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Positive Mental Health and Its Promotion: A Bicultural Perspective and Narrative Synthesis from Aotearoa New Zealand

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Abstract

Positive mental health frameworks in Aotearoa New Zealand have largely been shaped by Western individualist assumptions and have given limited attention to Indigenous and bicultural understandings of wellbeing. This article examines positive mental health and its promotion in Aotearoa New Zealand, through a bicultural lens grounded in *Te Tiriti o Waitangi.* It reports on two cross-cultural mental health searches and discusses several models of health from te Ao Māori (the Māori world). Based on the view that positive mental health (and, indeed, health as a whole) is both constructed and contextual, our understanding of it in Aotearoa New Zealand must reflect the nation's bicultural foundation and obligations. Māori models of wellbeing are advanced as offering holistic, culturally grounded, relational, and equity-oriented frameworks for understanding positive mental health, challenging Western atomism and individualism while aligning with international calls for inclusive, contextual, and culturally responsive approaches to wellbeing. Drawing on *Te Tiriti o Waitangi*, the article proposes a meta-theoretical framework for positive mental health that is both locally grounded and globally relevant, suggesting that Tiriti-informed approaches may offer valuable

insights for culturally responsive mental health thinking in other national and Indigenous contexts.

Keywords
Positive mental health; mental health promotion; Māori; *Te Tiriti o Waitangi* (The Treaty of Waitangi)

1. Introduction

Although positive mental health has been widely discussed in Western scholarship, existing frameworks pay limited attention to Indigenous and/or bicultural understandings of mental health/wellbeing. As a result, there remains a significant gap in how positive mental health is conceptualized and promoted in contexts such as Aotearoa New Zealand, where Māori and non-Māori worldviews coexist.

A bicultural framework is particularly important in Aotearoa New Zealand primarily because dominant models of positive mental health have not adequately reflected the relational, spiritual, and collective foundations of Māori understandings of wellbeing, nor the obligations settlers have with regard to *Te Tiriti o Waitangi* (the Treaty of Waitangi), which is commonly regarded as the founding document of our bicultural nation. Engaging with positive mental health and its promotion from a bicultural lens, therefore, helps address the limitations of individualized Western models and provides a more contextually grounded basis for mental health promotion in this country.

In this paper, positive mental health refers not merely to the absence of mental illness, but to a state of wellbeing that includes relational, emotional, spiritual, and social dimensions. Biculturalism refers to the recognition and engagement of both Māori and non-Māori knowledge systems within the Treaty-based context of Aotearoa New Zealand. Culture is understood as the shared values, meanings, relationships, and practices through which wellbeing is experienced and interpreted.

The concept and practice of mental health has been confounded by the fact that the term ‘mental health’ refers both to positive mental health (PMH) as well as to mental ill-health and illness. In the Western (and Northern) intellectual tradition, in the past two generations, several authors have distinguished between these two usages, developed concepts and analysis, and undertaken research that promotes PMH and well-being. These include Marie Jahoda, who identified six concepts of mental health [1]; Howard Gardner, who identified different forms of intelligence [2-4]; Claude Steiner, who coined the term ‘emotional literacy’ [5] and went on to develop its theory and practice [6, 7]; Keith Tudor, who offered an expansion of concepts and, more importantly, a paradigm analysis of the field of positive mental health and its promotion [8-10]; and Corey Keyes, who has pioneered research on flourishing [11, 12]. However, very little of this research considers the cultural aspects or implications of the concepts identified. For instance, Jahoda’s [1] categories of concepts - attitudes of an individual toward his [sic] own self; the individual’s style and degree of personal growth; and the(ir) integration of autonomy, perception of reality, and environmental mastery - clearly reflect a Western individualism with human beings at the centre of the world.

A second problem with any discussion of mental health is that it focuses on one aspect of overall health. This is somewhat ironic given that the English word ‘health’ has its roots in words meaning

whole, i.e., Old English hǣlth = wholeness or a being whole. Thus, health refers to a state or process that is indivisible. Others who have explored the etymology of health also argue that health is to be whole or holy, which, as Graham [13] observes, 'clearly embraces both spiritual and physical features rather than merely the latter' (p. 53). Although the division of health into parts is generally blamed on Cartesian dualism - i.e., the split between mind and body represented by Descartes' ([14]) famous dictum 'I think, therefore I am' - there are many models of health and health practices, both Western and Indigenous, that acknowledge and reclaim health as holistic, some of which we discuss later in this article. In the meantime, and in this article, we do refer to mental health as meaning the positive form of health that particularly refers to the health and well-being of the mind, as well as spirit and emotions, in the context of the generic term 'mental health' being somewhat confused, conflated (with its opposite), and contested.

Finally, by way of introduction, we note certain terms and conditions in the field of cultural studies. The term 'cross-cultural' usually refers to comparing or contrasting different cultures, often from a distance, which is the focus of this special issue or, at least, the call for papers for this issue of the journal. The term 'transcultural' usually refers to something that transcends or is viewed as extending through all cultures and, thereby, suggests a universal or shared human elements above and beyond any single culture, the main problem with which is the dominance of Western thinking about universalism (for a critique of which, see [15, 16]). The term 'intercultural' describes the interaction and exchange between cultures, ideally with a focus on establishing and developing relationships and mutual understanding, and is the approach taken in the discussion in this article. We refer above to 'conditions' as there is always a context to such terms, the perspectives they represent, and the research they foster, not least the hegemony of the Western intellectual tradition and of the global North, and colonization. As people and researchers living and working in Aotearoa New Zealand, our context is that of a multi-cultural society in a bicultural nation, based on the social contract of *Te Tiriti o Waitangi* (the Treaty of Waitangi) signed by Māori rangatira (chiefs) and representatives of the British Crown (see [17]). We also note that, when discussing ideas from te ao Māori (the Māori world) and te ao Pākehā (the non-Māori) world, we do not assume a universality within either of these worlds.

2. Method and Methodology

As part of our research for this article, an initial search of the relevant literature was conducted in the EBSCO database based on the following parameters: "cross-cultural" OR "cross-cultural" AND "positive mental health", initially restricting the search field to "Abstracts" only. This resulted in 25 publications. Expanding the search to include all fields (i.e., "Title" and "Text") resulted in 11,164 publications, the first 200 of which were manually scanned for relevant articles not caught in the initial search of abstracts. This resulted in 20 articles, of which three focused on mental illness and/or ill-health, which is a common conflation in this field of research; seven focused on the nature and validity of research instruments; and one was an editorial. Having excluded these 11 publications, we briefly review the remaining nine (in the Findings section below).

One of the problems in researching culture and especially Indigenous culture(s), and also subjects involving ethnic minority populations and the global South, is the dominance of Western thinking and institutions (including search engines) based in the Northern hemisphere (see [18]). Thus, the above search did not reveal anything about cross-cultural mental health as it relates to Māori or,

for that matter, non-Māori New Zealanders. In order to counter this implicit bias, we adopted an 'inverse funnelling approach' ([19], p. 546) by conducting a second search through EBSCO on the following parameters: "cross cultural" OR "cross-cultural" AND "positive mental health" AND "New Zealand" OR "NZ" OR "Aotearoa" OR "Māori" OR "Maori" (as the latter is a common though incorrect spelling of the word). The search, which included all fields, produced 4,683 results, the first 200 of which were again manually scanned until they repeated themselves, a process that resulted in the initial identification of seven peer-reviewed articles. Again, after a closer reading of each of these, three were excluded due to their international focus (with only samples in Aotearoa New Zealand) (n = 2), and to the fact that they were concerned with the nature and validity of research instruments (n = 1). Finally, as the first author is a leading researcher in the field of positive mental health and its promotion and the second author is an established Māori researcher and academic who has worked in community mental health with Indigenous youth and their families, we were aware of some other literature on Māori mental health that had not been picked up this search, notably Durie [20, 21], Pere [22], and Tapsell's (2002) work (as reported by [23]), and so have also included these publications in our second literature review.

Bringing together and exploring the relationship between these two reviews, including similarities, differences, and the relationships within and between the literature(s), is a form of narrative synthesis in that, through our reading of the literature within the Western and Indigenous Māori traditions, we have come to a certain synthesis. With regard to our methodology, it is a critical, that is, taking a critical perspective on assumptions e.g., (Western individualistic), and of dominance (i.e., British colonisation of and rule in Aotearoa New Zealand); and, specifically, from a critical *Te Tiriti* analysis [24].

3. Findings from the Literature Review(s)

> Mā tāu rourou, mā tāku rourou, ka ora te iwi | With your food basket and my food basket, the people will flourish.

3.1 Components of Mental Health

In order to address the question of how mentally healthy persons are conceived in different countries, this cross-cultural study conducted by Minsel et al. [25] surveyed 595 teachers as "culture carriers" from France, Germany, Greece, and the United States of America (USA). Results revealed cultural and generational differences: younger respondents and those from more affluent countries (especially the USA and Germany) prioritized self-actualisation, autonomy, and emotional openness, while older Greek participants valued behavioral control and social conformity. These differences were interpreted as shifts from traditional, authoritarian norms to more individualistic, relational, and so-called feminine values such as sensitivity and care. The study suggests that conceptions of mental health are shaped by cultural, socioeconomic, and generational contexts, and calls for broader comparisons across professions and political groups to refine these insights.

3.2 An Integrative Theoretical Framework of Acculturation and Salutogenesis

Inspired by Antonovsky's [26] work on salutogenesis, Riedel et al. [27] propose a model linking acculturation processes to the salutogenic concept of a sense of coherence [28], to explain how

individuals maintain and promote mental health while navigating cultural transitions. The authors argue that existing models of acculturation often overlook the health-promoting resources and coping mechanisms on which individuals draw during cross-cultural adaptation. By integrating Berry's [29] acculturation strategies with Antonovsky's [26, 30] salutogenic theory, the authors' framework emphasizes how psychological resilience, identity negotiation, and the ability to find meaning and manage stress contribute to well-being in multicultural contexts.

3.3 Positive Mental Health

In this paper, Vaillant [31] examines whether a universal understanding of positive mental health exists across cultures. He critiques the Western focus on individual psychological traits such as autonomy, self-esteem, and happiness, arguing that such definitions may not capture what other cultures value as mental well-being. Drawing from global studies, the paper highlights how non-Western cultures often prioritise social harmony, spiritual balance, family interconnectedness, and moral maturity. Vaillant emphasizes that, while some elements of positive mental health, such as resilience and caring relationships, may be common across cultures, the expression and prioritisation of these traits are deeply influenced by cultural context. Ultimately, Vaillant calls for a more inclusive model of positive mental health that acknowledges diverse cultural values and avoids imposing ethnocentric mental health standards.

3.4 Positive and Negative Mental Health Across the Lifespan

This study comprised a cross-cultural comparison of both positive and, as the authors refer to, negative mental health, conducted by Schönfeld et al. [32], with population samples from Germany, Russia, and the USA. It highlights significant cross-cultural differences in mental health, resilience, and social support across the lifespan, shaped by each nation's unique economic, political, and social conditions. The findings underscore the complexity of comparing mental health across Eastern and Western populations, as macro-level societal factors influence psychological outcomes differently. It also cautions against attributing mental health trends solely to age, noting that historical context, cultural values, ethnic identity, and national systems, including healthcare or welfare, also play key roles. The authors emphasize the need for future longitudinal, culturally sensitive research to better understand how age and context interact to shape mental well-being.

3.5 Youth Wellbeing and Mental Health

This study explored the impact of school belonging on wellbeing and mental health among Turkish adolescents. The authors, Arslan et al. [33], examined the cross-sectional and longitudinal associations between school belonging and mental health indicators and wellbeing to understand the nature and direction of causal relationships. A short-term longitudinal study tracked 402 students aged 10-15 years old from two public secondary schools in an urban city in Turkey across measures of school belonging, internalizing and externalizing problems, and life satisfaction. School belonging was found to be a significant predictor of youth externalizing and internalizing problems and life satisfaction. Social inclusion strongly predicted youth life satisfaction, while internalizing and externalizing problems were strongly predicted by social exclusion. The study advocates culturally informed research and interventions, noting that protective factors (such as extended

family networks and spiritual practices) may differ widely between societies. The findings stress the importance of understanding local meanings of adversity and resilience in order to design effective, context-sensitive child welfare and mental health strategies.

3.6 Depression, Anxiety, and Happiness

This unusual study examines mental ill-health (in this case, depression and anxiety) in the context of an aspect of mental health (i.e., happiness), thereby representing an application of the two continua model of mental health ([the Canadian] [34]) and the relationship between mental well-being and mental ill-health [35], promoted and further elaborated by Tudor [9]. In a network analysis of Indian and Kenyan adolescents, the authors, Wasil et al. [36], examined how specific symptoms of depression and anxiety relate to happiness. The results showed that feeling sad and like a failure were most strongly and negatively linked to happiness, and, along with worrying and nervousness, were also the most central symptoms within the broader depression-anxiety network. These symptoms clustered separately from happiness indicators, a pattern that held consistently across both culturally distinct samples. The study highlights the value of focusing on individual symptoms rather than diagnostic categories, especially in low- and middle-income countries, in order to understand mental health dynamics better and to inform targeted interventions.

3.7 Prediction of Positive Mental Health

Two studies in this literature focused on prediction and positive mental health.

The first is a three-wave longitudinal prediction of positive mental health in Germany and China. Building on previous work from the Bochum Optimism and Mental Health project [37], this longitudinal cross-cultural study explored how salutogenic and pathogenic factors predict positive mental health (PMH) over time among university students in China and in Germany [38]. Using data from three time points, the study found that certain positive factors such as social rhythm, resilience, and social support had small but significant effects on future mental health, particularly in the Chinese sample. In Germany, social support and prior PMH were the strongest predictors. At the same time, negative factors such as depression, anxiety, and stress were more predictive of lower PMH in the Chinese group than in the German group. The findings suggest that salutogenic predictors play a more consistent role in fostering long-term positive mental health, while the impact of negative predictors varies across cultures.

The second study, a scoping review of the predictive power of PMH, conducted by Margraf with other colleagues [39], reviews 85 studies published between 2007 and 2023 on PMH using a PMH-scale, highlighting its relevance for adaptive functioning and mental well-being. The research spans seven themes: psychometrics, sociodemographic influences, mental disorders, suicidality, COVID-19, influencing factors, and treatment. Findings consistently show that PMH predicts mental health outcomes, supports resilience, and contributes to healthy development across cultural contexts and timeframes. However, the evidence base is limited by a lack of experimental studies. The review argues for PMH to be routinely assessed alongside psychopathology in mental health research and practice, given its value at both individual and societal levels.

3.8 The Right to Health Care

This cross-cultural study compared gender differences in mental health between university students in Pakistan and Germany, focusing on their access to care and well-being indicators such as depression, anxiety, stress, resilience, social support, and life satisfaction [40]. The results found that German women reported significantly worse mental health than men, while in Pakistan, no major gender differences emerged, despite overall poorer mental well-being. Notably, Pakistani women displayed high resilience and social support similar to their German counterparts. The study stresses that gendered patterns of mental health found in Western contexts do not always translate to South Asian settings, underscoring the need for culturally-tailored mental health strategies.

Having reviewed the Western literature, we turn our attention to the second literature on Indigenous Māori perspectives on mental health and its promotion.

3.9 Protective Resources That Promote Wellbeing

This study, conducted by Farewell et al. [41], investigated the factors that support resilience and mental well-being in mothers raising young children in high-deprivation areas of Auckland, Aotearoa, New Zealand. Through focus groups and interviews with 74 ethnically diverse mothers, researchers identified key protective factors including strong social support (especially from family), a sense of neighborhood cohesion and stability, and alignment with cultural and social norms. However, for some, cultural identity also emerged as a source of tension and stress. The study underscores how maternal mental health is shaped by the broader socioecological environment, and points to modifiable community and cultural factors that could be strengthened to improve outcomes for both mothers and their children. While alignment with cultural and social norms can foster resilience and happiness, particularly in collectivist cultures, it can also be a source of stress. Cultural connection has been shown to buffer depression, especially when paired with high cultural efficacy, or confidence in one's cultural identity. However, the benefits of ethnic identity vary across groups: Māori women may face more tension due to assimilation pressures and shifting identities, while Pacific and Asian women, often seen as more marginalized, might find their cultural identity more protective. Interestingly, an earlier article about Māori health [42], (which did not show up in this search), examines culture and, specifically Māori cultural efficacy, as a protective function on (against) psychological distress.

3.10 Applying the PERMA Framework to Young Volunteers in Aotearoa New Zealand

This study applies Seligman's [43] PERMA model to explore the well-being of 63 young people who volunteered in Christchurch, Aotearoa New Zealand between 2010 and 2020, particularly in the wake of disasters [44]. While all five PERMA domains - positive emotion, engagement, relationships, meaning, and accomplishment - were relevant, *meaning* emerged as the central connecting principle. This motivated volunteers, shaped their social connections, and drove their sense of purpose and achievement. However, the study also highlighted that meaning could be a double-edged sword: it was both a key source of wellbeing and a trigger for distress, especially when tied to trauma, injustice, or emotional overcommitment. The authors argue for a more nuanced use of PERMA in volunteer contexts, suggesting that meaning be given greater weight, and that volunteer organizations support young people's well-being through clear communication,

emotional safeguards, and structural boundaries to prevent burnout. The authors suggest that, in order to determine its universality, the framework should also be tested with volunteers across different cultures, especially those with greater levels of collectivism. Again, interestingly - and also somewhat ironically - this article does not acknowledge the collectivism of the indigenous Māori culture of Aotearoa New Zealand, the country in which the study was conducted, and only one respondent referred to their learning in terms of 'bicultural and Treaty-based practice' (p. 612).

3.11 Resistance, Resurgence, and Wellbeing in the Context of Climate Change

The authors, Johnson et al. [45], critique the dominant discourse in climate policy of loss and damage for its narrow economic and hazard-focused framing, arguing that this fails to account for the lived realities of Indigenous peoples, specifically Māori women in Aotearoa New Zealand. Drawing on ethnographic narratives of Māori women, Marama and Pania, the authors explore cultural resurgence as a means of counteracting the compounded losses stemming from settler colonialism, neoliberalism, and climate change. These women's narratives reveal that loss and damage are deeply socio-political and often intangible, impacting identity, wellbeing, and intergenerational connection, far beyond that which compensation models can address. The embodied, everyday forms of adaptation of these Māori women highlight a uniquely Indigenous and gendered approach to resilience, reframing adaptation through culturally-grounded, relational practices. The authors call for frameworks of loss and damage to attend to local context, support Indigenous-led responses, and decolonized approaches to climate resilience.

3.12 Refugees and Mental Wellbeing

This paper argues that mental health services for refugees in Aotearoa New Zealand must move beyond clinical, Western-centric models toward community-based, trauma-informed approaches that reflect the lived experiences of forced migration and resettlement. Based on a co-production between refugee communities and researchers, the authors [46] critique the current system, which narrowly focuses on diagnosing mental illness and fails to adequately acknowledge trauma, communication barriers, or cultural needs. The paper highlights how mental health recovery for refugees is a slow process shaped by past atrocities, ongoing discrimination, and the challenges of adjusting to a new country. Current policies, such as New Zealand's Refugee Resettlement Strategy [47], acknowledge some of these complexities, but their implementation remains inconsistent and inequitable. The authors call for culturally congruent, co-designed services that honor diverse worldviews of wellbeing, embed *Te Tiriti o Waitangi* principles, and address structural determinants such as housing, racism, and socioeconomic inequality. They advocate for integrated, participatory models of care that reflect the interconnected and generational nature of trauma in refugee communities, emphasizing collective healing over individual diagnosis.

While these four papers do discuss aspects of positive mental health in Aotearoa New Zealand, they do not refer to Māori models of health, so we now turn to consider four Maōri models of health (which are also promoted by [48]).

3.13 Te Whare Tapa Whā (The Four Sides of the Meeting House) [20]

This model, originally developed during a hui (meeting) of Māori health workers in 1982 and published by Mason Durie in 1985, uses the image of a wharenui (meeting house) of a marae (a central community space), to represent the hauora (overall health) of a person, and is arguably the most widely-referenced Māori model of health. Each side represents a specific dimension of health: taha tinana (physical), taha wairua (spiritua), taha whānau (family and social relationships), and taha hinengaro (mental and emotional health). The whare (house) is built on the whenua (land), representing identity and connection with roots, suggesting a secure grounding, a place to stand. If one of the dimensions is missing or damaged, a person or collective may become 'unbalanced and subsequently unwell [48].

Within the health sector in Aotearoa New Zealand, it is often said, 'What is good for Māori is good for all New Zealanders', or 'in uplifting Māori health, everyone is uplifted'. Te whare tapa whā is an excellent example of a Māori model that not only supports a Māori cultural paradigm but is also accessible across cultures. This, coupled with its simplicity and easily understood illustration (Figure 1), is possibly why the model is so popular in Aotearoa, New Zealand.

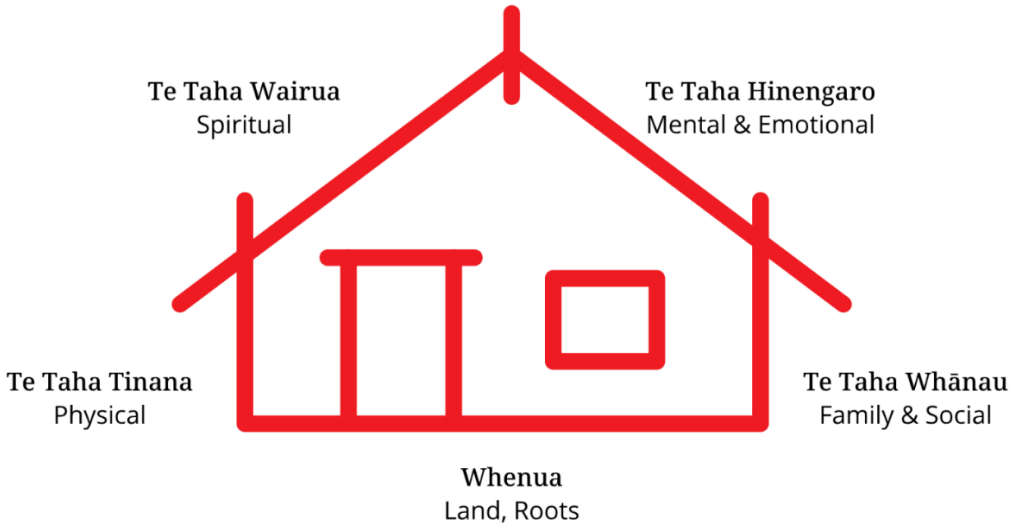

Figure 1 Te Whare Tapa Whā [49].

In terms of Māori, the model reflects a Māori worldview, in which health is not only physical but, rather, interconnected with spiritual, mental, and social dimensions. Further, the use of the wharenui holds particular significance, in that wharenui are viewed as, and also house, ancestors, and are built in accordance with the structure of the human body. For example, the maihi (front bargeboards) are the arms that welcome visitors and embrace those entering; the tāhuhu (large beam that runs along the length of the roof) is the spine, and the heke (rafters reaching around the walls) are the ribs. The depth of mātauranga Māori (Māori knowledge) just within this example can be basic (as is this example) or can be understood on a more esoteric level. Thus, te whare tapa whā provides flexibility and support for Māori wherever they are in their connection to, and understandings within, te ao Māori. Using a culturally grounded model fosters trust and participation, essential for effective engagement and care. Alongside wairuatanga (spirituality) and mauri (life force), this model is promoted as representing key concepts of Māori mental health and wellbeing by the Mental Health Foundation of New Zealand [50].

While rooted in Māori culture, the four dimensions resonate universally, and the model is adaptable for non-Māori as it moves away from reductionist approaches, encouraging practitioners to see all clients as whole beings rather than isolated symptoms. Finally, te whare tāpa whā not only bridges cultural perspectives and modern health practices, but also offers interdisciplinary application in other areas in which considering multiple aspects of well-being is essential. i.e., education, justice, and other social services.

3.14 Te Wheke (The Octopus) [22]

This whānau (extended family) model of health, developed by Rangimarie Rose Pere (and illustrated by Nancy Nicholson), draws on the image of te wheke (the octopus) as a metaphor for the interconnected dimensions of wellbeing. The eight tentacles represent eight elements of health and wellbeing: wairuatanga (spirituality); hinengaro (mind and emotions); te taha tinana (physical health); whanaungatanga (extended family and relationships); mauri (life force); mana ake (unique identity); hā a koro mā, a kui mā (the breath of life from ancestors); and whatumanawa (open and healthy expression of emotion). Additionally, the head of the octopus represents the whānau as central, with the eyes symbolizing waiora (total well-being) for the individual and the whānau [48], while, as McNeill [23] puts it. '[the] independence of all parts of the model [which] is a crucial factor, [is] symbolized by [its] intertwining tentacles.' (p. 100). While both represent interconnectedness, te wheke does so more explicitly, a meta-aspect which several authors and researchers in the field of positive mental health consider has to be addressed for well-being and optimal holistic health (and is something to which we return in our discussion).

3.15 Te Pae Māhutonga (The Southern Cross) [21]

Following his further work on Māori health [20] and Māori health development [21], and inspired by the work of the first Māori medical practitioner, Maui Pōmare (1876-1930), and by the *Ottawa Charter* [51], Durie developed a model for Māori health promotion: te pae māhutonga (the constellation of stars forming the Southern Cross). The model comprises the four central stars, representing mauriora or access to te ao Māori (sometimes also referred to as cultural identity), waiora (environmental protection), toiora (healthy lifestyles), and te oranga (participation in society), with the two pointing stars, representing ngā manukura (leadership), and te mana whakahaere (autonomy) [21]. While originally designed as a model for the promotion of *Māori* health, it may also be applied to Pākehā, with the first aspect being an invitation to non-Māori to find their cultural identity in Aotearoa New Zealand *in relation to Māori*, for instance, as tangata Tiriti (a person of the Treaty), as Durie stated:

> The hope is that the six stars which make up Te Pae Māhutonga will serve not only as a navigational aid to the south, or as an icon of New Zealand, but as a reminder about the potential for a healthy people and a healthy nation ([21], p. 7).

3.16 Te Ao Tūtahi (Worlds Standing Side by Side) (Tapsell, 2002, Cited in [23])

This model of mental wellness was shaped by research undertaken by Dr Rees Tapsell, a Māori psychiatrist, into the mental wellness of kaumātua (elders) of the Tuhoe iwi (tribe), as a result of which he identified four cultural influences that shape Māori existence: "te ao whakenekeneke (the

global world - literally the moving world), te ao Pākehā (the European world), te ao hou (the contemporary Māori world), and te ao tawhito (the ancient Māori world)."

Of particular importance was the emphasis within this article of "the right of different cultures and communities to define their own notions of health" ([23], p. 109), and the idea that Māori cultural concepts for wellness and healing must include, in fact, be inseparable from the political and social actions of the colonial enterprise.

While taking inverse funnelling to its logical conclusion of prioritising Māori models of mental health developed by Māori, we also acknowledge the work of Pākehā and Tau Iwi (non-Maōri) in supporting Māori health and its promotion. Notable amongst these is Heather Came, health promotion specialist and Treaty activist, who developed a *Te Tiriti*-based approach to mental health promotion [52]. Came Identified lessons from *Te Tiriti o Waitangi* for mental health promotion in Aotearoa New Zealand, including: (promoting) respectful relationships; supporting Māori sovereignty; (being) accountable to tangata whenua; (promoting) equity of outcome; acknowledging the past; (having an) awareness of Māori worldviews; and supporting Māori capacity (see also [53-55]).

4. Discussion

> E koekoe te tūī, e ketekete te kākā, e kūkū te kererū | The tūi squawks, the kākā chatters, and the kererū coos.

This paper argues that positive mental health (PMH) in Aotearoa New Zealand is best understood through a bicultural framework grounded in *Te Tiriti o Waitangi*, which integrates relational, spiritual, cultural, and structural dimensions of wellbeing. Positive mental health or wellbeing is much more than the absence of mental illness; it encompasses qualities (e.g., self-esteem, resilience), meta-skills (meaning-making), concepts (flourishing), dimensions (life stages), and much more - all of which are influenced by personal and family history, culture, and socioeconomic factors. Based on the literature reviewed, this discussion explores PMH through a bicultural lens based on *Te Tiriti o Waitangi* (The Treaty of Waitangi), a social contract signed in 1840 between rangatira (Māori chiefs) and representatives of the British crown, and considered to be the founding document of the modern New Zealand nation. While this Treaty is specific to the historical, political, and cultural context of Aotearoa New Zealand, its use here as a meta-theoretical framework illustrates how Indigenous-settler agreements can inform culturally grounded approaches to PMH. It may also offer insights for other post-colonial contexts seeking to integrate Indigenous knowledge systems into mental health promotion, inspiring others to develop an engaged, respectful, inclusive, and culturally grounded approach to positive mental health and wellbeing.

Here we frame our discussion of PMH in terms of these elements, using *Te Tiriti* and Māori models not merely as illustrative frameworks, but as interpretive lenses through which the reviewed evidence is reexamined (Table 1).

Table 1 Elements of *Te Tiriti o Waitangi* and their key concepts.

Elements of *Te Tiriti*	Key concept
Preamble	Whakawhanaungatanga The acknowledgment of existing relationships
Article 1	Kāwanatanga Governance and specifically co-governance
Article 2	Tino rangatiratanga Māori sovereignty
Article 3	Ōritetanga Equitable outcomes
The oral clause (Article 4)	Wairuatanga Religious/spiritual freedom

4.1 Whakawhanaungatanga

The preamble to *Te Tiriti* acknowledges existing - and pre-existing - relationships between Māori and settlers, especially, though not exclusively, the British. It sets the scene based on contact and connection *before* this (or any other) contract - concepts which, interestingly, are echoed in more recent literature about establishing therapeutic relationships [56, 57]. Interpreted through the lens of whakawhanaungatanga, findings in the PMH literature emphasizing social support, relational safety, and connection are reframed as foundational to wellbeing rather than as adjunctive or protective factors.

This approach demonstrates regard for both self and other, an accurate perception of reality, and openness to new experiences, and having - and intending to have - positive relations with others: all of which reflect aspects of mental health (see also Table 2). Māori models such as Te Whare Tapa Whā position these relational qualities as constitutive of wellbeing itself, suggesting that positive mental health cannot be adequately understood through individual-level constructs alone. We further suggest that this kind of preamble also acknowledges the existence of different worldviews, in this case about health, as represented in Figure 2.

Table 2 Positive mental health framed in terms of the elements and concepts of *Te Tiriti o Waitangi*.

Te Tiriti - Articles and concepts	**Positive mental health**
Preamble Whakawhanaungatanga | The acknowledgment of existing relationships	Self-esteem and self-concept, perception of reality (Jahoda) Openness to experience, extensionality (Rogers) Positive relations with others (Keyes)
Article 1 Kāwanatanga | Governance and specifically co-governance	Personal growth, autonomy, mastery (Jahoda) Self-development, social support, and movement, change (Tudor) Social acceptance, social actualization (Keyes)
Article 2 Tino rangatiratanga | Māori sovereignty	Self-esteem, self-concept, autonomy (Jahoda) Self-concept and identity (Tudor) Social actualization (Keyes)
Article 3 Ōritetanga | Equitable outcomes	Social actualisation, social integration (Keyes)
The oral clause (Article 4) Wairuatanga | Religious/spiritual freedom	Social support and movement, change (Tudor) Avowed quality of life, purpose in life, social integration (Keyes) Freedom of expression

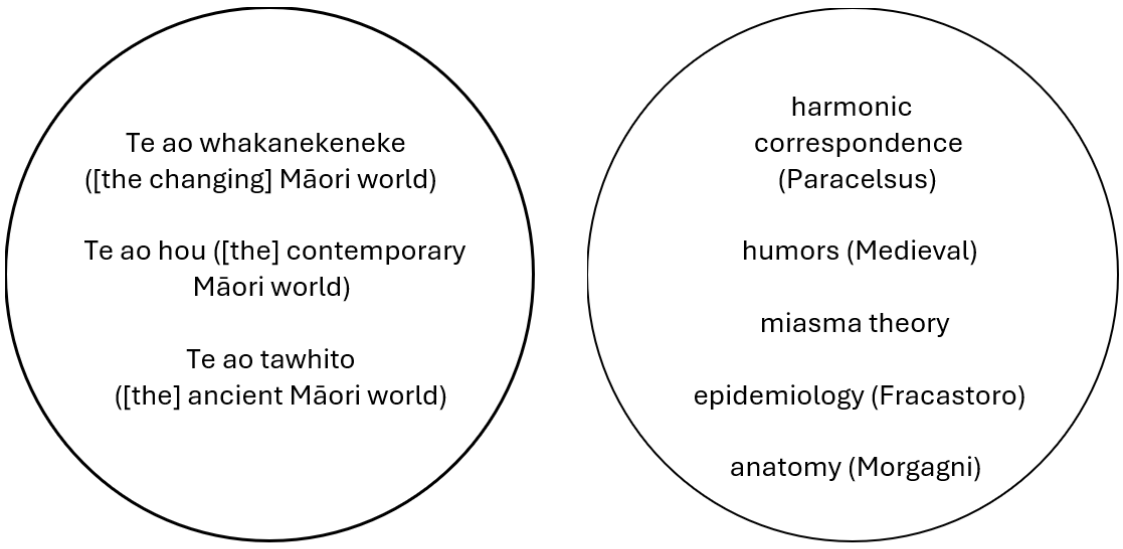

Figure 2 Frameworks of health in Aotearoa pre contact (i.e., pre 19th century Common Era [CE]).

Figure 2 represents ngā ao motuhake e rua | the two separate worlds of Māori and non-Māori, with their different cosmologies, ontologies, epistemologies, methodologies, and practices (or methods), and there are many accounts of how these two worlds met. O'Malley's [58] account of the first encounter between Ngāti Tūmatakōkiri and Abel Tasman's crew provides a critical lens on

how two distinct peoples navigated fraught beginnings to find what O'Malley refers to as *The Meeting Place* in Aotearoa before 1840. Viewed through a PMH lens informed by whakawhanaungatanga, these encounters highlight that wellbeing emerges through negotiated relationships across difference, rather than through epistemic dominance or assimilation.

4.2 Kāwanatanga

The first article of *Te Tiriti* concerns governance, that is, the separate, co-governance of Māori by Māori, and of Pākehā by Pākehā, as represented with regard to health by Figure 3.

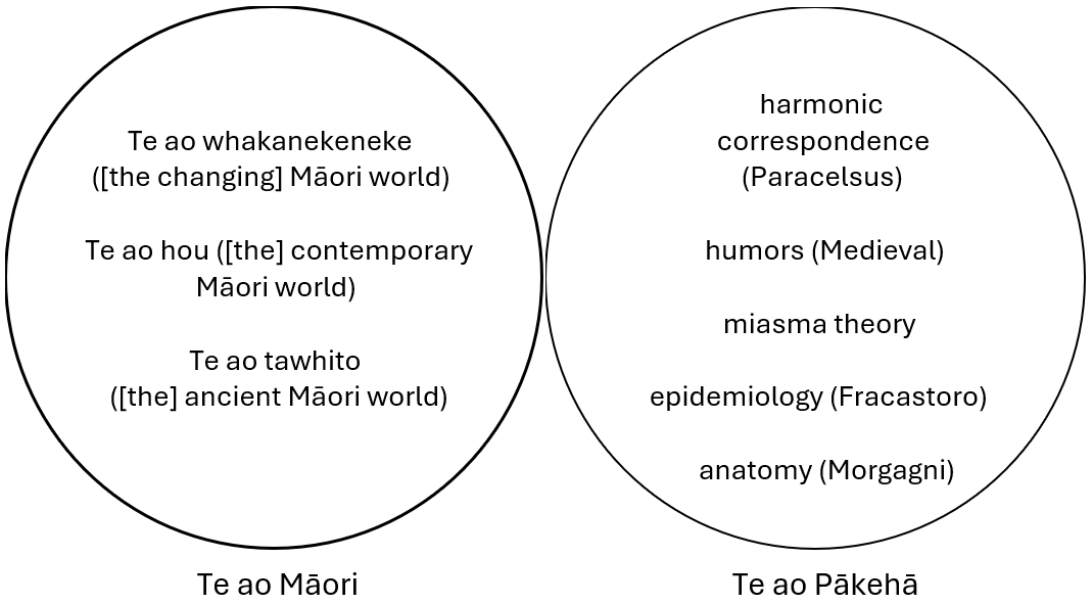

Figure 3 Frameworks of health in Aotearoa under separate governance as envisaged by *Te Tiriti* (developed from Tapsell, 2002, cited by [23]).

With regard to PMH, we suggest that the principle of co-governance is represented - and, indeed, furthered - by some of the concepts to which we referred earlier, such as personal growth, autonomy, and mastery [1]; by self-development, social support, and movement, and change [9]; and by social acceptance, and social actualization [11, 12]. When interpreted through kāwanatanga, these concepts describe not only individual capacities but collective processes that enable multiple knowledge systems to coexist without erasing difference.

While there are early accounts of positive engagement between these two peoples (represented by the touching circles of Figure 3), there are also stories of Pākehā women refusing to seek and/or accept the help of Māori women and midwives [59]. These attitudes represent more of what Salmond [60] refers to as the "collision of cosmologies" (p. 413). From a Māori-informed PMH perspective, such collisions expose the limits of universalist assumptions within dominant health frameworks and demonstrate how failures of co-governance undermine relational and collective wellbeing. These points of tension can result either in entrenchment and separation (Figure 3) or in curiosity, greater engagement, and the development of shared solutions (Figure 4).

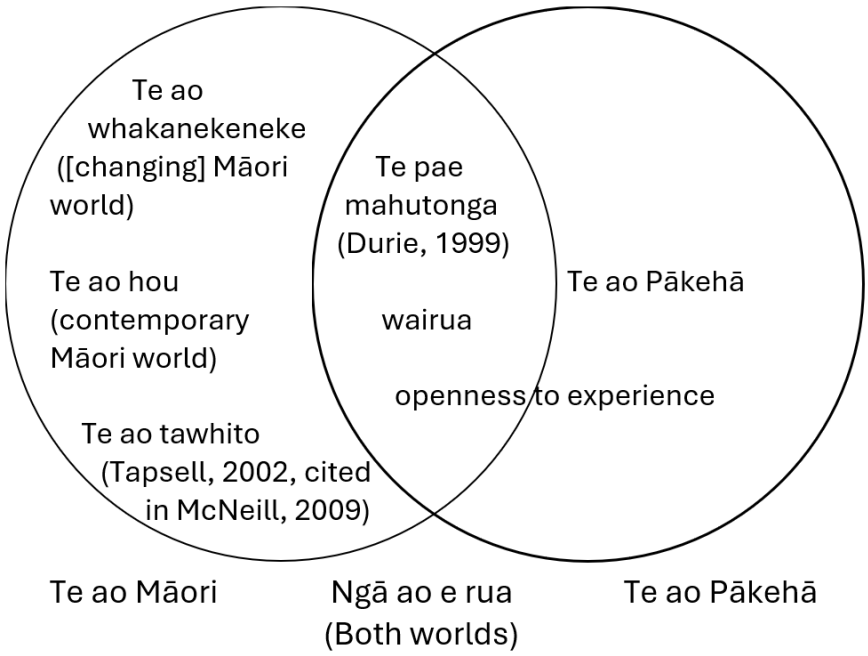

Figure 4 Frameworks of health in Aotearoa post contact (i.e., from the early 19th century CE).

Historically, in this middle ground, Māori and Pākehā traded, intermarried, forged alliances, and shaped each other's ways of life, until this balance was upset by a settler government reneging on *Te Tiriti* through the alienation of land and language, and the undermining of Māori health through war and legislation, e.g., the *Tohunga Suppression Act 1907* (see [61]). These historical processes continue to shape contemporary conditions for PMH, underscoring that governance arrangements are not neutral but, rather, have enduring mental health consequences. Our model has similarities with the tri-cameral model and sphere-based approach of [62], which proposes:

- The rangatiratanga sphere - where Māori make decisions for Māori, thereby exercising independent authority.
- The kāwanatanga sphere - a space in which the Crown makes decisions for its people.
- The relational sphere - a new, shared space in which both parties work together as equals to make joint decisions, moving beyond a simple, dominant-subordinate relationship.

We consider that this bicultural approach to PMH and its promotion is concerned with respecting differences rather than attempting to merge diverse frameworks into a single universal theory. It concerns fostering openness to experience, which Rogers [63] conceptualized as an element of maturity.

4.3 Tino Rangatiratanga

Māori models of health demonstrate that Māori values and understandings of the world continue to sustain positive mental and holistic health. Tino rangatiratanga (Māori sovereignty) remains central to PMH as it affirms cultural integrity, identity, and self-determination. Where Western PMH models often prioritize autonomy as individual independence, Māori frameworks reinterpret autonomy as collective self-determination grounded in whakapapa, place, and tradition.

Tino rangatiratanga strengthens both individual and collective identity, fostering a sense of belonging, mitigating anxiety and depression, and enabling the development of Māori-led health

services. These holistic approaches improve engagement and outcomes precisely because they align care with cultural values. In this way tino rangatiratanga is not only a constitutional right but a critical determentant of mental wellbeing [64, 65], particularly in light of ongoing state actions that continue to marginalise Māori health systems. This is especially important in the context of ongoing state actions that continue to marginalize Māori health systems, from the *Tohunga Suppression Act 1907* [66] to *The Pae Ora (Disestablishment of Māori Health Authority) Amendment Act 2024* [67] (see also [68]).

Māori have long demonstrated the capacity to navigate multiple realities and worldviews, holding diverse spaces, relationships, and modes of knowing simultaneously. The greater challenge—and invitation—lies with non-Māori: to relinquish the need to rationalize, master, or 'own' Māori models of health, and instead to learn how to be present—*to be themselves*—while allowing Māori to be Māori.

It is within this meeting ground that the possibility for both to come to healing. Salmond [60] conceptualizes this relational space as one of 'cosmo-diversity' in which multiple ways of knowing can co-exist without needing to collapse into a single, universal framework, and which itself

> may be a force for adaptation and survival. For the old Cartesian dualisms and their fragmented dreams are no longer working - in science, in material matters, or in human affairs… to find more adaptive ways of being, exchanges across different realities may be helpful (p. 3).

4.4 Ōritetanga

This refers to equity between Māori and non-Māori. Cross-cultural health in Aotearoa New Zealand cannot be understood without acknowledging the ongoing negative impacts of colonization on Māori, including land alienation. Persistent health disparities, between Māori and non-Māori, reflect structural inequalities rather than individual deficits. Interpreted through *Te Tiriti* and Māori models, these data demonstrate how PMH is shaped by political, economic, and institutional arrangements, not solely by personal resilience or coping.

- That Māori adults are almost twice as likely as non-Māori adults to have experienced any type of racial discrimination…
- That ischaemic heart disease rates are twice as high for Māori adults compared to non-Māori adults.
- That Māori females have a lung cancer registration rate over three times that of non-Māori females.
- That Māori males and females are around one and a half times more likely than non-Māori males and females to have diabetes.
- That Māori aged 5-34 years were more than twice as likely as non-Māori in the same age group to have been hospitalised for asthma [48].

Other alarming statistics, given that the Māori population makes up 17.1 percent of the total New Zealand population [69], include:

- Suspected self-inflicted deaths for Māori males were 28.1 per 100,00/non-Māori males, 14.2 per 100,000.

- suspected self-inflicted deaths for Māori females were 8.6 per 100,000/non-Māori females 5.1 per 100,000. However, given adjustments for total population size, this is equivalent to about 1.7 times that of non-Māori females [69].
- Māori rates of seclusion in inpatient mental health facilities are 4-6 times higher than for non-Māori.

The adequacy of Western flourishing models such as PERMA [43] is therefore limited when applied without attention to structural injustice, collective identity, and historical context. A bicultural gaze reframes PMH by situating distress within systems of inequity rather than locating it solely within individuals.

4.5 Wairuatanga

The final, oral clause of *Te Tiriti* guaranteed protection for the faiths/beliefs of all people in Aotearoa New Zealand. Wairuatanga refers to the spiritual dimension of life encompassing connection to whakapapa (genealogy), whenua (land), and atua (spiritual dieties), recognising that wellbeing is holistic (physical, mental, and spiritual), McNeill [23] argues that the most considerable difference between most Western models and most indigenous models of health is the inclusion of a spiritual component, and that this is particularly important in the field of mental health. Notwithstanding this, as a concept, spiritual health has been recognized in Western and Eastern thinking over the past few decades [70-73].

Within te ao Māori, healing and health are always connected to the spiritual world. Māori models require that spiritual health be treated not as an optional dimension of PMH, but as foundational to mental and collective wellbeing.

It is in this context that we summarise concepts of PMH in relation to the Articles of *Te Tiriti* (Table 2).

5. Conclusion

Evidence suggests that cultural connection and confidence in one's identity are powerful protective factors for mental health, especially in collectivist cultures. Māori cultural efficacy, for example, has been shown to reduce psychological distress [42]. However, this protective capacity is undermined by historical trauma or injustice and enduring systemic inequalities and pressures to assimilate. A *Te Tiriti*-grounded approach to PMH responds to this duality by supporting cultural resurgence while directly addressing the structural determinants of wellbeing.

There remains a meeting ground in Aotearoa New Zealand (represented in Figure 4 above), where mana-enhancing bicultural encounters that support positive mental health for all are possible. While there is ongoing debate within Aotearoa about the obligations, rights, relationships, and responsibilities under *Te Tiriti*, Māori continue to uphold *their* responsibilities under *Te Tiriti* and to welcome respectful intercultural interactions, the sharing of knowledge, and working together for the better health and wellbeing of all peoples.

Embedding the Articles of *Te Tiriti* and their embodied concepts within PMH models enables both structural redress and meaningful intercultural dialogue. While grounded in the specific context of Aotearoa New Zealand, this bicultural approach may offer insights for other societies grappling with the ethical integration of Indigenous knowledge within mental health systems.

The tūi squawks, the kākā chatters, and the kererū coos - as Elder [74] interprets this, “It takes all kinds of people.” (p. 41).

Author Contributions

Professor Tudor was responsible for the idea and development of this project; Dr Haenga-Collins advised about its cultural framing; both authors took responsibility for the searches, analysis, and write-up.

Competing Interests

The authors have declared that no competing interests exist.

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