"Hopefully You've Landed the Waka on the Shore": Negotiated Spaces in New Zealand's Bicultural Mental Health System*

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Abstract

The multifaceted context of Aotearoa/New Zealand offers insight into the negotiation of cultural discourses in mental health. There, bicultural practice has emerged as a theoretically rights-based delivery of culturally responsive and aligned therapies. Bicultural practices invite clinicians into spaces between Indigenous and Westernized knowing to negotiate and innovate methods of healing. Drawing on the negotiated spaces theory, this paper presents findings from a situational analysis of bicultural practice. Through iterative map-making we cartographically chart the discursive positions taken in the negotiated spaces between Indigenous and Western lifeworlds. In total, we identified five major positions of negotiated practices within the institutionalized discourses that constitute bicultural mental health. Findings indicate that negotiations from Westernized systems of care have been, at best, superficial and that monoculturalism continues to dominate within the bicultural framework. Implications are made for genuine engagement in the negotiated spaces, so treatment has resonance for clients living in multi-cultural, yet Western-dominant societies.

Keywords: negotiations of power, Māori and pan-Pacific healing, Westernized discourses, bicultural mental health, situational analysis

"Hopefully, You've Landed the Waka on the Shore": Negotiated Spaces in New Zealand's Bicultural Mental Health System

In Aotearoa[1], the mental health system operates within the boundaries of a bicultural society. Between the bodies of knowledge that constitute Westernized and Indigenous healing (NiaNia et al., 2016), cultural and sociopolitical boundaries are areas of negotiation between intersecting interests and epistemologies. Within these negotiated spaces, possibilities exist for the creation of culturally just practices that hold both Western and Indigenous ways of knowing as valid. These areas in-between must be intentionally navigated for the mental health system to respond appropriately to the needs of clients. Drawing on the negotiated spaces theory (Mila-Schaaf & Hudson, 2009), this situational analysis focuses on the negotiations made within Aotearoa's bicultural mental health system.

Throughout this article, we use the terms *Indigenous* and *Westernized*. Without the space to describe the overwhelming diversity within and between cosmologies, scientific methods, ways of healing, and beliefs about wellbeing, the terms used are pragmatic choices. Drawing on ideas put forth by Smith (2012) and Mila-Schaaf and Hudson (2009) to discuss the paradigms of Māori[2] and Pasifika[3] knowledge and culture, we employ the term Indigenous (Taitimu et al., 2018). Similarly, the term Western is an oversimplification that draws on previous scholarship to connote practices developed for and by White middle-class populations in Europe and the United States (Wendt & Gone, 2012). We also use the terms clinical and cultural workers. This is not to differentiate between Māori and Pākehā[4] clinicians, nor is it to suggest that Western mental health is an endeavor of science while Indigenous mental health is strictly cultural. In Aotearoa,

[1] Aotearoa- the land of the long white cloud (New Zealand)
[2] Māori- indigenous people of New Zealand
[3] Pasifika- Pacific Island-born persons or New Zealanders of Pacific descent
[4] Pākehā- New Zealanders of European descent

the term clinical workers denote those engaged in practices of medication, institutionalization, and individualized therapy (Health Research Council, 2017). These workers have undergone specific education and training and come from diverse cultural backgrounds. Cultural workers are employed within the health sector to provide specific cultural services grounded in Māori and Pasifika-identified protocols (Health Research Council, 2017). Often these workers are Māori or Pasifika, however they can also be trusted Pākehā.

A Bicultural Context

Aotearoa's bicultural context developed from a legacy of colonialism and an increasing focus on Indigenous rights (Came & Tudor, 2016; Green et al., 2014). As a sociopolitical term, biculturalism denotes the interrelationships between Māori and non-Māori, which was gifted to the British Crown at the signing of Te Tiriti o Waitangi (Network Waitangi, 2016). After the signing, an illegitimate translation of the treaty was used to legitimize colonial rule, and since then, Māori have resisted cultural domination (Huygens, 2016). In 1975, treaty violations were examined through the Waitangi Tribunals and successive governments have attempted to negotiate Aotearoa's identity as a bicultural nation (Came & Tudor, 2016). Nonetheless, the vestiges of colonialism ensure that almost "no institutions operate on Māori tikanga, cultural values, language, or worldviews" (Network Waitangi, 2016, p. 36).

Embracing biculturalism means recognizing the place and authority of Māori in parallel and equal status with Pākehā (Came & Tudor, 2016). Biculturalism is both a goal (equal partnership between two groups) and a process (the righting of past injustices) (Ward & Liu, 2012). There are many challenges to biculturalism, and it is often oversimplified, overlooking issues of power and oppression. While ideologically many support biculturalism, some promote a "we are all one Aotearoa" stance- a veiled attempt ensuring Pākehā cultural dominance (Sibley

& Liu, 2004).

Complicating the political advancement of biculturalism is Aotearoa's multicultural growth. With this growth have come calls for Aotearoa to develop multiculturally focused policies. The transition to a multi-rather than bicultural focus may be viewed with suspicion by those who find multiculturalism inadequate to critically address the rights of Māori (Huygens, 2016). Multiculturalism risks maintaining the dominant group as the central organizing culture from which other cultures are diverse, thereby legitimating the status quo of Pākehā centrality (Huygens, 2016). In contrast, a bicultural perspective grounded in the principles of Te Tiriti does not negate other cultures. Ideologically, biculturalism encourages partnership, accountability, equity, and inclusiveness of multiple cultures while holding treaty partners in equal status together (Bennett & Liu, 2018).

Biculturalism in Mental Health

Questions of colonization and healing are crucial in Aotearoa where Māori, Pasifika, and Pākehā coexist. As in most settler-colonial countries, Indigenous people in Aotearoa experience mental health outcomes directly related to the effects of colonialism (Paradies, 2016). Contemporary research provides evidence of Māori's high rates of diagnosed mental illness and Pasifika's high burden of unreported psychological distress (Lee et al., 2017). At the same time, research documents a significant lack of service usage among both Pasifika and Māori which has been attributed to cultural incongruity and racism in healthcare (Bennett & Liu, 2018).

Increasingly, practitioners and scholars are challenging the racism inherent in monocultural mental health (Came & Tudor, 2016), resulting in commitments to bicultural practice (Bennett & Liu, 2018; Huygens, 2016) that delivers culturally-safe services reflective of Māori and Pasifika rights and values (Green et al., 2014). Government departments such as the

Ministry of Health (2017) have promoted the adoption of Māori methods, greater representative workforce, cultural competence training, consultation with Māori elders, and hiring cultural practitioners. Diminishing these efforts, however, is the lack of a comprehensive and unified theory of bicultural mental health, insufficient funding, and disagreement among practitioners on the role of culture in mental health (Ministry of Health, 2017). The bicultural promise in mental health has given rise to the possibility of culturally relevant services for clients. What remains unknown, however, is how negotiations between Western and Indigenous healing practices are navigated in within this bicultural discourse.

Theoretical Framework: Negotiated Spaces

In this study, we sought to understand the movements within bicultural discourse. Of specific interest were negotiations made that advanced or hindered bicultural practice. Our critical-interactionist analysis was guided by the Indigenous-derived negotiated spaces framework, which describes the relationships and intersecting interests between epistemologies (Hudson et al., 2012). Originally developed to illustrate relationships in the boundaries of matauranga[5] Māori and Western science (Smith, 2012), it was expanded to include pan-Pacific knowledges (Mila-Schaaf & Hudson, 2009). This framework counters the argument that Indigenous scholars are relegated to precolonial or essentialized knowledges, or become caught between cultures (Hudson et al., 2012). Instead, it recognizes that Indigenous and Western paradigms are fluid, innovating, and unconstrained by static ideas of knowledge and culture. In this framework, Indigenous and Western sciences are equally valid, and neither system is complete without the other. Like Mi'kmaw Elder, Albert Marshall's concept of Two-Eyed Seeing, with one eye trained on Indigenous ways of knowing and the other on Western ways of

[5] Matauranga Māori- knowledge, understanding, wisdom of the visible and invisible, sciences

knowing, the value, strength, wisdom, and possibilities of both can be used together (Bartlett et al., 2012). Relationships of knowledge building occur in the meeting grounds in between, creating possibilities and bridging divides (Hudson et al., 2012). Through deliberative negotiations, critical appraisal, and knowledge exchange, epistemological systems can become inclusive rather than competing.

This study engaged the discursive elements that exist within negotiated spaces of bicultural practice. To conceptualize these spaces, we drew upon a situational analysis (Clarke, 2019) of data, derived from a critical-interactionist ethnography. Critical interactionism is grounded in the assumption that differences of perspectives and commitments exist within situations at the same time they are constitutive of them (Clarke, 2019). To gain insight on the critical interactions within the situation of bicultural mental health, the first author worked for a year with Māori and Pasifika health and community development institutes. The research question guiding this study was, "What positions of discourse exist within the negotiated spaces of the bicultural mental health system?"

Methodology: Meaning Through Mapping

Situational analysis is a "critical-interactionist theory-methods package" (Clarke, 2019, p. 189) that utilizes cartography to highlight complexities within data. Through abductive mapping, analysts move through data, experience, and theory (Clarke et al., 2017). To analyze the situation of inquiry, we developed a range of maps described by Clarke et al. (2017) to investigate the relationships between elements, the collectivities that have a stake in the negotiations of bicultural practice, and the discourses of biculturalism. What emerged was a portrait of negotiations traversed between intersecting interests.

Procedure

Participants were recruited by word-of-mouth and email invitations sent to professional organizations and district health boards. These materials described the goal of the study as developing understanding of how culture and justice have been achieved in mental health, with a specific focus on bicultural implementation. Utilizing maximum variation sampling (Patton, 2015), we sought a sample reflective of Aotearoa's geographical variation, cultural variation, and variations in mental health service types and practice settings. Participants consisted of thirty service providers who were Māori, Tauiwi (immigrants), Pākehā (of European descent), and Samoan persons who working as mental health providers (see Table 1 for participant demographics). Given the variation in provision types, we use the term service provider throughout this article. Rather than using pseudonyms, participants are labeled with the letter P and the number that represents the order in which they were interviewed. For example, the first participant is labeled P1.

[Table 1 about here]

The first author conducted korero mai (Swadener & Mutua, 2008) interviews over a period of four months in 2017. Korero mai is a kaupapa[6] Māori method, that is unstructured and narrative in nature. Each interview began conversationally, typically with a prompt such as "What led to your interest in meeting with me today?" Interviews took place at participant's preferred location, such as places of employment or cafes, were digitally recorded, and lasted from 45 to 110 minutes (averaging 70 minutes).

Subjectivity and Ethics

Data were collected as part of the first author's doctoral dissertation and Fulbright scholarship. This project was approved by the ethical boards of the author's University in the

[6] Kaupapa- purpose

United States and the host Aotearoa University. The first author engaged in research as a Tangata Tiriti: a bicultural partner (Came & Tudor, 2016). As a White American, she became aware of her positionality as a settler-colonial who speaks the colonial language and is situated in the contemporary colonial projects of Western academia and psychotherapy. With this status comes the colonizing power of whiteness and a historical legacy of genocide and oppression. As a non-Indigenous settler-colonial researcher, she focused on the knowledge that any research with marginalized peoples can mirror, collude with, and recreate colonizing practices.

Smith (2012) proposed that the establishment and maintenance of nurturing and reciprocal relationships between researcher, participants, and communities serve as the core of Indigenous ethics. After months in the field, the first author gradually nurtured whakawhānaungatanga, "whānau[7] relationships, literally by means of identifying … your bodily linkage, your engagement, your connectedness, and therefore, an unspoken but implicit commitment to other people" (Bishop, 1998, p. 203). Seeking guidance from critical friends and cultural advisors, the first author shifted her perspective on ethical being to focus on life-sustaining relationships and the preservation of justice. This process was fully documented through an autoethnographic account of the first author's experience (Jordan, 2018).

In line with situational analysis, our aim was to situate positionality in this production of knowledge (Clarke et al., 2017). The first author triangulated data through field notes, memos, and consultation with accountability partners. Her partners (Māori, Pakeha, and Samoan community leaders in Aotearoa) challenged her stance and beliefs of biculturalism throughout analysis. As new findings emerged, she conducted member checking and follow-up interviews to further understand emergent results and meanings developed from multiple perspectives. The co-

[7] Whānau- family, kinship

authors, who represent diverse ethnic and racial perspectives in the United States, reviewed results as they emerged in relation to the context and first author's relationship to the project.

Analytic Method: Iterative Coding and Mapping

Data analysis occurred concurrently with data collection in iterative phases of memoing, coding, and map making (Charmaz, 2006; Clarke et al., 2017). Each interview was transcribed and coded in MAXQDA (VERBI, 2012). During initial coding, the first author closely read each transcript, then compared across cases, to generate provisional and tentative codes. Mapping began once coding was underway. A 4′ × 6′ whiteboard, was used to create, rework, and interpret maps as findings emerged.

Situational Mapping

The first author created a situational map for each participant following initial coding. The situational map is a free-form representation that serves as an analytic strategy for articulating elements of the situation, while examining the relationships between these elements (Clarke et al., 2017). These maps overlapped with focused coding, and insights gained during mapping were synthesized and expanded to create themes relevant to the situation of interest: bicultural practice. After several iterations, the relational analysis of situational maps involved drawing lines between each element (in this case, codes) and attempting to describe the nature of the relationships. In the relational map, similar themes across cases were brought together with a focus on interpretations of participants positioning vis-à-vis each other within the discourse of bicultural mental health. The first author maintained a record of progress by drawing completed maps and writing subsequent memos in a sketchpad.

Social Worlds Mapping

To evaluate the collectives that have a stake in bicultural development, the first author

developed a series of social worlds maps, focused on the meanings made through collective action (Clarke & Star, 2008). Individuals often belong to divergent and intersecting social worlds at any given time, and boundaries between are permeable. Within the social arena of bicultural mental health, each social world consists individuals who contribute to the discourses and meanings within. To create social world maps, the first author looked for hidden sites of power, differing discourses, and the ways in which social worlds situate (or are situated) in relation to the social arenas. For this analysis, social world maps were created with the author's field notes, reviews of mental health policies and manuals, and interview data (Clarke et al., 2017).

Positional Mapping

As mapping and coding progressed, the first author visually synthesized the major discourses of bicultural mental health. Positional mapping captures the discourses illuminated from field notes, interview data, and memos (Clarke et al., 2017). While many discourses exist within Aotearoa's mental health system, this mapping exercise identified the discourses navigated in bicultural practice.

Findings: Negotiation Strategies in Bicultural Practice

Specific to the goals of this study, we sought to understand the complexity of negotiations around the discourse of bicultural practice. We developed a project map (Clarke et al., 2017) to visually communicate and summarize our findings. Two semantic axes were plotted- alignment with Westernized discourses (y-axis) and alignment with Indigenous discourses (x-axis); a line from the bottom-left to the top-right corner indicates the bicultural discourse trajectory (see Figure 1). Themes associated with positions of discourse were plotted within this map. Moving back and forth through the data, positions were placed in the areas most aligned with their relative power in the creation of bicultural practice. A total of five positions

were highlighted: opposition, resistance, assimilation, maneuvering, and collaboration. Below we define these positions, which are our interpretations developed from interactions in the mental health field, and from the terms, ideas, and actions reflected in the data.

[Figure 1 about here]

Position 1. Opposition: Negotiating by Minimizing and Scapegoating

Opposition appeared as discursive positions that proponents of Western practices used to resist biculturalism. As a maneuver to maintain dominance, oppositional discourses positioned matauranga Māori as inferior to Western science. This maneuver hinged on a variety of educational, philosophical, and professional factors, including the policy-driven demands for evidence-based practices (Gone, 2015). The discursive stance of opposition is best depicted by paradigmatic reliance on medical traditions. As one participant described the system itself is structured in such a way to stand in opposition to a bicultural approach:

> We have our biomedical model, the core of psychiatry and the center of our mental health system that is not conducive to a bicultural model. It locates illness within the person and often to a physical malfunction in the body and that doesn't fit well with Māoridom. (P6)

The system's design allowed for persons within that system to oppose biculturalism, and participants articulated the overt and covert processes that minimized or scapegoated Indigenous approaches. These processes denied the salience of cultural identification in healing and participants described how professionals in positions of power ignored cultural protocols in day-to-day practice. As one participant related, these processes could be passive and covert wherein:

> I'll often be in situations where I know it should be happening and it doesn't. I feel it acutely, but it doesn't seem recognized by others. When I say, 'Why isn't it happening?' I'm treated in a manner that dismisses not only the topic but my stance. (P13)

In other instances, participants expressed how persons of authority actively belittled Indigenous approaches. One participant described it in this way: "In the real world, it's quite

different- you get a lot of psychologists laughing at a culturally specific approach. . . calling it window dressing" (P7). Another highlighted opposition in the following statement:

> When the American…, our top clinical psychiatrist, entered the room, sat with us, and said 'Clinical takes precedence over cultural any day. That's how it's gonna be,' in front of three Māori from this world, then you know our people ain't gonna matter. (P14)

At the same time, participants described how powerholders oppose cultural practices through scapegoating tactics, blaming marginalized communities for their disenfranchisement. As described by one participant: "This idea is quite widespread in society: Why don't Māori just get past their issues; like, why are they still stuck in the past talking about issues, these issues?" (P6). Such scapegoating was described as neglecting the complicated impact of systemic racism and cultural trauma, as P2 explained:

> Fundamentally, it's failing to link mental health problems with colonization, if those links were made and we were seeing all of these impacts as the history of dispossession, loss of culture, loss of land—if we were viewing it from that perspective, then we would be looking at very different solutions. And as long as we see the problem rooted in individuals, we will never tackle those other issues.

Participants described opposition tactics as methods to negate context and history, while rejecting the importance of culture within healing. They expressed that due to this minimization, the funding provided for culturally-specific services has been reduced. Many participants belonged to or could name kaupapa organizations that lost government contracts and funding. As one participant shared, "culture is the first thing to go when money is on the table." As described by P19, whose kaupapa Māori service lost funding due to their decolonizing focus, "We had a contract through the mental health sector, then they decided it didn't fit and the contract was actually taken away from us". Through opposition tactics, participants were left feeling that they were denied places at the table.

Position 2. Resistance: Negotiating Through Manaakitanga

Resistance has historically been Māori's course of action in guarding against colonization (Cohen, 2014). In mental health arenas, resistance serves as a tactic for countering the dominance and colonizing effects of Pākehā mental health knowledge and practice (Cohen, 2014; Ranguhuna et al., 2018; Taitimu et al., 2018). Treatments that overlook the needs and resources of Indigenous communities can have adverse effects on those communities through the promotion of monoculturalism (NiaNia et al., 2016). As P2 described, "using Western psychiatric and psychological models on an indigenous population is deeply offensive, and it's deeply destructive to be transplanting those models."

Resistance-based stakeholders explained that they became kaitiaki (guardians) when they refused to accept or comply with mainstream services that could endanger their communities. In addition, stakeholders engaged in resistance, sought to protect Indigenous methods from appropriation by Western paradigms. They characterized such resistance as commitments made to maintain the integrity of cultural models, from being colonized, adopted, and diluted by Western paradigms. P29 explained:

> Every time we enter a discipline, we have had to transform it, make it relevant to the culture and not the Western way of being and doing. We know these ways of working, they are our traditions, [but] when they are "discovered" by the West, suddenly we need to be certified and licensed to do them. It is another act of colonization all over again.

To enact a resistance stance can also refute contemporary and problematic ideas popular in Aotearoa culture- that Indigenous culture is static, and pre-colonial. These static views have promoted an essentialized view of Indigenous culture, which is resisted through actions such as P16's suggestion that he "challenge[s] my people to remember that culture is not just a box you can tick—in Māoridom, there is a function behind culture," as asserted by P16. Another participant shared that resistance to colonization, appropriation, and essentialization, have left many Indigenous practitioners wary of "working with people who do not share the balance of

power" (P28).

In the resistance stance, clinicians coached clients on their rights so that clients could be self-determined rather than system-determined. P14 described the process in this way: "Whenever I can, I'll sit alongside these people and I will say, 'whanau, you need to go in with your code of rights, because this is about your rights.'" Practitioners also worked with communities to promote liberation from historical trauma. As P20 described, "The path to health has to be in empowering people, politicizing, and supporting." P17's words echoed this thought: "It's all around trying to conscientize our own."

Resistance appeared as a process in which clinicians support each other, guiding clients to culturally-safe practitioners, and educating communities on their rights and resources. P24 described these efforts in this way: "I always make sure they get the support they need but make sure they get it from the right sources. I become like a sieve." Participants described resistance efforts as changing how clients approach the system, assisting them to enter and utilize the system, actively and with information rather than through unquestioning passivity and compliance.

Position 3. Assimilation: Negotiation Through Conforming and Kūpapa

The discursive position of *assimilation* denotes the Western acquirement of Indigenous cultural protocols and workers. As described by P8, "It does feel like you can be bicultural within our culture. 'As long as you don't make too much song and dance about it, we'll let you do this.'" Through engagement in the field and discussion with cultural partners and participants, what emerged within the system was a recognition that cultural workers, approaches, and organizations had become absorbed and integrated into the mainstream clinical cultures, assimilating to the standards therein. The first author noted that frequently, cultural protocols

appeared to have a limited, standardized role in treatment. Overall, the culturally-based clinicians suggested that their, once specific roles, had become indistinguishable from the clinical members.

All participants, regardless of Indigeneity expressed awareness of their tendency to assimilate into the system. While participants were hired as cultural liaisons and workers, they recognized that they had conformed in actions of intentional compliance with the ideologies and practices of Western mental healthcare. These actions occurred in response to the struggle to stay afloat in the underfunded mental health system. Given the state of the mental health system, many described feeling powerless to fight culturally-negligent practices. P10 noted, "I find it easy to assimilate to the system that I'm working in, and quite often I don't see that I have a lot of power to do anything. So, I just go along." Feelings of helplessness and constrained by organizational policies and requirements to use evidence-based practices also contributed to assimilative negotiations, described by P2:

> I don't think it would be responsible for me to decide I am going to make up new ways of working just because I disagree with management... I am relatively powerless… If I were speaking up against injustices I see going on in my workplace, I probably wouldn't be in a job anymore. I'd just be pushing shit uphill.

In the assimilation position, participants described how Indigenous practitioners who conformed to Westernized practices became kūpapas. Like the concept of an "Uncle Tom" (P9) a kūpapa is someone who works within and is co-opted by Pākehā institutions. Kūpapa cultural workers were portrayed as those who negotiated away the integrity, principles, and needs of Indigenous communities to further their personal ambitions and gains. As P24 put it, "so, you have a Māori name, you have a Māori plan, but you still think white." Māori and Pasifika who kūpapa within the mainstream were more competitive hires than cultural workers who resisted assimilation. P18 said, "In this region, if you're a Māori guy who can talk the talk and smile the

smile, you're in. Forget the rest of us." Employing kūpapa workers allows mainstream services to fulfill governmental funding priorities (i.e., increased Māori workforce), while keeping Māori on staff who provided Western rather than Indigenous services. Of all the negotiations described by stakeholders, kūpapa elicited the most anger, sadness, and disappointment and was largely described as a process of internalized colonization. P14 shared:

> The kūpapas, within our world, all these different variations of labeling that impacts our own people. There are people that are all of those things with good intentions, but they're frowned upon by their own for selling us out. At the end of the day, assimilation did its job and did it well. It separated us, divided us, conquered our thinking.

Position 4. Maneuvering: Negotiating Through Tokenism

Maneuvering is a discursive position described by participants as occurring at each level of potential client interaction (e.g., within the organizational culture, as enacted by the worker, and through encouraged techniques). Maneuvering appeared to be a process by which those organizations who have power through government contracts and state funding manipulate indicators of culture, such as use of te reo in agency names or cultural protocols in sessions, to achieve the appearance of biculturalism. P2 explained how within the organizational culture his "experience around culture, if not from the dominant European culture, it is an add-on rather than anything integral to services."

Whereas in the assimilation position cultural workers were employed and subsumed into clinical work without the use of cultural protocols, through maneuvering, Indigenous approaches were used but in a tokenistic way. Like previous critiques of the cultural competency movements (Gone, 2015; Kirmayer, 2012), what became apparent is that oftentimes culture was intervention in a method that was cosmetic, rather than transformational. As P6 stated, "It is a very shallow, superficial way of looking at mental health services." These add-ons appeared to participants as simply a means to an end to satisfy funding or licensing requirements, rather than a genuine

engagement with bicultural practices.

Maneuvering is best depicted by the tokenizing actions of policies, agencies, and individuals who engage with culture in superficial ways. Agencies and clinicians were described as reliant on boilerplate cultural inclusions that perform culture as "lip service", "window dressing", a "tick in the box", or a "checklist." Although governmental entities have created blueprints for engaging Māori employees, culture, and clients, participants characterized these efforts as tokenism that stems from a lack of genuine policy involvement and funding. The policies in place suggest that culture is important, but participants felt there were no clear guidelines on how to engage in practices to fulfill those policies and no safeguards to enforce requirements. P10 asserts "it is the kind of thing we can just chuck aside without much legislative obligation. I don't see that we have a specific law that enforces us to do that cultural work." Another participant pointed to the superficial use of te reo (Māori language) in official documents as a political move to gain favor and placate Māori. As P18 described, te reo is used "to soft sew and put a veneer over the policy . . . to make us feel it's all right and not make us suspicious."

Similarly, participants experienced efforts to increase Māori and Pasifika representation in the workforce as tokenistic efforts towards appeasement. P8 states, "government will go, 'We've got so many more Māori and Pacific.' That's great, but ultimately, we need resources here as well. That's the important thing: it's not either/or, it's and." Indigenous workers described how they filled spots required for funding, as noted by P22: "I suppose when they've needed an extra body in the training, I'd go along. They want to make sure they are being culturally appropriate, or, you know, increase responses." These participants differed from those who described assimilative positions, in that they directly engaged in cultural work, however,

frequently delivering culturally competent techniques rather than culture as lived experience. Throughout interviews, participants emphasized that at the governmental level, Pākehā have primarily led policy changes that have resulted in tokenistic gestures, the lack of an engaged workforce, and a lack of funding. P7 said, "I think while there's efforts, they're still being led by Pākehā. On a superficial level, it's still top-down."

Position 5. Collaboration: Negotiating Through Unsettling and Bridging

The discursive position of *collaboration* entails there is a recognition of the benefits and limitations of Indigenous and Western paradigms to stimulate broader knowledge. For true collaboration to exist, Pākehā must fulfill the commitments of trust placed upon them to advance Indigenous mental health knowledge alongside Western mental health knowledge. This might mean forwarding Indigenous needs over those of Western ambitions. In contrast to the opposition stance, which maintains power and the resistance position which fights power, the collaboration position carefully shares and concedes power. As one participant described:

> We must see the world in threes: Māori, Pākehā, and Pasifika. As a Pākehā, you have to be willing to take a step back and to value the words and actions of your Māori/Pasifika colleagues. Sometimes you will feel stepped on but remember, it is colonization which is being stepped on- not you. (P26)

For Indigenous and Pākehā alike, working for bicultural health can be an unsettling process- an act of choosing discomfort by purposefully engaging with the difficult histories of the other. Part of being unsettled is learning to sit in the discomfort of providing culturally-aligned services when one is not of that culture. As P10 shared:

> That discomfort of being a non-Māori clinician working with a Māori client is something I don't think can ever go away. I don't think it should. It should only go away when the system enables it so that there isn't an issue. I guess that discomfort is something we experience as individuals but is a consequence of the historical context.

These feelings of discomfort extended to Indigenous participants who experienced unsettling feelings when working between two cultural systems, as P18 explained:

> It wears you down, working in the community, and when you start trying to address that you are marginalized within the whanau, hapū [clan], iwi [kinship group, tribe]. You have to function, but you are still marginalized, and you know you are marginalized. I don't know how to describe the layers of marginalization that happen.

Collaboration requires an active process of decolonizing to unlearn internalized histories and processes, while at the same time cultivating an awareness of the perpetuation of inequality through current colonial practices. P10 described it as a reflective process: "I'm a lot more reflective now of if am I pathologizing what's existing, to ask … am I colonizing?"

Participants described collaboration as enacting bridges across cultural systems, to become interpreters, mediators, and advocates in the negotiated spaces. These actions included not only bridging Indigenous and Western epistemologies but also bridging between the mental health system and client communities. P14 stated:

> When you say that in a Pākehā context- I am already translating across to Māori dictation… So, what we do is become the translators of a language they don't understand, and we translate it across into a Māori context that they might grab a hold of.

Collaboration must move beyond translation, as described by P22, real collaboration means changing the way clinicians work with diverse cultures: "Initially you got seen as interpreters… But then it changed to bridging the culture around some of the practices, or the best way, or safe way to talk to a Pacific family." Collaboration was described as providing increased availability and relevance of services. It serves as a strategy of hope but can also be one of frustration, requiring practitioners to return to an issue multiple times from multiple avenues to achieve the best outcome, as described by P14:

> We are the translators, we are the interpreters we do that all. We advocate, we translate, we interpret. And sometimes you don't get that right either, so you tailor the fit. And you know, hopefully you've landed the waka[8] on the shore

The participants who characterized collaboration appeared confident in the value within

[8] Waka- canoe, spirit medium

negotiated spaces. They saw the possibilities of both cultures and knowledge systems, and a path to bringing them together, not to merge into one, but to sit side-by-side, informing and guiding each other.

Discussion

The negotiated spaces framework describes the boundaries between worlds, the in-between spaces where there are infinite possibilities for connection. The current study positioned the intercultural interactions within bicultural mental health as negotiated spaces between Western and Indigenous lifeworlds (Jackson, 2017). From our critical-interactionist analysis, the negotiations in these spaces hinged on power; ranging from discourses of denial to collaboration. As seen in Figure 1, most positions remain in the Western-dominant axis, indicating which discourses maintain the most power in the system. From our analysis, these positions oppose, commodify, and essentialize Indigenous knowledge systems.

Power in negotiations can become power over, as seen in the opposition stance, or power against, as in the resistance stance. The oppositional discourses that emerged appeared to be grounded in a subtle cultural imperialism, adopted by organizations, supported by the government and that relied on delivering mental health treatments established through an evidence base of Westernized positivistic science (Bennett & Liu, 2018). The resistance position acts as a safeguard against insidious colonizing and to counter the assimilation, oppression, and appropriation of Indigenous knowledge (Cohen, 2014). Resisting the dominant narrative of the superiority of Western-methods puts practitioners at risk of politicization, being depicted as non-hirable, and exclusion from government funding. At the same time, in the absence of Indigenous engagement, mainstream mental health stakeholders promote an essentialized and primitivist Indigeneity or neglect it altogether.

In the assimilation and maneuvering positions, Western paradigms insidiously use power to "ameliorate" Indigenous health while subsuming cultural ways of healing. Assimilation serves as a tool of colonial powers that aim to "civilize" Indigenous others (Veracini, 2017) and generate a magnetic pull toward the belief in the superiority of Western science (Bermúdez et al., 2016).The power play of maneuvering subsumes Indigeneity through tokenistic cultural packaging (Gone, 2015).

The terrain of the negotiated spaces consists of distinctive yet interdependent lifeworlds; the social arenas where the bicultural negotiations occur between Indigenous and Western knowledge systems. In these intercultural spaces, there is an awareness that the colonial self is an identity related to the identity of the Indigenous self (Bhabha, 1988). The negotiated spaces framework problematizes binary descriptions of Indigenous/Western, and clinical/cultural, that emerge in debates about biculturalism (Cohen, 2014). Throughout the interviews and interactions with participants, it became evident that persons who held Western and Indigenous social identities were involved in the positions of negotiations, and that no one position "belonged" to a culture over another. Each position was described with tensions for the Pākehā , Māori, Samoan, and Tauiwi participants, who identified times when they relied on discourses of opposition, resistance, assimilation, and negotiation to further their goals of advancing bicultural mental health. In discussions with participants, it became clear that to develop a just bicultural practice, that both Indigenous and Western knowledge systems must enter the negotiated space while recognizing the unique contributions and barriers of both.

Entering Negotiated Spaces

The negotiated spaces framework provides entrée into "ethical spaces of engagement" (Ermine, 2007, p. 193). Such movements recognize that the constructed dichotomy between

Colonial and Indigenous entities neglects the intertwined patterns of engagement that enact power and resistance. To enter these negotiated spaces, policymakers, scholars, and clinicians must first recognize that the ideological goal of biculturalism is to challenge monoculturalism (Bennett & Liu, 2018). The findings of this study suggest that the predominant steps taken thus far in the development of a bicultural mental health system neglects the extent to which cultural practices are situated in Eurocentrism (Wendt & Gone, 2012). Scholars, clinicians, and clients alike exist in contexts structurally reflective of the dominant society. The findings of our analysis give evidence of a conversely unidimensional biculturalism that minimizes the personal and collective significance, dynamism, and mutability of culture. This focus limits ideas of culture to the "Indigenous" rather than an understanding that systems, like mental health systems, create and maintain their own cultures (Gone, 2015).

We framed our analysis around the distinctions of clinical and cultural, Indigenous and Western, as defined currently in Aotearoa's health systems (Health Research Council, 2017). This cursory terminology overlooks the fact that the Westernized clinical world is a culture (see Calabrese, 2008 for a discussion) that shapes the decision-making processes of service providers, understanding of symptoms, and the interactions between providers and clients (Came & Tudor, 2016). This culture is dominated by medicalized and individualized healing, predicated on a positivist science that determines the constitution of evidence (Taitimu et al., 2018). In this study, it appeared that this culture was determined and enacted by the organizations and professionals who took positions of opposition, assimilation, and maneuvering. Thus, what is deemed "evidence-based" becomes intimately bound in the decisions of policymakers from the advice of those who benefit most. Our findings indicated that bicultural practice hinges on governmental directives (see Health Research Council, 2017 for examples). From this stance,

monocultural practices promote an evidence-based approach developed by and for Westernized populations, while simultaneously espousing beliefs in integration of Indigenous healing (Ministry of Health, 2017). Yet, when leaders in health systems discuss Indigenous approaches, Indigenous science and evidence is neglected (Health Research Council, 2017). Indigenous becomes synonymous with culture, and culture becomes a term that separates Indigenous science from Western science. The relegation of Māori and Pasifika health to a cultural versus scientific endeavor was described in the positions of opposition, assimilation, and maneuvering, where Māoridom was positioned as pre-colonial and static and Western as non-cultural.

The less we understand culture as lived and mutable experience, we overlook how cultural identification is situational and dynamic (Good & Hannah, 2015). Current multicultural frameworks in healthcare promote cultural competency approaches (Gone, 2015; Kirmayer, 2012). As others have argued, the more we focus on developing the competency to work with a culture, the more we reduce that culture to symbols (Wendt & Gone, 2012). Shifting our focus from the development of culturally-competent modalities, we can seek understandings of the uniqueness of our clients while focusing on understanding our own cultural identifications. This requires that clinicians become aware of the ways in which culture manifests at differing levels, through time and within institutions. In doing so, clinicians learn to recognize that Westernized mental health practices are deeply rooted in colonialism and privileges individualism and Western ways of knowing (Paradies, 2016).

Implications

When the negotiated spaces are genuinely engaged, bicultural mental healthcare has the possibility of reflecting a wide array of epistemological orientations, ethical perspectives, goals, implementations, and political priorities. However, from our study it appears that stakeholders

may manipulate directives to maintain their positions and funding within the system. As described in the maneuvering position, simply adding te reo Māori to policy directives, or encouraging tokenistic, additive cultural cues, stymies genuine bicultural negotiations (Gone, 2015). From the assimilation position, the increased Māori and Pasifika workforce became meaningless when the causes of Māori and Pasifika overrepresentation in mental health were not addressed (Taitimu et al., 2018). As described by our participants, it is not enough to simply provide access to a service provider who "looks like" the client, if that clinician is unable to offer relevant services, supports, and resources. At the same time, it cannot be assumed that all Māori and Pasifika clients desire culturally-informed services. Relatedly, persons hired as cultural workers described being marginalized at work. This marginalization was evident when colleagues denounced cultural services as being less informed and expendable, which often led the workers to perform mainstream practices. Organizations must safeguard cultural workers, and their practices, from subtle and micro-aggressive assimilative efforts through consciousness raising and embracing cultural work as a constitutive element of healing and clinical practice.

Professionals and organizations in the collaborative and resistance stances echoed similar sentiments. They described that when they moved outside of the expectations of mainstream mental health culture to provide genuine bicultural health, they were often excluded from funding and contracts. To address this bind, we suggest that the funding mechanisms and policy-drivers intentionally seek out Māori and Pasifika leaders to sit on executive boards that determine grants and contracts. Similarly, kuapapa Māori and Pasifika organizations should be fully funded for the provision of services, and accompanying standards of care that might fall outside of the "mainstream."

Evident in the emergence of cultural-safety models (Wepa 2015), researchers and service

providers who redefine treatment (Bennett & Liu, 2018), and in kuapapa Māori community services (e.g. Tu Tama Wahine o Taranaki), Māori self-determination has led to the reclamation of Māori's place in society and science (Durie, 2011).The development of healing programs for and by Māori (Rangihuna et al., 2018) provide therapeutic interventions as a "means for (a) providing treatment in a culturally tailored and compelling manner, and (b) redressing the legacy of colonization by affirming robust indigenous identities, institutions, and practices" (Wendt & Gone, 2012, p 214). While these programs are continuing to evolve, in Aotearoa they exist within the tacitly monocultural landscape of bicultural mental health. Nonetheless, they continue to seek harmonization with Western modalities while recognizing the sovereignty of Indigenous science (Bennett & Liu, 2018; Cavalieri, 2013).

Throughout our interviews, participants described how this harmonization cannot occur until the meaning of biculturalism is explicitly defined in conversation with political, community, and academic leadership. At the same time, serious engagement with Māori and Pasifika must move beyond ideas of inclusion and into the realm of true partnership, as outlined in Te Tiriti (Came & Tudor, (2016). Participants described how issues of racism and diversity are frequently glossed over in Aotearoa society, and more specifically in mental health (Paradies, 2016). To begin bicultural negotiations, racism must be recognized, biculturalism must be better defined, and there should be active involvement with Māori models of self-determination (Durie et al., 2018) that move beyond precolonial ideas of Indigeneity (Wikaire, 2020). Similar calls are made in other fields and explicit suggestions for achieving harmonization can be found in education (see Fleras & Spoonley, 1999; Louie, 2015 for discussions). What has become clear from this study is that monoculturalism continues to dominate within a bicultural framework. Until we take seriously the science, achievement, and resistance of Māori and Pasifika scholars

and practitioners, we will maintain a monocultural framework that is oppositional, assimilative, and tokenistic to indigeneity.

Limitations

This study was bounded by our positionality as researchers from the United States. The differing political, cultural, and historical processes, systems, and traditions between the researchers and the participants influenced this project. As with any study that brings knowledge from one culture to another, we translate these findings with caution. There is value, however, in critically questioning the beliefs and ideas taken for granted by settler colonial nations and their outcomes for mental healthcare in any country.

The heterogeneity of the participants was a conscious choice made to further the goals of this study, although it limits the generalizability of the results. However, generalization was not our goal, and maximum variation sampling allowed us to build a sample reflective of the mental health services and cultural demographics of the nation. We did oversample for Māori service providers, which was a strength of this project, as it is often the Indigenous members of a society whose voices are the most marginalized. On the other hand, as the lead researcher was a Western-trained psychotherapist and scholar it is possible that the participants withheld information due to a lack of trust. Guarding against this possibility, the lead researcher spent a year living, working, and learning beside Māori kaumatua and Samoan matua (elders).

The method of situational analysis served as both a strength and a limitation. This approach emphasizes the relations between discursive elements to represent the conceptual tensions in the situation of interest (Clarke et al., 2017). Rather than providing strict analytical guidelines, processes are guided by broad conceptualizations of what analysis can be. We found this method offered a creative space for working with data that we utilized to challenge our

notions and standpoints. The act of mapping allowed us to reflexively enter the data with an eye toward the sociopolitical context of Aotearoa. The fact that we presented our results linearly, represents one concern, rendering it possible that the unidimensional maps may suggest that participants, experiences, discursive positions, and cultures are linear. We acknowledge that this is a limitation of the unidimensional space of writing and drawing, and that in reality, the emergent positions of power and discourse were porous, mutable, and transitory.

As with any research, results are limited by the researchers' worldview and application of theory and researchers may stray from the intentions of participants. This risk led to the first author's use of korero mai, an interview method described as a culturally-responsive approach to decenter the researcher when researching with Māori (Swadener & Mutua, 2008). Through these conversational meetings, participants provided their narratives in their own ways, discussing what they found meaningful (Baker, 1998). The interviews resulted in a broad range of data, which is both a strength and a weakness of the current study. In making critical choices about what to include and what to leave out of the analysis, it is possible that we strayed from the meanings expressed by the participants. To guard against this risk, participants were able to member check findings. Yet, we recognize that while findings and implications are specific to the mental health and political systems in Aotearoa, they are also implicative of the first author's Tauiwi-Pākehā status.

Conclusion

In our ever-expanding and complex societies, it is crucial for mental health practices to cultivate different methods of healing. In Aotearoa, attempts to develop an inclusive bicultural mental health system traverse the terrain between Indigenous and Western cultures. The negotiated spaces on the boundaries of these knowledge systems are areas in which the

relationships between different, similar, conflicting, and harmonious cultural ideas of mental health and healing can be explored. When entered purposefully, negotiated spaces become places of encounter and reconstruction, guiding treatment decisions that maintain resonance for all clients living in multicultural yet Western-dominant societies. We must actively meet midstream to bring in the waka of healing from other cultural shores, thereby expanding our knowledge of what is health and what is healing. To do any less would be to continue the legacy of colonial erasure of non-European cultures and bar Indigenous self-determination.

Notes. Hara ahau i te tangata mohio ki te korero otira, e tika ana kia mihi atu kia mihi mai. Throughout this manuscript, I use te reo Māori with English translations in footnotes as a political gesture to maintain Māori centrality. English translations are Imperial interpretations that are often linear, while in te reo words have many meanings that speak to a multidimensional cosmology.

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Table 1

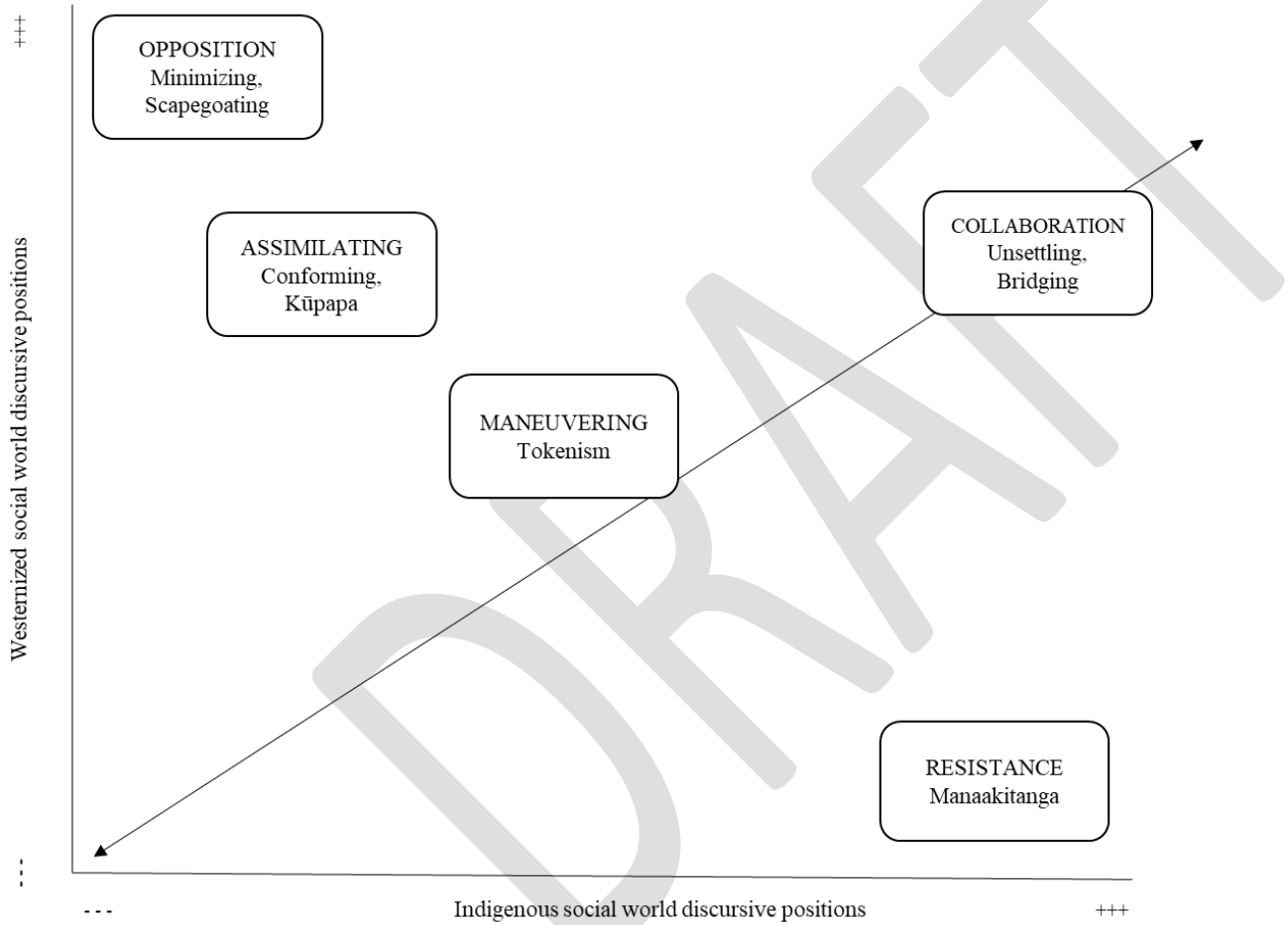
Participant Demographics and Occupational Characteristics

Demographics		Profession		Setting	
Culture/Ethnicity		**Occupation**		**Practice**	
Māori	10	Psychotherapist	8	NGO	9
Pākehā	9	Social worker	5	Kaupapa Māori	7
Tauiwi	7	Psychologist	4	District Health Board	7
Pasifika	4	Mental health advocate	3	University Clinic	5
Gender		Peer counselor	3	Private practice	2
Female	19	Psychiatric nurse	3		
Male	11	Whanau advisors	2	**Region**	
		Community advisors	2	North Island	24
				South Island	6
				Area	
				Urban	24
				Rural	6

Note. N = 30.

Figure 1.

Discursive Negotiation Positions



Note. This figure illustrates a map of the major discursive negotiations that were described by participants as occurring in the social arena of bicultural mental health discourse.