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Postpartum Depression in Sub-Saharan African Immigrant Women: A Narrative Review

Aashni Shah, M.A. Marriage and Family Therapy Candidate; &
Zvisineyi Chiromo, M.A. Marriage and Family Therapy Candidate.,
United States International University-Africa.

Abstract

The trauma immigrant women face as a result of the migration journey from their homelands to often unexpected host nations increases their vulnerability and risk of developing post-partum depression, a debilitating mood disorder that affects women in their childbearing years. Although prevalent postpartum depression symptoms are commonly known, the factors that affect women from different geographies worldwide may present uniquely based on background, culture, and the perspectives of mental health manifestations in their regions. Collectively, these factors require a review in order to inform appropriate psychological interventions. Systematically, eleven key databases were searched and identified thirty papers that met the inclusion criteria. A methodological assessment of the articles was done and a general trend seen within the global population of immigrant women, that is, Sub-Saharan Africans face three unique and often overlooked factors of post-partum depression which at times overlap with but do not always present in their worldwide counterparts. The first factor is associated with the traumatic immigration journey, the second being the impact of social support, and thirdly, the challenges to accessing maternal mental health care services in the host country that places them at a higher risk of developing post-partum depression. This review highlights these issues and further suggests narrative therapy as a systemic intervention that can be used to mitigate postpartum depression within the host nations of these Sub-Saharan Immigrant women.

Keywords: African immigrant women, postpartum depression, trauma, narrative therapy, maternal mental health.

Introduction and Background

Postpartum depression (PPD) is a severe mood disorder that typically occurs within the first 4 to 6 weeks of giving birth, and it can last several months or up to a year (McCabe, 2013; Patel et al., 2012; Andrews-Fike, 1999). PPD is often characterized by feelings of loss and isolation,

sadness, desperation, anxiety, irritability, crying spells, nausea, changes in sleep and eating habits, a loss of self-esteem and self-worth, decreased libido, thoughts of hurting oneself and/or the infant, and even suicidal ideations (Robertson et al., 2004; Olshansky, 2003). PPD is a major public health challenge globally, due to its long-lasting traumatic effects on not only the mother, but on her partner, and on the child's health and development (Skoog et al., 2022; Wisner et al., 2013). Furthermore, PPD has been found to adversely affect the quality of life, social functioning, and economic productivity of women and their families (Chisholm et al., 2003).

Globally, one out of every five women experiences PPD (Wang et al., 2021). While PPD can be experienced at any childbearing age, race, or social status, evidence suggests that immigrant women are at a twofold higher risk of experiencing PPD compared to their native-born counterparts (Falah-Hassani et al., 2015). Postpartum mental health needs amongst immigrant women are dependent on numerous factors. Cultural differences, language barriers, limited access to healthcare services, uncertain immigration status, gender inequalities, racial discrimination, and lack of employment all contribute to increasing the vulnerability of immigrant mothers (Dennis et al., 2017; Ganann et al., 2016; Gagnon et al., 2013; Mamisachvili et al., 2013; O'Mahony, Donnelly, Raffin Bouchal, et al., 2012; O'Mahony & Donnelly, 2012; O'Mahony, Donnelly, Este, et al., 2012; Alvi et al., 2012; Sword et al., 2006).

The prevalence of PPD varies substantially across countries suggesting that a woman's culture and country of residence play a role in her postpartum mental health (Halbreich & Karkun, 2006). The duration of stay in the host country also contributes to postpartum mental health such that longer-term immigrant mothers cope better compared to those who have migrated recently (Gagnon et al., 2013; Auger et al., 2008). Brown-Bowers et al. (2014) further suggests that immigrants carry a higher risk for developing PPD due to their increased exposure to violence and trauma from involuntary migration that may have led to them leaving behind family members in conflict zones. Additionally, acculturation stress may also contribute to increasing the vulnerability of developing PPD (George et al., 2015).

While there is a growing body of research to understand PPD among immigrant mothers, the process of migration itself as a risk factor for PPD has received little attention. This is evidenced by the handful of studies and literature reviews that have been conducted to assess the vulnerability of immigrant women in developing PPD. Of these, most have focused on cross-

sectional cohort studies including immigrant women samples from multiple nationalities within certain refugee destinations such as Canada (Stewart et al., 2015), the United States of America, and the United Kingdom (Shakeel et al., 2018; Ganann et al., 2016). This lends itself to broad perspectives of the process of migration and the subsequent mental health challenges and in particular, trauma that immigrant women of childbearing age face within specific host countries.
Furthermore, within the body of host country research, certain immigrant populations have received more focus including Latin American, Asian and Middle Eastern samples. Fewer studies have been conducted on African women and to the best of our knowledge, no review has been done on a global scale to assess the trauma experienced by immigration which predisposes African immigrant women to PPD. In expanding migration and maternal mental health research, scholars have pointed out the under-diagnosis and treatment of PPD, exacerbated within developing African countries by poor maternal health structures and the identity of being a good mother that leads to under-reporting of PPD symptoms (Afolabi et al., 2020; Ward, 2019; Jones et al., 2014).

Based on this background, the purpose of this review is to explore the prevailing literature highlighting how traumatic experiences during the pre-migration, migration, and post-migration phases influence the development of PPD in Sub-Saharan African (referred to as African within this review) immigrant women, how social support impacts this, and what challenges they face in accessing maternal mental health care in their host countries. By focusing on this population, and underscoring their traumatic experiences, this paper aims to fill the gap in literature and further suggests a systemic intervention that can be used to mitigate their PPD symptoms.
This review will further adopt the following definition of an immigrant to encompass individuals who voluntarily migrated and also those that involuntary migrated such as refugees and asylum seekers. According to the Office of the United Nations High Commissioner for Human Rights (OHCHR), an immigrant or also known as an international migrant is any individual who is residing outside a country of which they are a citizen or national (United Nations Human Rights Office of the High Commissioner, n.d.).

Methodology

The purpose of this study, which was a comprehensive review of the relevant literature, was to infer from several studies the difficulties PPD presents for Sub-Saharan African immigrant women. The study employed a qualitative systematic search strategy across a diverse range of academic journal databases. Eleven databases were included in the search. To ensure a thorough and consistent approach to literature retrieval, a set of carefully selected search terms and inclusion criteria was developed. These criteria were designed to identify scholarly articles that align with the scope of this review. The key search terms and phrases utilized included: African immigrant women, postpartum depression, trauma, and maternal mental health. Inclusion criteria were defined by three factors: (a) relevance of the article to the topic; (b) articles published in the last two decades between 2003 and 2023 to ensure currency and relevance; and (c) peer-reviewed journal articles to maintain high research quality.

Following the initial database searches, a rigorous screening and selection process was employed to identify articles for inclusion. This process consisted of title screening, abstract review and full-text assessment to confirm eligibility based on the inclusion criteria. For the included studies, relevant data points were extracted, enabling the identification of patterns, trends, and emerging insights within the literature. The review identified the following issues that contribute to and exacerbate PPD in African immigrant mothers globally. The first is the traumatic immigration journey (pre-flight, during, and post-flight) that plays a significant role in African immigrant mothers developing PPD. Secondly, the impact of social support on African immigrant mothers' PPD symptoms and thirdly, the factors influencing access to maternal and mental health care services among African immigrant mothers.

Following the results from this review, Narrative therapy, a systemic family therapy theory was suggested as an appropriate intervention for Sub-Saharan African immigrant women suffering from PPD.

Results

The traumatic immigration journey (pre-flight, during, and post-flight)

On a global scale, approximately 5-10 million people cross an international border annually to reside in a different country, with a higher percentage of women than men (Delara, 2016). African immigrants commonly migrate for job opportunities, education, social independence, or family reunification (Corley & Sabri, 2020). However, some are forced to migrate as a result of traumatic experiences in their home country such as war, political violence, extreme poverty, and gender discrimination (Omenka et al., 2020; Delara, 2016). While immigrants may have moved with the intent of searching for 'greener pastures', it may not be the case for all. Although there are several benefits that come with immigration, residing in a new society presents enormous challenges that may not necessarily make these women's status' better (Delara, 2016). The process of immigration itself can be dehumanizing and traumatizing, resulting in increased rates of mental illness within the migrant population (Bhugra & Becker, 2005).

Immigrants can encounter trauma experiences pre-migration, during migration, and post-migration. Pre-migration involves the decision and preparation to move, migration encompasses the journey of physical relocation from the home to the host country, and post-migration is the phase where immigrants absorb the social and cultural practices of their host country (Bhugra & Becker, 2005). Trauma experienced during either of the three stages of the immigration journey may be considered risk factors that contribute to African immigrant mothers being more susceptible to PPD. They may have witnessed or experienced sexual abuse, gender-based violence, or female genital mutilation (FGM) while in their home country or in refugee camps before settlement in their host country (Stewart et al., 2012; Urquia et al., 2012; Zimmerman et al., 2009). Zelkowitz et al. (2008) further found that some women had to leave either some or all their children behind, predisposing them to experiencing feelings of guilt and shame. Such traumatic experiences place immigrant women at a higher risk of developing mental health problems such as anxiety, depression, and post-traumatic stress disorder (PTSD) (Craig et al., 2009). According to the National Institute for Health and Care Excellence (2014) pre-existing or undiagnosed mental health issues are a risk factor in women developing PPD.

As highlighted above, sexual exploitation during flight has been documented to have deleterious mental health outcomes on Sub-Saharan African women. Italy has been particularly key in witnessing the traumatic after effects of sexual abuse perpetrated against women refugees and asylum seekers in Libyan detention centers on their way to Europe (Esposito et al., 2019).

Fontanelli et al. (2021) studied 110 pregnant women living in reception centers during the period 2016 to 2018, most of whom originated from either Nigeria at 55% or Eritrea at 31%. Many of these women faced exploitation during their time in Libyan detention centers, undertook prostitution to pay for passage to Europe, or were victims of onward sexual trafficking which led to unwanted pregnancies. The study highlighted a high number of health care requests to terminate pregnancies particularly among unmarried Nigerian women. This plight had earlier been highlighted in a commentary by Barbara et al. (2017) on sexual violence and unwanted pregnancies in migrant women which emphasized the need for some women to access health care in desperate efforts to terminate their pregnancies.

A recent qualitative study conducted by Corley and Sabri (2020) explored stressors experienced by African immigrant women upon moving to the United States of America. Seventeen in-depth interviews and 6 focus groups were conducted with 39 women. Pre-migration stressors included political violence, armed conflict and intimate partner violence. Some 10 women shared accounts of how they were forced to leave their family behind including their careers, possessions, and social standings, while some continued to experience anxiety and fear despite obtaining refuge in the United States. Five women disclosed that intimate partner violence was a significant stressor even before migrating. Due to the tradition of paying bride prices in many of their home countries, their relatives were not always supportive of them leaving violent partners for fear of having to pay back bridal charges. Consequently, they were forced to endure violence and escaped from their home country as they got a chance. Post-migration, their stressors included uncertain immigration status, discrimination, and lack of a supportive community to disclose abuse. Corley and Sabri (2020) did not reveal whether these participants were mothers, however, it is evident from their findings that African immigrant women experience trauma both before and after their migration journey, which then places them at a higher risk of developing mental illnesses such as PTSD, depression, or even PPD when they do become mothers.

Pre-migration trauma is further highlighted by Winter (2019) in qualitative research investigating perinatal mental health care provision to women with a refugee background in Australia. Seven South Australian healthcare providers were interviewed. There was consensus regarding the label of ‘survivor’ among the refugees. The birthing experience was considered a victory following the resilience built during resettlement and prior to, in some cases, escape from war and violence.

The research alluded to but did not specify the traumatic experiences specifically, but did point towards pre-resettlement trauma influencing the severity of mental health symptoms in the post-partum period. Indeed, while the South Australian Healthcare providers identify motherhood and mother-infant bonding as a protective factor against PPD, they did highlight that for those women who manifest symptoms, their symptoms are likely to be severe (Winter, 2019).

In contrast to the findings by Winter (2019) which highlighted resilience during migration, there are stark statistics of the outcomes of pregnant migrants infected with HIV. In a study conducted by Tariq et al. (2016) in the United Kingdom on 7211 pregnancies in 5390 women diagnosed with HIV and taken from 2 national data sets, one of which included pregnancies between 2000 and 2009, it was found that Sub-Saharan African women were at 3 times greater risk of stopping HIV treatment post childbirth. Of the sample, 6485 pregnancies equivalent to 90% were among Sub-Saharan African migrants. A key factor for this loss of follow up care was attributed to 318 women who were pregnant during their migration journey and reported this on arrival in the UK. The shorter length of time post migration contributed to attrition based on acculturation stress, lack of social or logistical support, and high levels of depressive symptoms which decreased the likelihood of adhering to anti-retroviral treatment post childbirth. These barriers to adherence were corroborated by Buchberg et al. (2015) in a study on 35 HIV infected low income pregnant women in the United States.

Further into the immigration journey particularly for immigrants who migrated involuntarily including unaccompanied minors, it has been found that post-migration trauma happens during the arrival transition into reception centers and semi-permanent refugee camps (Vervliet et al., 2014). Resettlement and acculturation trauma among African women experiencing PPD within current research is less apparent. Interestingly, the plight of women who have undergone FGM in their countries of birth but who undergo maternity care in their host countries presents a different trauma narrative. Somali women as studied by Jacoby et al. (2015) in the United States and a more recent study on a multi-African sample of 19 immigrant women in Australia researched by Due et al. (2022) highlight the experience of childbirth by women who have a history of FGM. Key challenges the women face are trauma and humiliation after revealing their infibulated perineum FGM scars to maternal care staff while often in the presence of male Somali interpreters.

Further trauma risks highlighted in the Australian study include the probing questioning that attending staff engage in during the assessment of a possible vaginal birth (Due et al., 2022), a risk factor for maternal mortality among the studied population. Cultural assumptions may play a part in these assessments as often maternal care providers upon acknowledging FGM may follow up with questions of Gender Based Violence. It is evident that the differences in the cultural meaning of trauma for immigrants and their hosts pose barriers to communication, understanding, and treatment of both physical health concerns as well as the subsequent mental health conversations that can bring to light any underlying PPD symptoms before they exacerbate.

The Impact of Social Support on African Immigrant Mothers' PPD Symptoms

In a Somali and Chinese sample of immigrants studied in Canada, Stewart et al. (2008) identified definitions of social support among most newcomer immigrants. The authors interviewed 60 Somali and 60 Chinese immigrants to understand the lived experience of social support among newcomers into Canada. Their experiences included a need for emergency services, donations from charitable organizations, being acknowledged as disadvantaged to allow for aid to be provided, as well as a need for employees to acknowledge their qualifications within Canada. Previously, Stewart (1989) conceptualized social support through coping theory which described coping as the relationship between the person and the environment. Among immigrants, scholars have identified social support as a key risk factor for PPD. The social supports for which they analyze their array of coping resources within the host country include strategies to cope emotionally, access to information, and professional services or norms that govern behavior in their present context. Navigating these social supports is paramount to women in the post-partum period having a sense of agency over their mental wellbeing.

Thirty-two Nigerian mothers who had a mean length of stay of 10 years in the United Kingdom were studied together with 79 British nationals to determine the interaction between social support, PPD, and maternal-infant bonding (Afolabi et al., 2020). British mothers had a greater exposure and access to social support networks and structures (mental health, health facilities, language, friends and family). Immigrant Nigerian mothers had a large family support but less local functional social support. Interestingly, the social support from family did not translate to

better maternal infant bonding for Nigerian mothers. This led the authors to tentatively analyze this as possible defective and potentially harmful practices that diminish mother child bonding. They further suggested that African families tend to have an enmeshed family structure which portends physical support but not necessarily emotional support that is necessary for healthy attachment in the post-partum period.

Conversely, Quintanilha et al. (2016) studied North-East African women from Eritrean, Ethiopian, Oromo and Somali during the pregnancy and post-partum period. They found that emotional support was a large factor when comparing social support back home and in Canada where they now reside. This may indicate that the meaning of emotional well-being is perceived differently in different parts of Africa or the nuances within assessment tools require more understanding of the cultural interpretations of emotional processes.

Factors Influencing Access to Maternal and Mental Health Care Services

Despite similar prevalence levels of PPD among Black, White, and Latina people in the United States of America, the utilization of mental health services is significantly lower among African immigrants (Venters & Gany, 2009). Fewer Black pregnant women in America seek treatment for depression compared to White pregnant women (O'Mahen et al., 2011). Venters et al. (2010) found that while mental health was amongst the top three medical problems that African immigrants in America experience, it was a rare occurrence for them to seek mental health services. In a report by Zimmerman et al. (2009), 54% of African immigrant women in Scotland and Belgium reported that their health was worse in the host country than it was in their home country. This poses a grave concern in identifying the factors preventing African immigrant women accessing healthcare in their host countries. An example of this is shown in Afolabali et al. (2020) in which British mothers had more access to the National Health Service facilities than did Nigerians, many of whom were hindered by immigration status, acculturation, discrimination, and stereotyping.

Pederson et al. (2022) confirmed stigmatization towards mental health as one factor that may prevent African immigrant women from seeking healthcare. They conducted a qualitative study using 14 women to assess the perspectives that African immigrant women held on mental illness. These women who were either pregnant or had given birth within the last 12 months completed a

semi-structured interview and a survey. The researchers found that the women carried a stigma towards mental health that restricts them from accessing help. Moreover, the conceptualization of mental health within their community further prevented them from accessing mental health services.

The word "mental" was associated with negative connotations as 4 participants believed that depression is not a medical illness, and 3 others reported that people with depression are dangerous. Additionally, many of the participants shared that mothers who experienced emotional struggles either during pregnancy or post-partum were thought of as "mentally retarded" or "crazy" by members of their community. About 50% of the participants stated that mothers who feel sad or depressed are a moral failure, while 42.9% of the participants reported that feelings of depression and sadness are a result of sin. Five participants shared that sadness and depression experienced by pregnant or post-partum mothers are caused by evil spirits. As a result of the stigmatizing beliefs towards mental health, African immigrant women have a low utilization rate of mental health services in their host countries, leading to higher rates of morbidity and mortality.

Furthermore, African immigrants were found to place a higher focus on their physical symptoms than mental health symptoms leading to a higher rate of somatization compared to black people born in America (Venters et al., 2010; Venters & Gany, 2009). This may be a result of cultural differences between Africans who have emigrated from their host country and Africans who are born amongst a Western society where mental health is highly regarded. As a result of somatization, healthcare providers may not recognize African immigrant women's presenting mental health symptoms, leading to the delay in their engagement with mental health services. Due to traumatic experiences, it is evident that African immigrant women are more vulnerable to developing PPD than their non-immigrant counterparts, placing them at a higher risk for suicidal ideations and actions (Vang et al., 2016; Falah-Hassani et al., 2015; Spallek et al., 2014). Therefore, when mental health symptoms are undetected, African immigrant women experiencing PPD are at an elevated risk of developing suicidal tendencies due to their continued morbidity.

Lubowzky et al. (2020) corroborate somatization among their sample of 212 Ethiopian origin mothers born in Israel. Ethiopian immigrants manifested more somatic symptom disorders than other populations studied. The difficulties in acknowledging mental health within the Ethiopian culture may require greater research on emotional distress with a focus on cultural differences as noted by the authors. Common risk factors that increase the risk for somatization and PPD include low socio-economic status, younger age of mother, discrimination, marital status and lower education.

Additional barriers to accessing healthcare were found in an Australian study conducted by Mohale et al. (2017) on the experiences of African women who had delivered children both within Australia as well as their countries of origin compared to women's experiences of accessing healthcare in both locations. The women attributed logistics, poor infrastructure, and a low socio-economic status as barriers to accessing healthcare in Africa particularly in rural locations. A specific concern was the mistreatment by midwives and healthcare workers during delivery and post-partum care. Many African based hospitals are poorly resourced and have fewer maternal care staff than in Australia which has a ratio of 10.6 midwives per 1,000 women. In contrast, there are 1.07 midwives per 1,000 women in Africa (Mohale et al., 2017). Health literacy among the women was found to be very low as many only accessed maternity services once in their first birth process and not in subsequent deliveries due to experience. It is evident that African immigrant women are among the population of global immigrants who can be considered a special group of people in need of targeted mental health care for the alleviation of migration trauma and the spectrum of PPD symptoms as revealed in the literature.

Discussion

The review aimed to analyze the vulnerability and risk factors that Sub-Saharan African immigrant mothers experience globally. While several issues were identified, there were three most significant ones found in the results. The results identified the traumatic immigration journey, lack of social support and finally challenges in accessing healthcare due to various reasons among which difficulties in seeking out supportive mental health information as a key barrier. All these point to cultural differences, language, and not knowing whom, when, where and how to ask for help in a culturally appropriate manner that honors their histories as well as

their current contexts. The implications for these findings point to a great need for psychological interventions within the population studied. As such, the following intervention has been identified to be a targeted and comprehensive support for alleviating the symptoms of PPD while dealing with underlying and often ignored trauma histories.

The narrative theoretical approach is a systemic intervention that was developed by Michael White and David Epston in the 1980's. Narrative therapy is a postmodern therapeutic approach that enables individuals to take ownership of their story by using empowering language that will help reconstruct their problem-saturated narratives (Saxena, 2022). The narrative therapeutic approach is an experiential therapy that is person-centered. Therefore, it embodies the postmodern therapeutic stance where the client is the expert of their life, and the therapist is a guide and facilitator helping the client re-define painful, traumatic experiences without blaming or pathologizing (Pataky, 2021). Narrative therapy can help individuals heal symptoms of depression, complex trauma, post-traumatic stress disorder (PTSD), anxiety, grief amongst others (Clarke, 2021; Pataky, 2021).

In 1990, White and Epston expanded their narrative theoretical framework to allow the inclusion of cultural, societal, and political subjective experiences. Therefore, narrative theory is sensitive to individuals of all cultures, societies, and political stances. Using narrative therapy, individuals can separate their problems from themselves and are then able to reconstruct their problems with a healthier narrative (Shakeri et al., 2020). Narrative therapy has been found to be beneficial in treating depression and trauma in both individual and group therapy (Shakeri et al., 2020; Khodayarifard & Sohrabpour, 2018; Vromans & Schweitzer, 2011; Semmler & Williams, 2000). Furthermore, several studies have shown its effectiveness when working with Africans in treating trauma stemming from racism, medical illnesses, and substance abuse, suggesting its cross-cultural applicability (Chioneso et al., 2020; Goddu et al., 2015; Qureshi et al., 2015; Ngazimbi et al., 2008; Semmler & Williams, 2000). Additionally, narrative therapy has also been found to be beneficial in treating trauma symptoms of immigrants (Draper et al., 2022; Farrell & Gibbons, 2019; Kwon, 2015), specifically African immigrants (Nwoye, 2009).

Narrative therapy is founded on verbal communication and indeed the review has identified language as a barrier to the immigration experience of accessing mental healthcare services. All

through the process of therapy, beginning with the referring bodies, immigration services as well as maternal care services, there is a need to use a multi-systemic approach to intervention. This approach would work closely with Interpreters and Cultural brokers to infuse health literacy into the process of therapy (Jacoby et al., 2015). Cultural brokers work as culture mediators who can bridge the gap of illness, healing, traditions, rituals and practices honored in the women's culture and that provide a framework of meaning to their experiences. Each woman comes with her own history and narratives of mental illness that include idioms of distress, words or phrases for communicating suffering (Toffle, 2015). Idioms of distress have become useful in psychological interventions with special populations and were introduced in the DSM-5 (American Psychiatric Association, 2022).

In order to merge technical therapeutic narrative language into a language that can be understood by women suffering PPD, psychoeducation must be emphasized at the operational level of maternal care staff as the first responders who assess for symptoms. Cultural brokers and Interpreters can provide the necessary link for African women immigrants to join therapeutically while maintaining emotional and symbolic meaning during the therapy process. The same principles of confidentiality, what to expect and using simple language must be emphasized in psycho-educational workshops prior to the beginning of narrative therapy and all through the process.

The specific stages and techniques used in native therapy for women experiencing PPD often begin with engage in conversations to listen out for a problem narrative of embedded in extreme forms of negative self-talk. The repetition of discouraging thoughts and distressing emotions worsens a client's depression, and so through narrative therapy, these women can re-author their stories with more positive interpretations, helping them to challenge any negative internal monologues (Saxena, 2022). Additionally, immigrant women using narrative techniques would re-narrate their stories, empowering them to reclaim themselves and recognize that their identity is not based on trauma (Saxena, 2022). As part of the narrative therapeutic intervention, we outline various narrative techniques such as understanding an individual's story, externalization, deconstruction of problem-saturated narratives, reconstruction of healthy narratives, and unique outcomes. All techniques are facilitated by the use of meaning-making questions that therapists

can use to treat PPD and trauma symptoms. Additionally, group therapy may also be beneficial in helping gain social support, and a sense of community in their host country.

The first step of the narrative therapeutic process is for both the therapist and the client to understand the client's story. This is done by the therapist helping the client put together their narratives. Through this process, the client is allowed to find her voice while exploring the meanings she has attributed to the various events in her life. As the story is pieced together, she becomes an observer of it using a third-person stance. At this stage of therapy, the therapist helps the client identify and challenge the dominant problematic aspects of her story.

Externalization is a narrative therapeutic technique that helps individuals separate their problems from their identities (Pataky, 2021), enhancing the observer stance. One way that externalization can take place is by helping the client name their problem. A therapist working with an African immigrant woman experiencing PPD may guide the client to externalize her depression by putting a name to her depression. For example, she may name her depression "gorilla". Therefore, every time she experiences a low mood, she would be able to refer to her mood as the "gorilla" and not a part of herself. The trauma that this immigrant woman may have experienced would also be externalized such that her traumatic experiences would be separated from her core self. Hence, she would then be in a position to observe how the trauma would have affected her, empowering her to see her capability to heal.

The narrative therapeutic process of deconstruction helps individuals gain clarity in their stories. When a problem-saturated narrative has been formed and ruminated over for years, it may be difficult for the individual to pinpoint its origin. This may cause confusion and lead to the individual attaching their problem-saturated story to their identity. Using deconstruction, a therapist would help them dissect their story into smaller parts, clarifying the problem, making it more amenable (Wallis et al., 2010).

After deconstruction, reconstruction takes place when clients are in a better position to understand their old stories, the impact of the language that they used to form these stories on themselves and will be able to re-author their stories using healthier and more positive language (Pataky, 2021). An African immigrant mother experiencing PPD who has gone through various

forms of trauma may now form more positive perspective to her suffering, helping her form healthier narratives. This practice can be repeated as many times as necessary to help individuals form coherent and healthy narratives around their traumatic experiences.

Sometimes a client may feel that her story can never change as it has become concretized. This results in getting stuck in problem narratives which negatively impact relationships, behaviours, and experiences (Clarke, 2021). Through the unique outcomes narrative therapeutic technique, the therapist can help individuals challenge their narratives by widening their perspectives to considering alternative stories. In all these processes, the sensitivities of trauma are honored by all therapists, both individual and in group formats, strengthened by multi-systemic support systems in the host nation.

Conclusion

This review sought to highlight the plight of Sub-Saharan African immigrant women experiencing postpartum depression. The focus of attention revealed PPD as a mental health challenge that resides in this under represented population. It emphasizes the need for systemic therapeutic interventions to support not only mothers, but the families in which they reside disrupted by both forced and voluntary migration from their African homelands.

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