



ADVANCING HEALTH EDUCATION & RESEARCH



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AVA Research Reviews provides AVA members with recent published, peer-reviewed articles in a broad array of violence and abuse topics. The goal is to highlight and disseminate violence and abuse research in a timely fashion, and to enhance healthcare providers' practice by fostering the educational mission of AVA

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AVA Research Review

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Review Title:

Evaluating a Coordinated Perinatal Mental Health Care Model: Intersectional-Feminist Insights for Clinical Practice

Reviewer(s):

Parker Killenberg
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Article: Stevens, N. R., Heath, N. M., Lillis, T. A., McMinn, K., Tirone, V., & Sha'ini, M. (2018).

Examining the effectiveness of a coordinated perinatal mental health care model using an intersectional-feminist perspective. *Journal of Behavioral Medicine, 41*(5), 627-640.

Introductory Comment:

Under the standard model of perinatal mental health care, factors such as race/ethnicity and socio-economic status (SES) influence access to treatment as well as type of treatment sought.

This interaction results in systematic and societal disparities in perinatal mental health. A coordinated care model informed by an intersectional-feminist perspective offers an alternative treatment approach. This model considers how different contextual factors (e.g., race/ethnicity, SES, traumatic experiences) interact to increase a woman's vulnerability to perinatal mental health problems. This article evaluated the effectiveness of the intersectional-feminist care model by analyzing the differences in treatment outcomes and engagement across ethno-racial groups. The authors offered evidence for how this model of care could benefit perinatal mental health by reducing systematic and societal disparities.

Brief Overview:

Racial and ethnic minority women, low-income women, single women, and women with traumatic experiences report a disproportionately larger number of mental health symptoms during the 12 months following pregnancy. The largest number of symptoms is reported at the intersection of these identities. Additionally, treatment barriers within a standard perinatal care model often encountered by socially-disadvantaged and ethno-racial minority women increase these mental health disparities. Stevens and colleagues assessed whether a novel, intersectional-feminist-informed, coordinated perinatal mental health care model could offer more effective treatment and reduce health disparities within a group of women. In particular, they were interested in treatment outcomes among single women, low-income women, and Hispanic/Latina and Black/African American women. Building on existing psychology literature, the authors analyzed how different factors (e.g., race/ethnicity, SES) affected treatment both negatively and positively.

Aims/Hypothesis:

The study was primarily exploratory, examining the treatment outcomes of an intersectional-feminist coordinated perinatal mental health care model. The authors hypothesized that this model of care would lead to effective treatment for all perinatal women (Non-Hispanic White, Hispanic/Latina, Black/African American). The authors also assessed whether treatment engagement levels of ethno-racial minority women differed from those of White women.

Method:

Data from 67 perinatal (i.e., pregnant or up to one year postpartum) women referred to outpatient psychotherapy at a large urban medical center were analyzed as part of this treatment effectiveness study. Participants were recruited from a pool of women who engaged in treatment within the coordinated perinatal mental health care model. Women were triaged into this care model if mental health symptom screeners resulted in a referral for mental health evaluation. Within this model, women received coordinated, individually tailored treatment by a multi-disciplinary team of practitioners.

This treatment consisted of a combination of some or all of the following services: individual psychotherapy, psychiatric medication management, group therapy for coping skills training, and referral to reproductive health care. Completion of at least six treatment sessions was considered necessary to sufficiently review patient assessment data, conduct treatment planning, and evaluate treatment progress and effectiveness.

Relevant Findings:

Because the study was not a controlled trial, it did not yield conclusive findings. Nonetheless, its findings highlighted several key pieces of information regarding the impact of the intersectional-feminist coordinated care model on perinatal mental health treatment. On average, participants showed high motivation for treatment at intake. Most participants (83.6%) completed at least 6 sessions, with the overall treatment dose ranging from 8 to 66 sessions. No significant disparities in treatment engagement emerged across ethno-racial groups, although African American women appeared slightly more engaged.

The majority of participants showed clinical symptom improvement on at least one symptom assessment. None showed a worsening of symptoms. No statistically significant differences in these changes were shown across ethno-racial groups. Lastly, no causal links emerged between a patient's treatment outcomes and the examined care model. However, the benefit experienced by African American women upon treatment completion appeared similar to that experienced by Hispanic/Latinas and Non-Hispanic White women. Of note, the participant sample was diverse across socioeconomic characteristics, with 43.3% receiving Medicaid and 35.8% having little or no support from a partner.

Author's Conclusions:

Mental health care disparities remain significant, with patients at the intersection of marginalized identities receiving the poorest care. Study findings indicate that a coordinated perinatal mental health care model holds promise for reducing these disparities. Although not conclusive, some positive outcomes were observed across a diverse pool of participants.

Limitations:

Although participants were compared across ethnicity/race, this study did not include a control group. Causality of the treatment effects could therefore not be determined. Moreover, the participant sample size was small, limiting the strength of the study findings. Additionally, participants were recruited from a pool of women already seeking treatment at a medical center. Thus, the findings do not represent women unable to return for postnatal treatment. Furthermore, this study only assessed care provided in an academic medical setting. It did not examine care in a community-based mental health center, where patients of a lower socioeconomic status traditionally seek care. Thus, these women were not included in the participant sample. Hispanic/Latina women unable to speak English were also not included, as there was a lack of providers able to communicate with them. Lastly, there was a lack of continuity in the assessment used to measure perinatal depressive symptoms, as the providers switched between the Beck Depression Inventory-II (BDI-II) and the Patient Health Questionnaire (PHQ-9).

Reviewer's Comments:

The lens through which the authors approached perinatal mental health treatment is a current trend in psychological care: personalizing treatment and providing the most effective interventions based on the whole patient. This approach runs contrary to a medicalized model of psychotherapy (i.e., uniformity in care). This study provides an interesting perspective on the tension between uniformity and personalization within an academic healthcare setting.