorders from the normal and appropriate stressfulness of the initial postpartum period is the inability to sleep, despite exhaustion. What is especially striking and most touching about a woman’s experience with postpartum depression is her own awareness that she is having difficulty engaging with her infant, yet feeling immobilized to act on her intuitive sense. Some women describe themselves as “going through the motions” of caring for their newborn, but feeling emotionally detached.

While most of the symptoms of postpartum depression are generally akin to the DSM-IV’s (APA, 1994) diagnostic criteria for a major depressive disorder, women with postpartum depression are especially prone to feelings of guilt, anxiety and maternal inadequacy with accompanying distortions in their thinking. They often feel frightened about being left alone with grave
concerns that they will be unable to cope with the overwhelming demands of caring for an infant. Many women in the throes of this depression believe quite genuinely that their infant would do better in the care of a different mother, and they see themselves as replaceable. These overpowering feelings of maternal inadequacy and incompetence surface with debilitating consequences for the new mother, resulting in her painful sense of helplessness against seemingly unexplainable physiological and psychological forces.

Most often, new mothers find their depressive symptoms intensified by overwhelming feelings of anxiety that potentially can interfere with day-to-functioning, especially around caring for their infant. It is not uncommon, however, for postpartum depression to coexist with another diagnostic component such as a postpartum panic reaction or post-traumatic stress reaction. For others, the compelling feature of their depression is an obsessive-compulsive reaction in which they are plagued by spontaneously occurring, but repetitive and disturbing thoughts or images, usually having to do with harming their baby. Women’s fears about acting on their thoughts usually generates behaviors designed to reduce anxiety, like hiding knives, or ceasing to hold their infants for fear of dropping them. The obsessive-compulsive sub-type of postpartum depression can also involve repetitive behaviors, like diaper counting, or checking on the baby’s breathing many times during the infant’s sleep. Generally, these clinical varieties of postpartum mood disorders originate with some family and/or personal history of anxiety disorder, panic attacks, or obsessive-compulsive behaviors. Because childbirth is so physically and emotionally stressful, it frequently restimulates sensations and memories of an earlier traumatic event for women diagnosed with post-traumatic stress disorder.

Although the time frame for postpartum depression is the first four to six weeks following childbirth, any woman who has given birth within the past year is vulnerable. Weaning a baby from the breast and the return of the menses are significant events that also affect the timing of a depression.

Many women frequently delay in asking for medical and therapeutic help out of shame, guilt, and mistaken beliefs that a “good mother” should be content and capable of handling the overwhelming adjustment of caring for a new baby with little or no need for her own care. Too often, family members and health care providers fail to recognize the symptoms of a postpartum depression, attributing a mother’s complaints instead to the stressful adjustment of caring for a new baby.

Who is at risk?

Although there is no exact way to predict the occurrence of a postpartum depression, it is possible to identify the psychosocial factors that increase risk. Isolating the numerous biological, environmental, and psychological stressors that contribute to onset helps to determine the focus of treatment.

The most important risk factor for postpartum depression is a personal and/or family history of depression and/or bipolar disorder. In fact, more than 50% of women who have had a previous postpartum depression are at risk of a recurrent depression following a subsequent birth. Women are also
more vulnerable if they have been depressed during their pregnancy or have a history of premenstrual dysphoric disorder.

Stressful situations that include marital tension, health problems with the baby, a complicated pregnancy and/or delivery, and a lack of social support also place a woman at increased risk for postpartum depression. Among the psychological factors that set the stage for a postpartum mood disorder are an early history of sexual abuse or trauma, chemical dependency in the family of origin, ambivalent or negative feelings about the pregnancy, and ambivalence about the maternal role.

Other issues that may have an impact on a woman’s mental health during the postpartum period are previous fertility problems and unresolved losses, such as miscarriage and stillbirth. It is not uncommon for delayed grieving to date as far back as childhood experiences of loss, like divorce or the death of a parent, and be restimulated by the birth of a child.

There are several screening tools used to detect postpartum depression, including the “Postpartum Depression Predictors Inventory” (Beck, 1998) and the “Antepartum Questionnaire” (Posner, 1997). The “Edinburgh Postnatal Depression Scale” (Cox, Holden, & Sagovsky, 1987) has been the most widely used screening tool to assess for postpartum depression. This self-assessment scale consists of 10 short statements, each with four possible responses, designed to help the new mother report to the practitioner how she has been feeling over a seven-day period. Responses are scored according to the increased severity of symptoms and receive a rating of 0, 1, 2, or 3. Mothers who receive a total score above 12/13 are likely to be suffering from a depressive illness.

The Postpartum Depression Screening Scale (Beck & Gable, 2002) targets specific symptom areas like sleeping/eating disturbances, anxiety/insecurity, mental confusion, and loss of self. The PDSS uses a 35-item Likert-type scale to assess for the severity of a woman’s depression within a two-week period. Both the Edinburgh and the PDSS are designed to identify possible depression and not intended to replace clinical judgment.

**TREATMENT OPTIONS**

Decisions about treatment for postpartum mood disorders vary according to the severity of symptoms. Professional consensus, however, seems to support the use of antidepressant medications in combination with either interpersonal or cognitive behavioral psychotherapy. Group psychotherapy has also been found to alleviate some symptoms by reducing the feelings of isolation that many women feel after childbirth and during a depression. The more severe the depression, the more experts usually recommend the use of medication. Women who present a personal and/or family history of psychiatric illness tend to be good candidates for antidepressants or mood stabilizers.

Since the feelings associated with postpartum blues tend to ameliorate by two weeks, most women with “the baby blues” do quite well with added rest and extra help caring for their infant, along with reassurance and emotional support that their feelings are normal and temporary. For the mother
with severe symptoms, such as suicidal or psychotic thoughts, hospitalization may be necessary to protect her and her child while the depression is being stabilized. Other symptoms that suggest the need for emergency treatment include rapid weight loss without intentional dieting, refusal to eat, and sleep deprivation of more than 48 hours duration. In those extreme cases when a mother is not responding to trials of medication or has a psychotic depression with postpartum onset, she may benefit from a course of electroconvulsive therapy. ECT or electroshock therapy involves the induction of a series of brain seizures under anesthesia as a way of treating the depression.

For women with depression that intensifies and persists beyond the time frame of the blues, psychotherapy provides a supportive framework in which psychosocial stressors can be addressed. At a psychological level, postpartum depression is a reflection of profound feelings of loss that are left unexpressed. Concurrent with the overwhelming demands of caring for an infant is a loss of time with one’s spouse, the loss of adult companionship, loss of a previously known freedom and a departure from the way things were. The struggle for most families is their wish to return to that which is familiar and the conflicted feelings inherent in knowing that their lives will never again be the same.

A woman’s partner may have his own reactions to the birth of their child as he experiences the loss of time with his spouse or worries about his new role as a provider for the family. When a postpartum illness occurs, he may have additional concerns about his wife’s health and fear that their lives are deteriorating as a result of her depression. Interestingly, most men who find themselves caring for a partner with a postpartum mood disorder are not strangers to depression themselves. History-taking frequently reveals their personal knowledge of depressive illness, either because they have suffered from depression themselves or have experience with a family member who was challenged by some type of mood disorder. Their earlier experience often heightens their emotional reactivity to the current situation.

Systemic Considerations
Whereas traditional treatment identified the woman as the patient, more recent practice recognizes that the birth of a baby reverberates throughout the family system and treatment goals must address the experience of the entire family, particularly that of the marital couple. As family members struggle with their own unspoken expectations of how things should be, guilt and fear often interfere with a family’s comfort in talking about the ambivalent feelings that are absolutely normal and appropriate during this time.

Instability in the marital relationship is one of the key risk factors in the onset of a postpartum depression. Therefore, the initial therapeutic work should strive to normalize the reactions of both partners and their individual feelings of frustration, uncertainty, anger, and sadness that may create distance between them. As MFTs assist the family in this reorganization of roles, it may also be significant to explore with them ways in which they
BIOMETICAL ISSUES

A variety of antidepressant drugs are used to treat postpartum depression. These include the tricyclics, like Norpramin (desipramine) and Pamelor (nortriptyline), as well as the SSRIs, of which the most commonly used are Prozac and Zoloft. Effexor and Celexa, two other drugs in the SSRI family of antidepressant medications, are also being prescribed. The most frequent side effects associated with SSRIs are headache, anxiety, insomnia, nausea, and sexual dysfunction. Patients who use TCAs often complain about dry mouth and blurred vision. Less commonly used because of their deleterious side effects, but nonetheless effective in treatment resistant depressions, are the MAO inhibitors, i.e., Nardil and Parnate.

The most dangerous side effect of the MAOs is a hypertensive reaction, which, although reversible with medication, can be life threatening. This reaction is caused by an interactive effect between the drug and the absorption of large amounts of tyramine, a substance found in certain foods. Consequently, patients who take MAOs must follow a tyramine-restricted diet and avoid foods such as aged meats and cheeses, wine, and beer. Another disadvantage of MAO inhibitors is harmful interactions with other drugs such as Demerol, nasal decongestants, and certain asthma inhalers.

In some cases, depending on the antidepressant that is being used, mothers who begin a course of treatment need to be informed that it may take between three to six weeks before they begin to feel better so that they don’t become quickly discouraged and quit taking their medication if they don’t feel more immediate results. Women also should know that individual body chemistry and sensitivity to medication affects the type and combination of drug choices. No single medication is effective for all women. Because anxiety and agitation are often a component of postpartum depression, anti-anxiety drugs such as Ativan or Xanax may be used in conjunction with an antidepressant to provide added symptom relief. In cases of more severe depression or a postpartum psychosis, lithium is sometimes given to counteract the uncomfortable effects of rapid mood cycling. Thyroid medication also seems to alleviate depressive symptoms in women with an underactive thyroid. Subsequently, therapists should encourage clients to have a medical evaluation so that organic causes for her emotional state are ruled out.

One of the most controversial issues facing breastfeeding mothers receiving treatment for postpartum depression is the safety of medication for their nursing infant. Recent studies endorse Zoloft (sertraline) and Paxil (paroxetine) as top choices for breastfeeding moms with little or no medication detected in infants (Moline, et al 2001). Celexa (citalopram) and Prozac (fluoxetine) do enter breast milk in small amounts but are considered acceptable choices when mothers are not responding to Zoloft or Paxil. Although some of the older tricyclic medications may cause more side effects in the mother than the SSRIs, drugs like Tofranil (imipramine) or Pamelor (nortriptyline) may be more effective for some mothers and are recommended as alternatives.

For severe depressions with psychotic features, it is often necessary to combine an antidepressant with an antipsychotic like Haldol or a mood regulator like lithium (a drug which is contraindicated for breastfeeding moms). Haldol, a widely used antipsychotic medication, is usually chosen over some of the newer drugs like Risperdal or Zyprexa primarily because as of date, the latter two have not been tested enough in breastfeeding mothers and their babies.
have dealt with change and loss in the past, as this will have a bearing on their current behavior.

**Transition to Motherhood**

Pregnancy and delivery gives rise to a psychological process as many women struggle with their notions of what constitutes a “good mother.” The advent of motherhood also reconnects women with their earliest memories and sensations of their experiences as daughters, and the birth of a child rekindles those images. Inevitably, the quality of a woman’s past relationship with her own mother has an enormous impact on her current responses to her baby as she takes on this new role of “Mommy.”

Most women rely on their knowledge of their own mothers as a role model for motherhood. A woman’s previously unsatisfactory relationship with her own mother may create ambivalence about the maternal role, and leave the new mother feeling isolated and inadequate about her coping skills. Women with postpartum depression tend to question their ability to develop a secure attachment to their infant and a genuine concern that they may not have the emotional stamina to be appropriately responsive, adequately attuned, and sufficiently nurturing to meet the ongoing demands of their newborn.

Treatment consists of helping women after birth and even during pregnancy to gain emotional access to some of the negative and confusing beliefs that influence their behavior, thoughts, and feelings. Failure to man-

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**POSTP ARTUM DEPRESSION AND ITS REPERCUSSIONS ON THE FAMILY SYSTEM**

A systems approach offers the view that the functioning of one person in the family cannot be understood out of context of the people closely involved. Although women with postpartum depression were formerly perceived as the “identified patient,” current thinking acknowledges that the birth of a baby creates a dynamic reaction throughout the family system.

Bowenian theory takes the perspective that individuals usually marry at the same level of differentiation, which directly affects the level of emotional reactivity and anxiety in the marital dyad. The case example in the chart indicates that both individuals have a history of depression and significant loss in their respective families. As their roles shift from couple to parents, there is a parallel process regarding the feelings of loss in response to the enormous changes after childbirth. Although the mother with postpartum depression is the “presented patient,” it is clear that both spouses are reacting with intensity to the changes in their lives. For the father in this case example, his current feelings of fear, anger, helplessness, and confusion may be a restimulation of his earliest experience of fear, anger, loss, and powerlessness.

Systemic treatment helps to reestablish emotional intimacy within the relationship by looking at the family as “patient,” and exploring the emotional experience of everyone involved. Family treatment opens communication channels and enables partners to respond to each other more objectively and not reactively.
age the psychological tasks of the postpartum period, an inherent part of the transition to motherhood, is implicated in the downward spiral of cognitive and emotional processes that result in maternal depression.

**Preventive Strategies**

For women at high risk of developing a major depression with postpartum onset, much of the treatment can begin during pregnancy with a preventive program that entails starting psychotherapy several months before the due date and then adding an antidepressant at the appropriate time. It is also vital that families use this time to put an adequate support plan in place. In this way, the new mother will be assured of receiving enough help with household responsibilities and infant care in the weeks and months following delivery. This plan ensures sufficient rest for the new mother and reduces feelings of being overwhelmed, a common experience of the postpartum mother. In addition, a good social support network might even include some kind of weekly psychotherapy group to lessen a new mother’s feelings of isolation.

**REFERENCES**


A brief article that gives a concise explanation of symptoms, risk factors and biomedical issues as relates to the development of postpartum mood disorders.
Postpartum Depression


An informative and highly-referenced collection of clinical papers that explore the sociocultural and psychological impact of postpartum depression on women and their families with a focus on the repercussions for the mental health of the developing infant.


Research article that addresses assessment and treatment issues during pregnancy and the postpartum period.

**Screening Tools**


**RESOURCES FOR PRACTITIONERS**

**Books**

In addition to the preceding books:


A treatment manual for the professional and non professional which offers information on assessment and treatment in a user friendly and concise manner.


A thorough guide to assessing and managing psychiatric conditions in women with an emphasis on the biological, psychological and sociocultural factors that influence a woman’s mental health.


A practical and comprehensive guide that addresses the range of postpartum adjustment problems. Good choice for clients, as well.


One of the foremost works towards an understanding of postpartum mood disorders, this book presents research and treatment considerations with an emphasis on the organic components of postpartum illness.

Postpartum Depression

Contains information and specific recommendations to help partners cope with the impact of depression after the birth of a baby.

This is a comprehensive, well-organized and recent overview of all aspects of postpartum mood disorders, including the effects of postpartum disorders on child-rearing.

An in-depth and sensitive look at the psychological processes involved as women move towards motherhood.

Organizations
Postpartum Support International
927 N. Kellogg Avenue
Santa Barbara, CA 93111
805-967-7636
www.postpartum.net
The purpose of the organization is to increase awareness among public and professional communities about the emotional changes that women often experience during pregnancy and after the birth of a baby.

Depression After Delivery, Inc.
91 East Somerset Street
Raritan, NJ 08869
1-800-944-4773 (4PPD)
www.depressionafterdelivery.com
Depression After Delivery, Inc. is a national, non-profit organization that provides support for women with ante and postpartum depression. Its focus includes education, information, support groups, telephone support and referral for women and families coping with mental health issues associated with childbearing, both during pregnancy and postpartum.

ABOUT THE AUTHOR
Diana Lynn Barnes, Psy.D., LMFT specializes in women’s health concerns and life cycle changes, particularly those involving issues of pregnancy and birth. Dr. Barnes is a frequently interviewed trainer and internationally recognized writer and presenter on the subject of postpartum mood disorders. She has received acclaim as the consultant for MSNBC’s “A Mother’s Confession” and Discovery Health Channel’s “Medical Diary.” Dr. Barnes has appeared on CNN, Fox News, and Lifetime Television, and is a frequent consultant for the print media. She is the past president of Postpartum Support International, a Clinical Member of the AAMFT, and CAMFT. She started The Center for Postpartum Health in Woodland Hills, California in order to address the needs of pregnant and postpartum women and their families. (www.postpartumhealth.com).