Examining Beliefs About Mental Illness Among African Canadian Women

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This paper examines how social constructs such as race, culture, gender, age, socioeconomic status, educational level, language and immigrant status influence the ideologies, beliefs and attitudes that many African Canadian women hold about "mental illness", symptom presentation and treatment. In this paper, interview data from six informants, two of whom speak about their emotional and mental health problems are provided. The remaining four informants were mental health professionals who provided additional data on many of their African Canadian female patients experiences in dealing with mental health problems. Standardized interview guides were used with each informant. Interviews lasted approximately one hour and thirty minutes. The data were analyzed by using a categorization system that was based on themes arising out of the author's earlier research.

Like race, gender and class, "mental illness" is a socially constructed concept. The interpretation of behaviour is a social construction that is informed and given legitimacy by the common-sense knowledge within a given society (Wright & Treacher, 1982, p. 129). The actions, beliefs, motives and feelings that provide the basis for understanding "mental illness" are conceptualized in unique ways depending on the society and are used by individual societies to define norms and standards of behaviour. Moreover, the notion that "mental illness" is based on an objective, physical knowledge of the brain has long been seriously questioned. Gilman (1985, p. 23) argued that in every society, there exists laws, taboos and diagnoses that distinguish the healthy from the sick.

This paper examines the particular conceptualizations that African Canadian women hold about "mental illness" and its treatment. I argue that social constructs such as race, culture, gender and class have bearing on how African Canadian women understand, cope with and seek help for mental health difficulties. I attempt to create a dialogue between what would at first seem to be two irreconcilable mental health traditions: Western psychiatry and traditional/ indigenous mental health practices of African peoples of the diaspora.

There is some urgency in addressing diversity within mental health sites in a multiracial and multicultural society. Because of the scarcity of mental health research about African Canadian people and other people of colour in Canada, many of the ethnoracial mental health agencies and

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organizations as well as the more mainstream ones tend to rely on mental health data on people of colour in the United States and England. Although similarities in racial classification make it possible to use this population to make broad assessments of the African Canadian population, the differences between African Canadians and African Americans in terms of history of migration and the Canadian and American social and political structures demand studies that are unique to Canada and African Canadians. My research can provide these organizations with the theoretical framework and data with which to conduct further research on the African Canadian population and other communities of colour.

"Mental illness" is one of the most powerful models upon which pathology is based because it is associated with violence and because the behaviour of the "mad" is construed as the antithesis to the discipline, control and logic that define the self. According to Wright and Treacher (1982, p. 124), "mental illness" can be interpreted in three unique ways:

1. The "disease model" regards physical impairment and pathology as the cause of "mental illness".
2. The "deviant model" regards an individual who deviates from particular norms and rules of conduct in a particular society as mentally ill and psychiatric treatment is used as a means to control his/her behaviour.
3. Finally, a distinction is made between "badness" and "madness" in the ascription of "mental illness", where "madness" is considered to be the result of a lack of rationality and not of a deviation from norms ("badness").

These three distinct interpretations of "mental illness" demonstrate the lack of consistency in the psychiatric discourse in explaining "mental illness" causation. Definitions of "mental illness" are shaped by the political forces in a particular society and by the professions that are responsible for maintaining social control. Consequently, a universal definition of "mental illness" and its causes has yet to be defined.

One of the more popular debates in psychiatry has pertained to overly simplistic notions of "mental illness" and the implication that there is an underlying organic or physical explanation for it. One reason why it is hard to settle on a unified notion of "mental illness" is because the meaning of "illness" is context-dependent and defined according to the rules and norms within a given society. Foucault's concept of knowledge is useful here for understanding how medical knowledge is constituted within historically specific regimes of power. In The Birth of the Clinic

(1975), he demonstrated how bodies are manipulated and controlled by the power operating within the normalizing discourses of medicine, criminology and psychiatry and within their respective institutions.

He also showed how the health-care systems, in particular, use "scientific knowledge" to create and perpetuate hierarchical relations and to exercise control over individuals, families and societies. Foucault demonstrated how the formalization and institutionalization of medical knowledge legitimized and authorized initiatives by health experts to create disease classifications for "the ill" and how the normalizing discourse of medicine operates to identify, categorize and define behaviours that deviate from the norm.

But, normality and abnormality are context-dependent. Initiatives to construct the parameters within which "madness" may be defined are largely based on the ideological assumptions of the dominant group because it is the dominant group that holds the power to decide what constitutes "mental illness". Perhaps what most distinguishes Western medicine and psychiatry from the traditional healing systems (i.e., indigenous) of non-Europeans is their tendency to separate the material from the non-material in explaining illness causation and in treating illness. The material are those tangible explanations that can be seen concretely, whereas the non-material are those psychic, spiritual and mystical explanations that may not be visible in a concrete way. Whether we use the terms "mind-body", "mind-body-spirit", or the more inclusive "mind-body-spirit and emotions", we are describing the truly whole and integrated nature of ourselves and our beings.

While Western medicine has separated mind and body and largely ignored the importance of mental and spiritual health until recently, Eastern and African healers have long recognized the interconnectedness of the parts that make up the whole. Fernando (1991, p. 128) argued that the divide between the material and the non-material or the mind and body has been sustained in Euro-Western psychiatry. In the following quote, Fernando (1991) characterized "mental illness" as a socially constructed concept:

> Psychiatry depends on identifying illness, but it has neither an objective means of measuring, nor a precise culture-free classification of illness. At best, psychiatry is a body of knowledge about people built on a framework of hypotheses and information... these norms —the values, ideologies and assumptions that have fashioned psychiatry and continue to permeate it— come from the culture within which psychiatry lives and grows. This has been and still is, broadly Western culture —or perhaps West European culture. So psychiatry, by

> its very nature, is ethnocentric to European culture (i.e., Eurocentric). The fact that it has been applied —or rather imposed— all over the world says something about power and status rather than about usefulness or validity (p. 10).

Since the 1980's, the term "indigenous" has been used along with the term "knowledge" to signify a social scientific, philosophical and ideological perspective that recognizes the significant role that knowledge plays in the power relations that emerged from the expansion of Europe (Roberts, 1998, p. 59). As an intellectual/discursive project, the field of indigenous knowledge allows us to interrogate the marginalization and denigration of the knowledges of minoritized peoples in Eurocentric discourse, as well as to examine its value to minoritized peoples. As a political project, it allows us to locate ourselves within multiple subject positions (race, gender, culture, nationality etc.) as individuals or, more importantly, as a collective to resist the imposition of dominant knowledge.

Several studies (Asuni, Schoenberg & Swift, 1994; Baker, 1994; Barbee, 1994; Bulus, 1996; Center for Addiction and Mental Health, 1999; Fontenot, 1993; Foster & Anderson, 1978; Madu, 1996; Sow, 1980) on "mental illness" among African peoples of the diaspora showed that conceptualizations of "mental illness" stem from people's own observations, understandings and interpretations of specific symptoms, the behaviour of persons who are affected and how those symptoms are uniquely experienced and explained in a particular society or culture. They found that for African peoples of the diaspora, medical traditions are shaped by the makeup of the physical environment, the occurrence of specific diseases or the disease experiences of the people, the level of exposure and access to Western medicine, levels of literacy, social class and the beliefs that people hold about diseases and cures that are inherited from past generations.

Fontenot (1993, p. 42) found that community members in a rural southwest Louisiana parish perceived "mental illness" as being the result of both "natural" and "unnatural" causes. A natural cause of "mental illness" is said to occur as a form of punishment against someone who has sinned or wronged another individual by lying, stealing, committing incest and other malevolent acts. In these circumstances, the Christian belief dictates that God punishes those who commit such acts. Conversely, malevolent acts committed against another to cause physical harm or misfortune are considered to be unnatural causes of "mental illness". These acts are defined as "hoo doo" and "curse" and are said to result in psychological illness.

Studies conducted by Madu (1996), Bulus (1996), Asuni, Schoenberg and Swift (1994), Sow (1980) and the Center for Addiction and Mental Health (1999) found that many African peoples on the continent and African Caribbean peoples in Canada perceive "mental illness" as being caused by external sources (such as evil spirits or gods) as punishment for wrongful deeds. Consequently, the persons affected are often blamed for the apparent weaknesses in their character and for causing their own mental health problems.

The study conducted by the Center for Addiction and Mental Health (1999, p. 18), in particular, found that common beliefs about mental health problems in the Caribbean community in Toronto are that: a) it is brought on by a spell or spirits, b) it is a punishment for wrongful deeds, c) the person affected is crazy, dangerous, or weak in character, d) it is hereditary and e) the persons affected are pretending to have mental health problems. According to this study (p. 18), common beliefs among Caribbean people in Canada about treatment and coping mechanisms include: a) the belief that treatment will not cure or help control one's problems, b) the belief that if you admit to having mental health problems and seek treatment for it you will be institutionalized and drugged for the rest of your life, c) the belief that going to church and repenting will cure your problems and d) the belief that home herbal remedies and spiritual healers will resolve your problems.

Several authors (De Jong, 1987; Laguerre, 1987; Madu, 1996) identified three main types of help-seeking behaviours among individuals in the Caribbean and in Africa who suffer from mental health problems: a) the traditional type who uses religious faith/indigenous healing exclusively, b) the mixed type who uses Western therapy as a complement to religious faith/indigenous healing and c) the Western-oriented type who uses Western therapy exclusively.

Interestingly, African Caribbean indigenous healing was part of the mainstream of medical ideology during the colonial era. Although it is now tolerated, it is no longer recognized as an orthodox form of medicine by the mainstream medical establishment (Laguerre, 1987, p. 10). African indigenous medical knowledge remains marginal to this day because its adherents remain powerless in the context of a Western scientific domain in which political power is key to legitimacy (Laguerre, p. 10). Indigenous healers and the treatments that they use have been criticized by Western practitioners for being unprofessional and unscientific because they incorporate magic and superstition and use supernatural methods to cure supernaturally caused illnesses (Torrey, 1986, p. 229). In the following sections I will provide the methodological framework and findings of this study.

METHODOLOGY

This research study is based on my doctoral thesis entitled *African Canadian Women Storming the Barricades!: Challenging Psychiatric Imperialism Through Indigenous Conceptualizations of "Mental Illness" and Self-healing* (2002). The study was carried out between July 1999 and February 2001. The study examined how the various conceptualizations African Canadian women hold about "mental illness" influence their propensity to seek out particular forms of treatment methods.[2] Since most of the interview data on these issues were provided by mental health professionals, their quotes are emphasized in this paper. I should also point out that most of the data were obtained from interviews from mental health professionals because I encountered difficulties in finding African Canadian women who were willing to talk about their mental health problems. This is not surprising given the discomfort in the African Canadian community about talking about "mental illness".

Sample

I identified two broad categories of informants for my study: a) African Canadian women who had sought treatment for mental health problems and b) African Canadian mental health professionals who had treated African Canadian female patients. I chose patients who were culturally diverse, were of diverse socioeconomic status, belonged to different age groups and who had sought assistance for their mental health problems from diverse sources (friends, psychotherapists, psychiatrists, community mental health workers). I also obtained data from mental health professionals who were employed in diverse mental health professions (psychotherapist, psychiatric nurse, community mental health worker, psychologist, director of mental health agency) and who had many insights into the beliefs that African Canadian women hold about "mental illness" and treatment.

I used a snowball technique to locate and recruit appropriate informants based on the sampling considerations that I detailed above. I used my own initiative to identify African Canadian mental health professionals by looking at community newspapers in the African Canadian community and obtaining referrals from friends and family. These professionals assisted me in identifying patients and other mental health professionals who may be interested in participating in my study.

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2 I should point out here that since my thesis examined various other issues that are not of concern in this paper (including the impact of oppression on mental health etc.), I only included interview data from those informants who spoke directly on the issue of how African Canadian conceptualize and seek help for "mental illness".

I would like to point out, however, that none of the patients in this study were being treated by the mental health professionals that I interviewed. In the current paper, I report data from interviews with six informants (pseudonyms are used in order to protect the identities of the informants). The two informants who were receiving treatment from mental health services were: Dwina and Barbara.

Dwina provided me with two interviews, one discussing her experiences as a psychotherapist providing mental health services to African Canadian women and another discussing her own experiences as a patient being treated for depression. Dwina is in her 50's and was born in Cape Town, South Africa. She is a registered psychiatric and oncology nurse and a registered midwife. She currently works as a psychotherapist in private practice and as a manager for a mental health program in a mental health agency in Toronto.

Barbara is in her 60's and is a nurse by profession. She provided me with an interview as a patient receiving treatment for depression and anxiety. She was born in Trinidad and immigrated to Canada twenty-two years ago with her former husband who made the move to be closer to his family in Toronto.

In addition to Dwina (who was interviewed both as a patient and as a mental health professional), data from four mental health professionals are provided. Of the latter group, one is a male (Linda, Yvonne, Rhonda and Barry). Linda, who was born in Trinidad, provided me with an interview as a mental health professional. She has a doctorate degree and she was trained as a psychiatric nurse, psychotherapist and psychoanalyst. She has been practicing psychiatric nursing since 1970 and has been working as a psychotherapist for the last 20 years. She uses the term "healer" as a "catch-all" term to describe her profession. She is currently the head of a healing center, the executive director of a women's shelter, a consultant, an anti-oppression trainer, a policy developer and a political advisor.

Rhonda provided me with insights as a director of a community mental health agency. She was born in the Phillippines and is the only non-black informant in my study. She is a registered nurse by training who has been practicing as a mental health therapist for 34 years. She is also a part-time faculty member at a college where she teaches group dynamics and group leadership.

Yvonne was born in Trinidad and is a psychology professor at a university. She also works part-time as a psychologist in private practice, providing counselling to many African Canadian clients.

Finally, Barry, the only male in this study, was born in Guyana. He is a psychiatric nurse by training and currently works as a community mental

health professional. He discussed his experiences in treating African Canadian female patients at a community mental health site in Toronto.

Data Collection

I conducted one interview with each informant with the use of a tape recorder. Each interview lasted approximately one hour and 30 minutes. I used two versions of the standardized interview guide: one for the women experiencing mental health problems and another, for mental health professionals. Both guides consisted of a set of questions that were carefully worded and arranged with the intention of taking each informant through the same sequence. Questions asked were mostly open-ended so that informants could provide a detailed account of their experiences. This type of interview guide allowed me to minimize variation in the questions that I posed. Although I had a clearly defined purpose in questioning, I sought to achieve it through some flexibility in the wording and in the presentation of the questions.

Data Analysis

I used my research questions to develop themes around which I could identify patterns in my data and, consequently, provide a framework of analysis. My research questions are as follows: a) how are conceptualizations of "mental illness" among African Canadian women informed by their individual locations at the crossroads of race, culture, gender, class and other social oppressions? and b) how are conceptualizations of "mental illness" held by African Canadian women get incorporated into knowledge production within mental health sites?

I assessed the extent to which the data described patterns and phenomena that my informants had conceptualized and defined. I sorted these patterns into categories as recurring regularities in the data continued to emerge and completed this process once all sources of information had been exhausted and when sets of categories had been saturated.

FINDINGS

At this juncture, I would like to point out that my objective in this paper is not to make declarations about any inherent differences between African Canadian women and European women in terms of how they understand or seek help for "mental illness", but to simply provide data on the help-seeking patterns of African Canadian women. Given that there is a lack of research on mental health issues in this community, I thought that it was crucial to add to what little research there is on this

issue. Moreover, unlike my study, few studies on this topic use a critical integrative framework to look at how social categories like race, gender, culture, age, socioeconomic status and educational level influence beliefs around "mental illness" and help-seeking.

In general, African Canadian women often heal their mental health problems by combining the more traditional practices that are indigenous to their cultures with Western psychiatric approaches. This would include one or any combination of psychiatry , psychoanalysis, a family doctor, meditation, yoga, herbal remedies, solitude, diet regulation, relaxation, social support networks, divination, spirituality and prayers. Rhonda notes that diet practices like Ayurveda (which is often practiced by many South Asian peoples) have become such a normal, taken-for-granted part of the lives of these women that many of them are not even aware that they are engaging in legitimate healing strategies:

> When you work with Black women you find that there are many remedies that they use but it is just that they don't really recognize that they are using these remedies. For example, how they regulate their diet. They would never say that it is a strategy that they use from their cultures because they know the content of their body and they will not eat certain foods. They are already practicing that so they will just recognize that the doctor tells them to do certain things but these women in their own lives already do those things because they are the ones who know their body. When you ask them how they deal with problems they will tell you all kinds of things other than the doctor and will tell you that they meet friends or go to the movies or need to relax.

I found that factors such as age, socioeconomic status, educational level, language, culture and beliefs about psychiatry and "mental illness" causation greatly influences the types of help-seeking that African Canadian women engage in, whether it be from formal/professional resources like family doctors, psychiatrists, hospital emergency wards and psychotherapy or from more informal resources like social support networks of friends and family, church and other religious activities, spirituality, meditation and relaxation, solitude and diet regulation. Of these approaches, the most common source of assistance utilized by African Canadian women are social support networks of friends and family and family doctors.

These women are least likely to attend psychotherapy and psychiatric counselling, mainly because of the shame and stigma that is still often associated with these approaches within the African and Caribbean

communities. As a result, many African Canadian women have a tendency to speak more with their bodies than with their emotions when they express symptoms of "mental illness". Moreover, they will often visit their family doctor to treat these physical ailments and/or camouflage their emotional problems by discussing their ailments with a counsellor or psychoanalyst. Dwina speaks on this further:

> A lot of women in South Africa and Canada, we speak with our symptoms and of course they never come and knock on our door in Canada and say "I am depressed". They would come with bodily ailments, either with conversion reactions, very common in South Africa, or with fainting spells or they will talk with their bodies —a pain in their stomach, a pain in their heart, not being able to eat, or overeating. It is represented in physical symptomatology and it is only when you delve into that you will realize that there are other psychological elements there. I think that goes for women both in South Africa and Canada.

Similarly, Linda contends that the stigma and taboo associated with "mental illness" in African Canadian community often results in these women masking their problems by focusing on their physical ailments:

> You see behaviours like "my back hurt me", "my belly hurt me", "my head hurt me". So it is expressed in a physical way and I do clearly understand it. It is easier not just for Caribbean people, but for all people, to come to the practitioner and talk about their bodies. They are not comfortable expressing their emotional thoughts and feelings so the emotional stuff is always manifested in a physical way because the physical part is more socially acceptable and because they don't accept this "mental health" approach. They will engage in that comfortably not just with the mental health provider but also in the park and the bus, they will tell you about the dizziness, the high blood pressure and the pain but they will not say "I am feeling so low today" and "I am hearing a voice."

In general, the choice of treatment that is utilized by African Canadian women depends on what they think causes "mental illness". If they are struggling with relationship problems, their response is typically medical and they will go to a family doctor or psychiatrist. If they believe the cause to be spiritual, however, they may go to an indigenous healer or engage in prayer or meditation. Several of the mental health professionals in my study indicated that many African Canadian women believe that "mental illness" is caused by three main factors:

a) external, evil and punitive spirits, b) a biological/genetic/physiological malfunctioning and c) a "breakdown" that results from the inability to cope with severe stress caused by workplace issues and personal/relationship problems. Yvonne, a mental health professional, elaborates further on this:

> If we use the term "mental illness", there are defined ways that people from the Caribbean and Africa, especially Nigeria and Ghana, look at this... There are two streams of thought. One looks at it as it is a familial biological condition... The second stream of thought has to do with spirituality. They believe in the spiritual phenomenon. In Trinidad it is called "obeah". In other countries they call it different things. When they see someone having a mental breakdown they think that someone did that person something. They feel that one's spirit is being messed with. In Nigeria and Ghana, that thinking is very strong that someone has done some "jou-jou" on her. When I move from the Caribbean population to Canada, both of these streams of thought are prevalent but there is a third issue which has to do with the stresses of functioning in this society and, primarily, workplace issues.

Similarly, Rhonda stated that spiritual notions of "mental illness" among these groups hold much weight: "One belief is that they are under the influence of the devil or a spiritual being... there is a tendency to look at it as it is some kind of outside thing or some other factor or a curse and that is the explanation."

Linda notes that there is growing acceptance of Western conceptualizations of "mental illness" among many Caribbean people in Canada and in the Caribbean: "With the entrance of Western medicine, we are now starting to see Caribbean people thinking that "mental illness" has a biological basis. The older folks still feel that it comes from someone doing them something wrong."

Educational level and socioeconomic status also play a role in African Canadian women's choice of treatment, with those of higher educational and socioeconomic status more likely to seek out a psychoanalyst or therapist than women of lower educational and socioeconomic status. Women of lower socioeconomic status and education are more likely to see a family doctor, an indigenous/spiritual healer, or visit a psychiatrist or the emergency department of a hospital on the urging of friends or family. Dwina argues that educational level separates those individuals who believe in traditional conceptualizations of "mental illness" from those who embrace more westernized beliefs in South Africa: "... in South

Africa, the more educated and westernized you are, the less they tend to think that it was impinged because of "evil eye", jealousy and spiritual discontent. The more traditional people would tend to believe in those things."

Linda also points out that since seeking help from a therapist or psychoanalyst is often perceived as a status symbol in Western society and may not carry the same shame and stigma of psychiatry, African Canadian women of higher socioeconomic levels may be more comfortable than poor women in accessing formal sources of support:

> The wealthy woman will go to the psychiatrist who is doing psychoanalysis but it is a status thing for wealthy people to go to the analyst. You don't see poor people saying "I am going to my analyst". The wealthy woman is not going to the psychiatrist. She will go to the psychoanalyst or therapist first to try to deal with her stuff. The less privileged woman who does not have this concept clear will keep her problems to herself for a long time. Her friends and family might tell her that she needs help because "mental illness" is a stigma she will try to cope with. When she can't cope, she will end up by her family doctor who will assess her and refer her to a psychiatrist who will give her medication.

Age also plays a factor in treatment choice, with younger African Canadians more likely to embrace Western conceptualizations of "mental illness" than their more mature counterparts, primarily because they have either grown up or were born in Canada, making them more likely to embrace Western values and beliefs. Linda points out, however, that for young African Canadians who are more closely affiliated with their cultures, there is often a reliance on the indigenous practices of their Caribbean and African cultures when they perceive Western approaches as having failed them: "The younger generation tries to lean on Western understandings, however, if they don't get fixed or heal themselves, they tend to go back to the traditional thinkers and traditional practices."

The issue of culture is also important when one considers the differences between African and Caribbean women in Canada in terms of how they seek assistance for their mental health difficulties. Linda acknowledges that African women, in general, are less likely than Caribbean women to attend psychiatric counselling and therapy, perhaps because they are more likely than Caribbean women to retain their traditional cultural practices when they come to Canada:

> In Africa, Western medicine is making small changes because CNN has taken over the world. African women still strongly believe in their rituals and they bring their practices with them and they don't fit into the mainstream because they have their chants and their rubs and their dances and their circles to bring about their own healing. You don't really see an African woman going for therapy. Not as many because they just started coming here. There are not a lot of them on the ward either. They have a lot of underground practices.

Spirituality and religion also play a crucial role and in some cases the most crucial role, in helping African Canadian women cope with mental health problems. The belief in a higher power for dealing with life's hardships has long been an important source of strength for African peoples of the diaspora. According to Rhonda, the historical importance of spirituality for this group, in particular, lies in its role in providing emotional comfort during and since slavery:

> The medical approach does not include spirituality. Spirituality plays a big role in a person's mental health. History tells us that people regained their health during slavery, for example, spirituality was an important factor in how people developed their community and built their strength through their spiritual connections. We can't underestimate the role of spirituality. I am not talking about organized religion, although for some that is important... Being in touch with one's soul. I don't think this is well understood by the Western world because there is so much reliance on what science should be doing. Spirituality does not have any role in science.

Similarly, Barry stated that religion and spirituality should be woven into the fabric of treatment for African Canadians because of their importance to them:

> It plays the greatest role because all of the Caribbean and African people I have treated believe in God and tend to believe in different ways depending on their God. There is not one that I have met that has doubted that there is a God. It helps them. I have dealt with Somalians and Ethiopians who bring the elders to see them. Caribbean people always go to church. I encourage them to, because I know in the Caribbean, it is important.

Barbara revealed that she deals with her depression by combining solitude, faith, meditation, prayer and a family doctor:

> I have been depressed. I was able to pull myself out of it. I was depressed for a few weeks and decided if I allowed this to go on, what would happen to me and that would give them the upper hand. I am not going to do that. I decided to snap out of it. I am a praying person too. I have a lot of faith in God. I use that a lot. I fall back on that. I brought myself back from depression twice. When I was depressed I stayed in bed and would not get out of bed. I cried a lot. It had to do with my job. I brought myself out of it with a doctor in Toronto who was treating me. I sit in the library a lot. I help myself that way. I feel that deep meditation and prayer and deep faith in God and faith in yourself... You must care about yourself and understand who you are and what makes you function.

Several of the mental health professionals in my study stated that they acknowledge, respect and incorporate into their treatment approaches the diverse knowledges, traditions and practices of Caribbean and African peoples. In fact, I found that many of them used holistic and/or Afrocentric or African-centred approaches that acknowledge the physical, mental, emotional and spiritual well-being of their patients and that attempt to heal them within the context of the concrete, day-to-day realities of their lives. An African-centred perspective on mental health values and utilizes diverse traditional or indigenous approaches to mental health, including spirituality, herbal remedies, divination, psychic healing, prayers, as well as complementary care (possibly involving Western bio-medical approaches). Rhonda discussed the importance of using a holistic approach that properly situates clients within their social realities:

> My agency was founded on the principle of looking at holistic approaches to health and to operate within an anti-racism framework... Our services and programs include things like spirituality, alternative therapies and issues of employment, literacy and English classes.

For Dwina, an inclusive healing approach for African Canadian women, specifically, is one that is inherently spiritual and grounded in a social reality that borrows from the history, culture, philosophy and collective orientation to the reality of African peoples:

> In my program we use an Afrocentric treatment model. It is new to Canada and the agency but we utilize seven Kwanza principles, including faith, self-determination, creativity, purpose and cooperative economics. An Afrocentric approach

> is being totally inclusive and sensitive around culture and diversity. Including Afrocentricity means including the family and the community and the school. Using a holistic approach where we acknowledge all of the dimensions of the human being and that means physical, emotional, cultural and spiritual. All the other pieces of Afrocentricity includes the fact that Black people have a spiritual DNA and we recognize that. And that we are in tune with nature. To be Afrocentric, we have to ask the person how they understand where they are coming from.

Some of the mental health professionals in my study stated that many African Canadian women are intimidated to access formal mental health sites because they fear that mental health professionals may not understand, respect, or be attuned to their cultural, ethnic and racial traditions and experiences. Linda stated that the beliefs and practices of African Canadian women are often perceived as strange and abnormal: "What we see on the wards is Caribbean people who put out their beliefs and practices and they would be judged or seen as crazy because what they believe in is considered unacceptable by Western thinkers and Western medicine..."

It is critical, then, that mental health professionals acknowledge and validate the important role that spirituality plays in helping many African Canadian women cope with mental health problems and respond to the diverse conceptualizations that they hold about "mental illness" and its treatment. There is an urgent need for mental health professionals to critically question the knowledge they perceive as superior/inferior and valid/invalid, to interrogate the relevancy of that knowledge to non-White and non-European peoples and to ensure that diverse forms of knowledge permeate every aspect of the mental health sector.

DISCUSSION

Given that the knowledges and practices of many racially and culturally diverse groups are often marginalized within many mental health institutions and institutions of learning, their incorporation into these mainstream sites can only be realized if there is the willingness, initiative and commitment on the part of decision-makers (most of whom are from the dominant group) to do so. Perhaps the medical community must begin to re-think its ideology on how best to integrate the mental health knowledges and practices on non-European peoples. Thus far, medical syncretism has merely meant the borrowing, appropriation and stealing of medical remedies, knowledges and techniques from

indigenous medicine by Western therapists and patients. But, in taking only a portion of what it wants from indigenous medical knowledge and rejecting the rest, Western medicine continues to deny indigenous knowledge from achieving a legitimate status in the healthcare system.

Mental health professionals must continue to critically interrogate their own effectiveness in delivering services to culturally and racially diverse groups and to engage in ongoing discussions on how best to adapt, modify and transform the system to meet the needs of this segment of the population and the wider community. Moreover, mental health decision-makers must see as urgent the need to incorporate marginalized knowledges at every level of the mental health system, from the hiring of staff that is representative of the diverse society they serve and that have diverse perspectives on mental health, to the delivery of service, the development of curricula within institutions of learning and medical schools and the development and implementation of mental health policies. In addition, more research needs to be conducted and disseminated on marginalized knowledges within the mental health field so that data are available to mental health professionals and educators and in libraries and research centres globally.

All knowledge should be shared knowledge. No one racial or cultural group should be thought to have primary ownership over any particular body of knowledge. The medical and psychiatric communities must begin to acknowledge the urgency in forging connections that will help bridge the sociocultural gap in a world where racial divisions are becoming increasingly blurred and increased globalization demands a re-analysis of theories and practices that have only served to marginalize and silence alternative voices.

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