
Psychologists Partnering With Obstetricians and Gynecologists

Meeting the Need for Patient-Centered Models of Women's Health Care Delivery

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As obstetrics and gynecology (ob/gyn) practices move toward becoming patient-centered medical homes for their patients, the need for providing integrated behavioral health care has increased. Themes common in ob/gyn settings—such as menstruation concerns, initiation of contraception, pregnancy, childbirth, and menopause—serve as occasions for health promotion and as life transitions where behavioral health concerns may arise. When these transitions are complicated by issues such as trauma, infertility, and pregnancy loss, the need for sensitive, collaborative care between psychology and obstetrics/gynecology becomes particularly critical. Women's health psychologists can serve a key role for ob/gyn practices by co-managing patients' care, offering consultation to providers, providing brief behavioral health consultations to patients, facilitating psychotherapy engagement, and providing treatment for women and their families.

Keywords: women's health, collaboration, depression, patient-centered care

Obstetrics and gynecology (ob/gyn) providers increasingly have been called upon to address identification, assessment, prevention, and treatment of behavioral health concerns as part of their mission to deliver reproductive health care. In response to the emerging U.S. health care agenda, over the last several years the American College of Obstetrics and Gynecology (ACOG) has published guidelines recommending that its providers address a broad range of behavioral health problems, including depression (ACOG, 2010), intimate partner violence (ACOG, 2012), smoking (ACOG, 2011), and substance abuse (ACOG, 2008). Yet research consistently shows that ob/gyn practices fail to assess and treat women's behavioral health needs adequately, including anxiety, depression, eating disorders, and substance abuse (Kelly, Zatzick, & Anders, 2001; Scholle, Haskett, Hanusa, Pincus, & Kupfer, 2003).

Ob/gyn providers address the full range of women's health care needs, and they often have a primary focus on developmental issues, such as menstruation, initiation of contraception, pregnancy, childbirth, and menopause. These developmental issues may serve as windows of transition during which behavioral health concerns de-

velop. Challenges often seen in combination with these transitional periods—such as unintended pregnancies, infertility, pregnancy loss, chronic illness and pain, mood and sleep difficulties, caregiving challenges, interpersonal trauma, and poverty—can leave ob/gyn providers feeling uncertain and overwhelmed as to how to respond to the complexity of their patients' needs. Given that many women use their ob/gyn provider as the primary resource for behavioral health care (Alvidrez & Azocar, 1999; Scholle & Kelleher, 2003), ob/gyn practices present unique opportunities to provide women with access to psychological treatment integrated into their overall health care. Thus, as ob/gyn practices move to adapt to their role within patient-centered medical homes (or patient-centered, comprehensive, coordinated, and accessible health care delivery models; Davis, Schoenbaum, & Audet, 2005), opportunities for women's health psychologists are rapidly increasing.

In this article, we describe issues commonly presented in ob/gyn practices and review how behavioral health concerns typically present in this context. We also discuss the roles of a women's health psychologist, including screening, consultation, psychotherapy engagement, provision of psychotherapy, collaboration, facilitation of patient-provider relationships, education, and research. While we use

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the term *ob/gyn provider*, the content described here applies to any professional providing women's health care, including those in internal medicine, family medicine, or pediatric practices. While much of the focus is on depression and evidenced-based psychotherapies for the sake of brevity, most of the recommendations that follow can and should be extended to other psychological conditions as well as to the brief assessment and psychosocial consultation approaches discussed in more depth elsewhere in this issue.

Women's Health Patients Are Undertreated for Behavioral Health Needs

Women across the life span deal with many competing concerns, such as parenting young children, integrating work and home responsibilities, and caring for an aging spouse or parent. Women are twice as likely as men to experience depression, with rates of first onset of depression peaking during the childbearing years (Weissman & Olfson, 1995). Approximately 10% of all women in private ob/gyn practices and 20% of women in publicly funded ob/gyn clinics meet criteria for major depression (Miranda, Azocar, Komaromy, & Golding, 1998; Poleshuck, Giles, & Tu, 2006; Scholle et al., 2003; Spitzer, Kroenke, Williams, & the Patient Health Questionnaire Primary Study Group, 1999). Unfortunately, the majority of women with depression, including those who are pregnant and postpartum, fail to receive adequate treatment for their depression (Grembowski et al., 2002; Jaycox et al., 2003; Rost et al., 1998; Wang, Langille, & Patten, 2003). Multiple studies of depression among pregnant women in obstetric practices, for example, show both underdetection and undertreatment of

depression by ob/gyn providers, with depression detection rates less than 25% (Kelly et al., 2001; Marcus, Flynn, Blow, & Barry, 2003; Scholle et al., 2003; Smith et al., 2004; Spitzer et al., 1999). Even among those women who do initiate treatment for depression, few receive enough treatment to achieve and maintain remission (Lin et al., 1998; Stecker & Alvidrez, 2007; Stockdale, Klap, Belin, Zhang, & Wells, 2006).

Women's competing demands, life stressors, and social issues (such as poverty, violence, and parenting young children) can make it difficult for them to give high priority to their own behavioral health needs. The women's health psychologist is particularly well-positioned to improve access, engagement, adherence, and outcomes for women with depression and other behavioral health concerns. By close collaboration with ob/gyn providers, barriers can be reduced and behavioral health treatment engagement improved. This is particularly the case when the women's health psychologist is integrated directly into the ob/gyn practice. Women's health patients are nearly four times more likely to follow up with behavioral health treatment when services are offered at the same site (Smith et al., 2009).

Common Concerns in Obstetrics and Gynecology Practices

We describe below typical issues often presented by women's health patients, and we identify the opportunities they provide for women's health psychologists. We also outline common types of depression that can occur across the life span and that coincide with developmental milestones.

Menstruation

For most women, the onset of menstruation does not cause significant difficulties. For some, however, menstruation is complicated by numerous physical and emotional problems. Premenstrual dysphoric disorder (PMDD) and chronic pelvic pain are two examples that often cause patients to present to their ob/gyn providers. PMDD, which causes more clinically significant disruption than premenstrual syndrome, has an estimated 5% prevalence rate (American Psychiatric Association, 1994). While antidepressants are used often to treat PMDD, women can benefit from cognitive-behavioral psychotherapy (CBT) to help them identify triggers for their irritability, reduce their dysphoria, improve their coping, and effectively communicate with others about their needs (Blake, Salkovskis, Gath, Day, & Garrod, 1998; Christensen & Oei, 1995; Cunningham, Yonkers, O'Brien, & Eriksson, 2009; Kirkby, 1994; Yonkers, O'Brien, & Eriksson, 2008). Chronic pelvic pain is experienced by approximately 15% of women 18–50 years of age (Mathias, Kuppermann, Liberman, Lipschutz, & Steege, 1996), and it is often significantly exacerbated by menstruation. Chronic pelvic pain can have a disabling impact on women's function, roles, and relationships. Providers, patients, and families alike often feel discouraged and frustrated when the etiology of the chronic pelvic pain is difficult to diagnose or the



James Woods

pain fails to respond to medical treatments. The women's health psychologist can play an important role by participating in meetings with the patient, family, and providers to discuss their concerns and goals. The psychologist is well-suited to introduce the concept of interdependence between physical and emotional well-being and to offer psychological approaches to improve function and reduce pain interference. Both CBT (Butler, Chapman, Forman, & Beck, 2006; Hoffman, Papas, Chatkoff, & Kerns, 2007) and interpersonal psychotherapy (IPT) (Polshuck et al., 2010) are helpful for the treatment of women with chronic pain. Moreover, many women with chronic pelvic pain experience depression, posttraumatic stress disorder, and a history of abuse (Meltzer-Brody et al., 2007; Paras et al., 2009; Walker et al., 1995), suggesting they are likely to need psychotherapy to address these concerns.

Initiation of Contraception

Commonly, a woman's very first gynecology visit is for her contraceptive needs. These visits provide an opportunity for providers to take a sexual history, provide psychoeducation, and elicit concerns. Information about healthy relationships, pregnancy prevention, sexual functioning, communication, and intimate partner violence may contribute to safe and satisfying sexual behavior. Identifying concerns about sexual dysfunction or pain with intercourse, or a history of childhood sexual abuse or rape, provides opportunities for the provider to recommend a women's health psychologist for support and intervention.

Unfortunately, the compressed schedule of most ob/gyn providers often limits the time they spend on these important issues. Moreover, many ob/gyn providers feel ill-equipped to talk with their patients regarding emotional and safety issues related to their intimate relationships and

sexual activity. As a consequence, approximately one third of ob/gyn providers fail to ask about sexual activity during initial visits or annual exams (Wimberly, Hogben, Moore-Ruffin, Moore, & Fry-Johnson, 2006). Women's health psychologists can fill a gap by providing consultation to providers about ACOG guidelines on how to assess and address sexual dysfunction (Armstrong, 2011) through educational lunch time in-services, or informal discussions as issues arise. Discussions might include taking a thorough sexual history, facilitating healthy relationship functioning, pregnancy prevention, and engaging in physically and emotionally safe sexual contact. Knowing that untreated depression is associated with elevated rates of sexual risk behaviors (Lennon, Huedo-Medina, Gerwien, & Johnson, 2012) may increase recognition and treatment of depression. Patients with complex needs can be invited to meet with the psychologist for evaluations, education, and therapy.

Infertility

Coping with infertility can be very difficult for women and couples, many of whom engage in a complex process that can involve years of demanding procedures, financial demands, and disappointed hopes. While there is substantial variability in women's psychological responses to infertility treatment, many experience depression, fear, isolation, failure, and shame (Greil, McQuillan, Lowry, & Shreffler, 2011; Nelson, Shindel, Naughton, Ohebshalom, & Mulhall, 2008). Infertility also can have a profound impact on relationships, affecting communication, sexual functioning, and sense of closeness (Monga, Alexandrescu, Katz, Stein, & Ganiats, 2004). Women's health psychologists can work closely with ob/gyn providers, including reproductive endocrinologists, to help women and couples navigate the complex, emotionally difficult, and often ethically involved medical decisions facing them. For example, it is often difficult for women and couples to decide how much treatment they can tolerate, with its accompanying physical demands, costs, and ongoing rollercoaster of hopes and disappointments. They may struggle with whether they want to stop fertility treatments, not knowing if they still might be able to conceive. Psychotherapy can provide coping strategies, create an increased sense of control, and reduce stress. Relaxation training, eliciting social support, and modifying expectations of oneself and others can all help manage the difficulties associated with infertility. Women undergoing in vitro fertilization, for example, had significantly higher rates of pregnancy after receiving a 10-session group mind-body intervention compared with those women assigned to a control group (Domar et al., 2011).

Pregnancy and the Postpartum Period

Pregnancy and the postpartum period are times of enormous change for women and their families. Most adapt well to pregnancy-related changes and do not demonstrate significant difficulties (Dunkel-Schetter & Lobel, 1998; Lobel, 1998). Many women and their partners are particularly open to change during the transition to parenthood and

desire to address unresolved issues from their own childhoods or their current relationships or to learn new skills for the sake of their unborn child. The psychologist can offer family therapy or psychoeducational counseling on health in pregnancy, parenting skills, nurturing an intimate relationship while caring for an infant, preparing older children for the birth of a sibling, self-care skills as a new parent, and navigating intergenerational relationships as a new parent.

Nearly half of pregnancies in the United States are unintended (Finer & Zolna, 2011), often generating significant stress and uncertainty. Unintended pregnancy may be particularly problematic if there are multiple life stressors, such as when the pregnant woman is very young, was impregnated by force, has a tenuous relationship with the father of the baby, already has more children than she feels she can manage, or simply does not feel ready to have a baby. Approximately half of women and couples choose to continue their pregnancy even if it was not initially planned (Finer & Zolna, 2011). Ob/gyn providers can recommend that women and couples who express surprise or ambivalence about the pregnancy meet with the women's health psychologist. Support and psychotherapy can ease the transition and help them to work toward embracing a new baby. The psychologist can help women and couples explore their feelings, reframe their expectations, elicit resources and support as needed, and prepare for the anticipated changes.

For women unable or unwilling to raise a baby, other issues must be addressed. Approximately 1% of American women and couples will choose adoption (Child Welfare Information Gateway, 2011). The psychologist can guide women through this decision-making process and help them anticipate what to expect and how to prepare. Others will choose to have an abortion. In the United States, approximately 22% of pregnancies (excluding miscarriages) are terminated (Jones & Kooistra, 2011). Although abortion is not associated with negative mental health outcomes for most women, some are at risk for difficulties following abortion, including those with a significant history of mental health difficulties or limited social support (American Psychological Association, Task Force on Mental Health and Abortion, 2008; Munk-Olsen, Laursen, Pedersen, Lidsgaard, & Mortensen, 2011). For women and couples experiencing difficult reactions, the psychologist can recognize their feelings regarding the abortion, address past trauma or loss experiences triggered, and provide support through the grieving process.

With widespread use of modern ultrasound and prenatal genetic testing, some women and couples learn during the course of pregnancy that their baby has a congenital condition that will compromise the baby's quality of life or ability to survive. In this situation, parents may make the decision to terminate a highly desired pregnancy. Women's health psychologists can provide psychotherapy to women and families who find they are depressed or struggling with their feelings beyond what the obstetrician can offer. Support through the bereavement process, developing rituals to mark the loss, and problem solving about how to navigate

uncomfortable situations such as handling invasive questions from acquaintances or responding to invitations to baby showers can be very helpful.

Approximately 14% of pregnant women and 7%–13% of postpartum women experience clinically significant depression (Evans, Heron, Francomb, Oke, & Golding, 2001; Stewart, 2006). Risk factors for perinatal depression include individual and family history of depression; ambivalence about becoming a parent; inadequate social support; intimate partner violence; and life stressors including poverty, unmarried status, and obstetric complications (Goyal, Gay, & Lee, 2010; Lancaster et al., 2010; O'Hara & Swain, 1996). Prenatal and postpartum visits provide opportunities to assess women for depression. Given that the symptoms of depression overlap with common symptoms during pregnancy and the postpartum period (e.g., changes in sleep and appetite), a standardized assessment tool like the Edinburgh Postnatal Depression Rating Scale (Cox, Holden, & Sagovsky, 1987) can be very useful to assist with identifying depression.

Untreated depression during pregnancy and in the postpartum period is particularly problematic because of the effect it may have not only on the health and well-being of the woman but also on her fetus or baby and her family. Pregnant women with depression are at increased rates of problems related to poor birth outcomes, such as smoking (Kyrklund-Blomberg & Cnattingius, 1998), substance abuse (Kelly et al., 2001), hypertension (Sibai et al., 2000), preeclampsia (Kurki, Hilesmaa, Raitasalo, Mattila, & Ylikorkala, 2000), and gestational diabetes (Kozhimannil, Pereira, & Harlow, 2009; Sibai et al., 2000). Not surprisingly, therefore, a meta-analysis found that depression during pregnancy was associated with an increase in preterm birth and low birth weight (Grote et al., 2010). Many women believe they should reduce or discontinue the use of medications while pregnant or nursing (Dennis & Chung-Lee, 2006), and psychologists can play an important role initiating a conversation about the potential risks and benefits of medication (Wisner et al., 2009). There are surprisingly few studies examining the effectiveness of psychotherapy during pregnancy (Dimidjian & Goodman, 2009). Interpersonal psychotherapy has been studied more than other psychotherapies as a treatment for depression during pregnancy, and it has been shown to be effective for pregnant women in the prevention and treatment of depression and posttraumatic stress disorder (Grote et al., 2009; Spinelli & Endicott, 2003; Zlotnick, Johnson, Miller, Pearlstein, & Howard, 2001; Zlotnick, Miller, Pearlstein, Howard, & Sweeney, 2006).

Postpartum depression also has long-term implications for the social, emotional, and physical health of the baby, mother, and family (L. J. Miller, 2002). Moreover, postpartum depression and intimate partner violence often co-occur, with nearly 40% of postpartum women with depressive symptoms reporting intimate partner violence after the birth of their baby (Woolhouse, Gartland, Hegarty, Donath, & Brown, 2012). Women's health psychologists can play a critical role in working with women, their partners, and ob/gyn providers to provide treatment and

thus reduce the potential impact of depression during pregnancy and the postpartum periods. Psychotherapy for postpartum depression can include normalization of negative feelings about becoming a mother, identifying practical ways to achieve sufficient sleep, negotiating new roles with a partner or other family members, attending to self-care, and nurturing the partner relationship in the context of parenthood. Evidence suggests that CBT, IPT, and general counseling are all associated with reduced depressive symptoms for postpartum women (Cuijpers, Branmark, & van Straten, 2008).

Pregnancy Loss

Pregnancy loss can be a devastating experience regardless of the gestational age of the fetus or baby. First trimester losses are associated with increased risk for the onset of depression and anxiety up to three years later (Blackmore et al., 2011). The death of a late gestation baby, stillborn, or a neonatal death is usually intensely painful for the parents; these losses are emotionally complex and can cause acute stress reactions as well as long-lasting symptoms of grief (Cacciatore & Bushfield, 2007). Yet social norms and traditions often fail to provide structure and guidance about how to mourn the loss of a pregnancy or of a newborn baby, making the grief process and interactions with others even more challenging and isolating. Pregnancy loss also can be painful for the ob/gyn provider, who likely had to give the bad news and was intimately involved with the parents through the loss experience. The provider may experience grief and sadness of his or her own, may have feelings of guilt, and therefore be uncertain as to how to help the woman and her family. Women's health psychologists can provide support to both the providers and the parents through the mourning process. They can normalize providers' feelings, coach them on how to interact with the family, and help them find support if necessary. The psychologists can also encourage the parents to elicit support from family and friends, find ways to talk with others about their loss, and develop rituals that fit the family's personal circumstances.

Menopause

The transition to menopause, particularly late perimenopause, is a window of increased vulnerability for the onset of depression (Bromberger & Kravitz, 2011). While most women with menopausal symptoms do not experience psychological difficulties, many women with a history of depression do encounter challenges. Moreover, women with significant vasomotor symptoms—such as hot flashes or night sweats, life events, and limited social support—are at elevated risk for menopause-associated depression (Bromberger & Kravitz, 2011). Many women find that the transition to menopause is accompanied by significant life transitions, such as children leaving home, divorce, the responsibility to care for ailing parents, and other physical signs of aging. Psychotherapy can be a very appropriate treatment, particularly if there are significant life changes or losses. Psychotherapy approaches can range from helping women develop coping strategies to managing their

vasomotor symptoms and sleep disruption to developing a narrative of their life journey; discussing hopes, dreams, and fears for the future; and/or renegotiating a more satisfying relationship with their partner.

Interpersonal Trauma

Women may not present their interpersonal trauma experience as a concern to their ob/gyn provider. Yet, rates of trauma are extremely high among women. Between 34% and 40% of women's health patients report experiences of physical abuse, 28% report unwanted sexual intercourse (Miranda et al., 1998), and 8% report experience with intimate partner violence in the past year (Thompson et al., 2006). Moreover, women who experience interpersonal trauma demonstrate increased health problems such as sexually transmitted infections, unintended pregnancy, exacerbation of chronic illness, recurrent vaginal infections, and chronic pain (Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012; Campbell, & Boyd, 2003; Campbell et al., 2002; Poleshuck et al., 2005; Walling et al., 1994; Wuest et al., 2008). Women who report interpersonal trauma also are more likely to seek multiple consultations from medical professionals, undergo major surgical procedures such as hysterectomy, demonstrate nonadherence to medical regimens, view their health as poor, and report physical disability (Eisenstat & Bancroft, 1999; Kulkarni, Bell, & Wylie, 2010). Not surprisingly, women with trauma experience also show increased health care use, emergency room visits, prescription medication use, and increased health care costs (Campbell et al., 2002; Koss et al., 1994; Poleshuck et al., 2005; Walling et al., 1994; Wuest et al., 2008).

The majority of providers are not aware of their patients' trauma experiences (Flicker, Cerulli, Swogger, Cort, & Talbot, 2012), and they are not prepared to address the implications of trauma as it relates to potential difficulties regarding discomfort with physical exams and women's overall health. Despite ACOG mandates, the majority of ob/gyn providers consistently fail to assess for physical or sexual abuse (Stayton & Duncan, 2005). Women's health psychologists can facilitate screening and provision of treatment, which is related to reductions in recurrence of violence and improvements in depression, posttraumatic stress disorder, and substance abuse (MacMillan et al., 2009).

Women's Health Psychologists in Practice

There are several ways a practice can organize to incorporate women's health psychologists, including the following: basic collaboration offsite, basic collaboration onsite, close collaboration in a partly integrated system, and close collaboration in a fully integrated system (Doherty, McDaniel, & Baird, 1996; Heath, Wise Romer, & Reynolds, 2013). The women's health psychologist can be employed directly by ob/gyn practices and be fully integrated in the clinical care, with insurance reimbursements covering psychologists' costs to practices. This can be optimal, as

having both an ob/gyn provider and a women's health psychologist in the same setting models the framework that physical and behavioral health are interdependent, while reducing stigma and improving access to psychotherapy. Moreover, if a practice can support some of the women's health psychologist's salary in a fee-for-service environment or grant funding can be obtained, an expanded array of patient-centered services can be provided without the limitations of determining which services are revenue generating. Yet, many other approaches are feasible as well. For example, women's health psychologists can lease space and operate a private practice co-located in an ob/gyn practice (Coons & Gabis, 2010).

Screening

Developing, implementing, and supporting the use of routine screenings by the women's health psychologist to identify psychosocial needs enhances the quality of care provided by ob/gyn practices when supports are in place for follow-up (Farr, Dietz, Williams, Gibbs, & Tregear, 2011). Brief psychosocial screenings used as part of routine evaluations can be completed online, at annual exams, at perinatal visits, and among women with new diagnoses, pregnancy losses, and chronic diseases, and they provide an ideal opportunity for identifying women with needs. Women's health psychologists can provide training in the administration and scoring of screens of women for behavioral health and quality of life concerns, and they can develop and implement protocols. There are many excellent options for screening in ob/gyn practices that are freely available, easy to administer, and easy score by medical staff that have been validated with women's health practices. The Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001) for gynecology patients and the Edinburgh Postnatal Depression Scale (Cox et al., 1987) for pregnant and postpartum women are excellent options for depression screening. Similarly, the women's health psychologist can suggest screens for common problems such as intimate partner violence, substance abuse, and anxiety. While establishing screening and response procedures might require some initial investment, once a screening and referral process is implemented, it should require minimal ongoing effort to sustain.

In order for screening to be effective, follow-up referrals and services must be offered in response (Farr et al., 2011). Many ob/gyn providers fail to screen for concerns like trauma and depression because they feel uncertain as to how to respond when positive screens occur (Leddy, Lawrence, & Schulkin, 2011). Some providers may view medication as the first or only approach to addressing a behavioral health concern. Yet, psychotherapy is a critically important treatment option, especially among pregnant and breastfeeding women, who may be particularly hesitant to consider medication. A women's health psychologist can play a critical role in providing education to the ob/gyn practice about the need for assessment, and about signs and symptoms of psychosocial concerns affecting their patients. Women's health psychologists also can describe how these concerns relate to their patients' physical health,

adherence, and response to health care, and normalize common life challenges that affect behavioral health. Women's health psychologists can help the providers to find ways to talk effectively with their patients about these concerns and how to make an effective referral for psychotherapy.

Whenever possible, the women's health psychologist should meet briefly with referred patients and their providers to initiate the relationship, address any concerns, and support the provider's recommendations. Emphasizing the use of a brief practical approach in a collaborative environment can reduce patient concerns about time commitment and negative stereotypes about the therapeutic process. This type of warm handoff is important for patients who may be ambivalent or have trepidation about initiating psychotherapy. Aided by the necessary resources, support, and infrastructure established by the women's health psychologist, ob/gyn providers will feel more comfortable addressing psychosocial concerns.

Assessment and Treatment

The majority of the women's health psychologist's day is spent providing diagnostic assessments; brief consultations; and individual, family, and group psychotherapy to the practice's patients. Brief psychotherapies delivered in primary care settings are effective (Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010) and, thus, are recommended to ensure that the psychologist remains available to support providers as new referrals arise. Psychologists can also help to monitor patients' responses to psychiatric medications and assess when psychiatric referrals may be indicated. Patients requiring longer term care can be transferred to community mental health centers, private therapists, or others available in the community.

Health promotion and prevention is another important activity provided by women's health psychologists. Women often live with obesity, smoking, unsafe sexual practices, lack of exercise, and other lifestyle challenges. Evidence continues to mount about the negative implications of poor health behaviors, such as increased risk for diabetes mellitus, heart disease, and cancer, as well as increased risk leading to negative birth outcomes among pregnant women. There are many health behaviors the women's health psychologist can assist with in order to benefit the health of women in ob/gyn practices. For example, behavioral smoking cessation interventions have been found to reduce low birth weight and preterm births among pregnant women (Lumley et al., 2009). Moreover, multidisciplinary teams including the provider, psychologist, and specialists in nutrition and exercise have been found to be optimal for effective treatment of obesity (Laddu, Dow, Hingle, Thomson, & Going, 2011).

Collaboration

Women's health psychologists play an important role in supporting ob/gyn providers' treatment of their patients; having a women's health psychologist as part of the practice is likely to improve the practice's general sensitivity to psychosocial concerns. Most collaborations occur via com-

munication in the electronic record, brief informal conversations in private work spaces between patient appointments, or more lengthy discussions at the end of the patient session while completing documentation. These interactions facilitate identification of novel, patient-centered responses to a specific patient's needs.

A key part of the role of the women's health psychologist is supporting the ob/gyn providers and staff. As an integrated member of the team, it is important for the women's health psychologist to be open and flexible as needs arise. At times, for example, this may mean leaving a scheduled patient waiting while attending to an urgent concern such as a patient with a suicide plan or in the midst of a manic episode. Possible benefits of effective collaborative relationships may include increased treatment engagement, improved quality of care, and greater job satisfaction for the women's health psychologist, the ob/gyn provider, and the entire women's health team.

At times, the ob/gyn provider may be more invested in the patient seeking behavioral health consultation than the patient herself. In these cases, it is important to consider how the women's health psychologist can participate as a member of the patient's health care team by providing support and consultation to the provider about how to proceed with the patient. Toward this goal, the women's health psychologist can provide psychoeducation and can work together with providers toward developing a plan to monitor and respond to physical, psychosocial, and behavioral health goals.

Confidentiality concerns are seldom raised by patients, as women's health psychologists explain at the initial intake the importance of working together as a team to provide the best care possible. Many practices obtain written consent for collaborative care to ensure the communication is explicitly discussed. When patients experience significant difficulties with treatment engagement or poor responses to prescribed treatments, the ob/gyn provider and women's health psychologist can collaborate to understand the difficulties and work with the patient and her family to address them. At times, women will express dissatisfaction regarding the health care they are receiving from their ob/gyn provider. The women's health psychologist can work with the patient and her family members to review how they can communicate their needs and identify ways to work more effectively with their ob/gyn provider. The women's health psychologist can also provide feedback about the patients' concerns to the ob/gyn provider and can help to develop a plan about how to respond to these concerns. Ob/gyn providers will find, on occasion, that their interactions with patients elicit intense emotional responses. Women's health psychologists can offer support and assistance to providers wanting to understand their own reactivity to patients or improve their interactions with patients they find challenging interpersonally. In addition, women's health psychologists serve as a resource to refer the practice's physicians and staff to community-based psychologists for their own behavioral health issues when they arise.

Women's health psychologists can play a major role in ob/gyn specialty settings as well as in general settings, such as in reproductive endocrinology, gynecologic oncology care, pelvic pain, and maternal fetal medicine (high-risk pregnancy). Psychologists can serve as part of the multidisciplinary team and can address lifestyle issues among women with polycystic ovarian syndrome, conduct evaluations for women and couples considering egg or sperm donors for fertility treatment, or offer group support to patients and families living with cancer.

Education

In academic settings, there are multiple ways the women's health psychologist can contribute to the education of health care trainees, including those studying to become physicians, psychologists, nurses, medical assistants, and physician assistants. Psychologists, for example, can teach didactic material, participate in journal clubs, serve as a clinical supervisor, help with values clarification exercises for residents considering provision of abortion care, provide continuing education workshops, and offer reflection groups to process emotionally difficult cases and professional identity issues.

Innovating Research and Practice

Women's health psychologists are optimally poised to advance knowledge and best practices through clinical research in ob/gyn practices. Myriad opportunities exist, and two brief but potentially important illustrations follow.

Attending to inflammation in women.

Inflammation has been identified as an underlying mechanism for diseases associated with perinatal complications such as miscarriage, preeclampsia, and preterm delivery (Christiansen, Nielsen, & Kolte, 2006; Coussons-Read, Okun, & Nettles, 2007; Piccinni, Maggi, & Romagnani, 2000; Romero, Gotsch, Pineles, & Kusanovic, 2007). For years, inflammation has known to be linked closely with life-threatening health conditions such as heart disease, diabetes, and cancer (Barton, 2005; Dantzer, O'Connor, Freund, Johnson, & Kelley, 2008; A. H. Miller, Maletic, & Raison, 2009; Smolen & Maini, 2006). More recently, depression has been associated with elevated markers of inflammation (Dowlati et al., 2010; Howren, Lamkin, & Suls, 2009; Zorrilla et al., 2001) and relationship stress (Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002), leading to the hypothesis that depression may be caused by elevated inflammation (Andersen et al., 2008; Dantzer, 2009; A. H. Miller et al., 2009; Raison, Capuron, & Miller, 2006). Several studies now suggest it may be possible to reduce inflammation using behavioral interventions such as mindfulness-based stress reduction (Witek-Janusek et al., 2008), cognitive-behavioral therapy (Zautra et al., 2008), and other psychological interventions (Thornton, Andersen, Schuler, & Carson, 2009). Thus, the psychologist may be able to facilitate change that reduces risk for inflammation and its health consequences among women. More research is needed to understand and maximize the poten-

tial for behavioral interventions to improve physical health and to prevent development of health conditions.

Increasing access to behavioral health for underserved women. Women's health psychologists are in a unique position to improve engagement and outcomes of underserved women. While the majority of individuals with behavioral health needs are undertreated, women who live in poverty, are African American, or are young are even less likely to receive adequate behavioral health treatment than other groups (Arnow et al., 2007; Gadalla, 2008; Miranda & Cooper, 2004; Simon & Ludman, 2010). Moreover, underserved women are more likely to go to their ob/gyn provider for help with their behavioral health needs than to a specialty behavioral health setting (Alvidrez & Azocar, 1999; Scholle & Kelleher, 2003). Research focused on novel approaches to engagement and treatment of underserved women in ob/gyn practices has the potential to create a significant public health impact. For example, Grote, Zuckoff, Swartz, Bledsoe, and Geibel's (2007) engagement session has been found to increase utilization of psychotherapy among low-income women's health patients. This 45- to 60-minute interview uses ethnographic and motivational interviewing approaches and takes place before active treatment begins. Finding ways to incorporate active outreach and the engagement session into usual care appears promising. In another example, underserved women may not perceive their difficulties as behavioral disorders, and they may be more focused on coping with issues related to poverty, obtaining employment, finding someone who will simply listen, or other issues that are of priority to them (Polshuck, Cerrito, Leshoure, Finocan-Kaag, & Kearney, 2013). Studies currently are underway to explore whether addressing the issues identified as most important to women—including social, legal, physical health, and family concerns, in addition to behavioral health needs—may improve satisfaction and outcomes among underserved women with depression in ob/gyn practices.

Summary and Conclusions

Many women present to ob/gyn practices in need of behavioral health treatment, yet their needs are often missed. Common physical health issues seen in ob/gyn practices—such as problems with menstruation, pregnancy, and menopause—are closely linked with behavioral health. Moreover, women struggling with the physical health implications of interpersonal trauma and poverty are likely to seek help from their ob/gyn providers. As a result, ob/gyn practices benefit from having a women's health psychologist on their health care team to offer screening, engagement, assessment, consultation, treatment, and health promotion to women's health patients and consultation and support to ob/gyn providers. As models of health care delivery continue to evolve, opportunities for psychologists with broad competencies to partner with ob/gyn practices will increase for research and training as well (Coons, Morgenstern, Hoffman, Streipe, & Buch, 2004).

This article describes how psychologists can respond to these opportunities.

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