2
A Pōwhiri Poutama Approach to Therapy

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Abstract
The Treaty of Waitangi calls upon both parties to work together for the benefit of the community. An approach to understanding the psychotherapeutic process is offered which draws on knowledges from both Māori and western psychotherapeutic perspectives.

Introduction

In his Waitangi Day address of 1989, Judge Eddie Durie pointed out that if Māori are the tangata whenua, the original people, then Pākehā are the tangata tiriti, those who belong to the land by right of the Treaty (CCANZ, 1990). Durie argues that as a Bill of Rights for both Māori and Pākehā, the Treaty places obligations upon both parties to form a partnership that benefits the community. Tolich (2002) has noted that a widespread 'paralysis' has arisen among Pākehā researchers (and I might add practitioners), for fear of breaching cultural boundaries. This 'paralysis' is creating some difficulties for Pākehā therapists in meeting their obligations under the Treaty to treat Māori clients adequately (Article Three) (Orange, 1987). In my own experience, I have also encountered a number of Māori practitioners attempting to fit their knowledge of Māori into existing non-Māori paradigms, as this is what they were taught when studying for their qualification. As Tolich notes, the exit from this bind lies through the development of cultural safety (Wepa, 2004). This paper explores an approach to psychotherapy which, if goodwill is shown by all sides, can allow cultural safety and Treaty obligations to be met.

The client's 'theory of change'

Meta-analytic studies and 'common factors' research have consistently failed to find major superiority in any particular model of psychotherapy (Asay & Lambert, 1999; Wampold, 2001). This in turn has led Duncan and Miller to develop an approach to therapy where the client's own assessments of progress and the therapeutic alliance are central (Duncan et al., 2004), allowing the therapist to utilise any approach if it is

judged by the client to be working. They call this a client-directed, outcome-informed (CDOI) approach (Andrews, 2007; Drury, 2007). This approach is congruent with the call for cultural safety in Aotearoa New Zealand, where the power of definition is given to the person served (Wepa, 2004).

One of the central tenets of the CDOI approach to psychotherapy is that the client will have a 'theory of change' or 'life view' (a 'folk psychology'; Bruner, 1990). Aligning ourselves as therapists with this 'theory' will enhance the therapeutic alliance and make it easier to utilise the client's own strengths, the two factors that have the largest influence on successful outcome (Duncan et al., 2004). In reviewing the common factors research, Duncan and Miller (2001) suggest that rather than integrate the various approaches into a single eclectic 'meta-theory' we would do better by matching our clinical orientation to the client's 'world-view' and psychology of problem resolution. For example, Scheel et al. (1998) found that when the therapists' and the clients' rationales were congruent there was greater success, and Hubble et al. (1999) report that when there was a match between clients and therapists as to whether alcohol was best treated as a disease or as a learned habit outcomes were higher. As solution-focused therapist Insoo Kim Berg says, the art of good therapy is to aspire to the Zen saying – 'leave no footprints in your client's life' (Berg, 2006).

Therapy as a rite of passage

It has been suggested that Turner's ritual process might be helpful as a meta-theory of psychotherapy (Epston & White, 1992; Grof & Halifax, 1977; Kobak & Waters, 1984). Turner, following van Gennep (1960), proposed that there is a three-stage process in transitioning from one social position to another, and that rituals facilitate such transitions. First there is a separation stage, where one becomes detached from familiar roles or social positions, followed by a liminal stage where one is 'betwixt and between' ('no longer/not yet' status), and ending with the post-liminal or reintegration stage where one re-enters the social world but now occupies a different position (Deflem, 1991; Turner, 1969). An individual in crisis can be seen to have become separated from their usual way of being, and is in search of a new status or way of being where they can say 'Now I can go on' (Wittgenstein, 1953, no. 151). Such transitions occur during developmental changes such as puberty, as well as times of affliction, grief and crisis.

'Knowledge'

It is perhaps useful to consider the peculiarity of western cultures' Cartesian understanding of 'knowledge', which is now so widespread it passes almost unnoticed. Let us begin by considering the distinction between performance knowledge (e.g. riding

a bicycle) and intellectual knowledge – a difference between 'know how' and 'know that'. Descartes' legacy, philosophers have argued, was to try to position 'know how' as a form of (or expression of) 'know that' (Austin, 1961; Rorty, 1979). This was because Descartes' philosophy of science was based on a theory of perception developed by Renaissance artists obsessed with obtaining accurate three-dimensional representation (Foucault, 1971; Romanyshyn, 1989), and led to the idea that the primary function of perception was to accurately represent the world. From this idea that knowing what 'something is' occurs first, Cartesian philosophy was led to the idea that action or performance follows from it.

An alternative view of the function of perception has arisen in recent years, suggesting that its primary purpose is not so much to identify what things are in the world ('know that') so much as to keep track of our relationship with the world (Gibson, 1979; Noë, 2004). Perception is the development of sensori-motor skills to maintain this relationship – a matter of 'know how'. Wittgenstein (1953), Rorty (1979) and other philosophers further argue that intellectual knowledge ('know that') arises out of 'know how', and not the other way around as Descartes and his progeny (including Cognitive Behavioural Therapy) have suggested. Unfortunately, as a result of 400 years of privileging representational knowledge over performance knowledge, a form of illiteracy has arisen in western culture, with regards to feeling at home in the world or knowing how to 'go on' with each other (Drury, 2006; Shotter, 2005).[1]

We witness this obsession with representational knowledge today in the importance given to obtaining a comprehensive assessment of clients. As outlined above, the CDOI approach places primary emphasis on developing and maintaining a relationship with clients (although a tacit function of a mental health assessment is that it may allow this relationship to develop). Most of the postmodern and poststructuralist approaches to therapy privilege the development and maintenance of the therapeutic alliance (performance knowledge), and generally take the view that any 'assessment' or representations of the problem will arise during the course of the conversation. Whether such 'assessments' are recorded becomes more a matter of taste (or the result of edicts from Cartesian third parties).

Understanding the role of 'performance knowledge' is of particular importance in understanding non-Cartesian cultures and the role of ritual. Cultural 'performances' are not expressions of 'beliefs' (representational knowledges, or 'mātauranga' in Māori), but rather 'beliefs' are expressions of performance ('way of life' or 'mohiotanga') (Geertz, 1973; Royal, 2004; Wittgenstein, 1993). Non-literate cultures store knowledge, not just in oral traditions, as those enamoured of Cartesian science would have us believe, but also in the performance of ritual. Whereas structuralist

anthropologists such as Levi Strauss, under the sway of Cartesian science, regarded ritual as an expression of cultural beliefs or myths (and the task of science was to expose those beliefs), poststructuralists saw that rituals had the property of 'multivocality' and 'unification' (Turner, 1969). That is to say, they were open to numerous interpretations, and contained ways of unifying a culture through various social dramas.

Turner (1969) described his approach to understanding ritual as 'anti-structuralist', but today one might call him one of the first poststructuralists. In brief, knowledge of the social dramas of life is 'packed' into ritual performances and can be 'unpacked' for a variety of situations. As Turner noted, rituals are made up of 'storage units'. For example, for New Zealand Māori, the pōwhiri ritual, among its many interpretations, can be taken as a set of instructions on how to conduct an appropriate courtship (Wharekura, 1996). Royal (2004) notes that Māori Marsden suggests that mohio-tanga (performance, 'way of life') is a higher form of knowing than mātauranga (belief). According to Marsden, ritual can bring forth experiences from te kete-tuatea (the third of the three baskets of knowledge Tāne brought back from the twelfth heaven), experiences that take us beyond 'space and time' (Royal, 2003). Here we can experience our oneness with each other and the past, and this can be therapeutic in that we can 'pick up a missing stitch', so to speak.

Ritual and collaborative therapy

During the liminal stage of ritual, Turner noted that all performers are equal and no longer occupy 'hierarchically arrayed positions' (Turner, 1967, p. 100). We recognise this 'communitas' relationship, as Turner called it, as the collaborative stance in the postmodern psychotherapies, where as therapists we are no longer positioned as experts on how our clients are to live or the arbiters of the meaning of their lives or difficulties. Our expertise lies at the performance level, in that we know how to facilitate conversations where tangata whaiora ('seekers of health') can discover how they wish to live and make their own meaning of their lives (Drury, 2006; Holmes, 1994).

The pōwhiri poutama

Durie (2001) observes that we haven't fully appreciated 'the potential of marae encounters for shaping thinking and behaviour and providing guidelines for codes of living' (p. 70). The ritual that is most familiar to New Zealanders today is the pōwhiri, and it is enacted most commonly as a welcome on the marae. Paraire Huata (Te Ngaru Learning Systems, 1997) has developed what is called the 'pōwhiri poutama' model to represent learning or development based upon the processes contained in

the pōwhiri. Poutama is a stairway design commonly seen in tukutuku (weaved lattice) panels on the walls and ceiling in whare whakairo (decorated houses). A pōwhiri poutama, then, is a meta-map, or framework for the task of scaffolding across a developmental phase, a learning, or therapy.[2]

In Māori culture, Turner's stage of separation (or that of van Gennep, 1960) is when the tangata whaiora has become detached or alienated from their usual ways of being, and comes seeking help. Marae protocol positions the tangata whaiora as tapu (unsafe, his/her potentiality is restricted) before being called to the pōwhiri. The marae has a narrow gate (te waharoa) that the visitor has to pass through before entering the marae ātea (courtyard). A sightseer, or a person (a prisoner) sent or forced to go to a marae would remain outside the gate, would remain tapu, until such time as they wanted to take part in the pōwhiri process. There is even a challenge (wero) to ascertain whether the visitor's intentions are honourable. In a wero the warrior (kaiwero) is watching closely the non-verbal response of the visitor to see if their intentions are fitting. Many clients arriving for mental health are not tangata whaiora (seekers of health), being forced by law or told to go by others, and protocol suggests that they remain tapu and outside the gate. Some from the host marae would go out and talk to the potential visitors, and whare (houses) may even be constructed outside the marae for holding such folk until such time as they wished to enter the marae. Motivational interviewing may be called for (Miller & Rollnick, 2002), or alternatively family or social network therapy (e.g. Seikkula & Arnkil, 2006) because the whānau are seeking help. In that case the person would be brought on by their whānau, or following Seikkula's lead we would visit their whānau on their marae.

The liminal stage

In his pōwhiri poutama Paraire Huata (Te Ngaru Learning Systems, 1997) has unpacked the pōwhiri process by suggesting seven steps that will enable an individual to cross the liminal space described by Turner. As we shall see, these steps are not unknown to non-Māori psychotherapists. A familiarity with them may enhance the alliance and allow greater utilisation of the tangata whaiora's resources, as well as allowing non-Māori therapists to better meet their Treaty obligations. These are performance knowledges that generate the context of therapy. As I understand these steps and the parallels they have with most therapies they are:

1. **Mihi**. This is the establishment of a personal and social relationship. It is the development of the therapeutic alliance. The importance of developing and maintaining this alliance as the key to successful therapy is reviewed above. The mihi would also include discussion about the take (the reason we are meeting). We should note that

Gassman and Grawe (2006) found that successful therapists focused on the client's strengths from the start, usually before moving on to dealing with their problems. In marae protocol this is the waioha tuarua – acknowledgement of the manuhiri or visitor's mana (the power of the life force to flow through you as a result of strong connections with land, history and social standing). In Māori protocol, if one party (tapu) overpowers another party (tapu) it signals a negative form of noa (freedom from restrictions), in that the person is rendered powerless, such as happens to slaves and prisoners. As such they are treated poorly, some going as far as to claim they are now otaota (rubbish). Thus a collaborative relationship is essential if we do not wish to position more mental health clients here. Durie (2001) notes this does not mean promoting sameness or abandonment of boundaries; rather, 'relationships based on vertical hierarchies take second place to relationships … of mutuality and reciprocal obligations' (p. 78).

2. **Karakia.** Opening to the divine. Most schools of therapy call for a surrender of self to allow the new to emerge, the most obvious example being Alcoholics Anonymous' call for the intervention of a 'higher power'. Acceptance and Commitment Therapy (ACT) invites the client to stop struggling in the quicksand of the problem, and when they do they begin to discover something (usually forgotten) that transcends the limited view they had of themselves. Solution-focused therapy utilises the 'miracle question', which invites clients to see that a kind of divine intervention has already occurred, but they had not noticed it before the therapist drew their attention to it. Most therapies call for the client to 'transcend their ego' in some manner. The collaborative schools of therapy also invite the therapist to transcend their own knowings by inviting them to embrace a 'not knowing' stance (Anderson, 2005). As Kunz (2002) suggests, it is this humility by both that makes therapy sacred. Epston and White (1992) have suggested that when we have entered that sacred zone of a collaborative relationship we lose track of time as we experience Turner's sense of 'communitas'.

3. **Whakapuaki.** Revealing. This allows that which is invisible to journey to a place where it can be known. While the structuralist or Cartesian thinking might interpret this as a requirement to plumb the depths of people's lives for suppressed secrets and the 'truth', Geertz (1973) and other poststructuralist anthropologists suggest traditional cultures tell and retell stories of their experiences, so that alternative plots and exceptions to dominating themes can emerge. The retelling originates. Rather than 'surface-depth' (which positions the therapist as the powerful judge of 'truth'), Geertz talks of 'thick-thin' stories. During this, and the next two stages, Māori talk of the 'loosening and binding'; a loosening from whatever was destructive and a

binding to what is life-giving. A collaborative therapist is sensitive to exceptions to problematic stories, accounts that lead to less problematic outcomes, and these can be 'thickened' (or 'bound') into preferred narratives. Now, rather than 'applaud' these tellings and retellings, which can be experienced as patronising by the tangata whaiora, the collaborative therapist shares what these stories have aroused in him or her, what curiosities have been awoken, memories invoked, etc. (Andersen, 1987). In this way the therapist, via revealing, is also open to being changed. While describing the interchange between orators, Durie (2001) talks of how an 'event on one marae will spark memories of similar events on other marae, perhaps several generations ago' (p. 84), and this sets off a series of exchanges. Royal Tangaere (1997) calls this whāriki, the weaving of the mat for us to sit on.

4. **Whakatangi.** Emotional shift or expression. Sometimes interpreted as 'weeping', this can suggest the structuralist notion of therapy as being a venue that facilitates a cathartic release of suppressed emotions, but a poststructuralist view suggests being 'moved'. Turner's 'communitas', the sense of being totally open and present to each other as equals, means that we will both be moved and become other than who we were as a result of these retellings. The tangata whaiora has moved into new ways of being and identity, and we feel moved to be part of this (White, 1997; White & Morgan, 2006). After such sessions many therapists report feeling refreshed and invigorated. 'Marae communities become powerful … by the capacity to negotiate mutually rewarding relationships … A marae encounter becomes robust when people leave feeling stronger than when they arrived' (Durie, 2001, p. 82).

These two steps, whakapuaki and whakatangi, I see also in Levinas' central idea of 'substitution' (Levinas, 1998). Levinas' 'ethics first' philosophy claims that our first response to Other is a reflexive one, and if I give myself to this 'call', opening myself totally to Other, then I am a 'hostage' of other. In this 'passivity', aspects of myself are drawn forth or elicited, and a new 'self' is created 'ex nihilo' (Levinas, 1998, p. 113). As the stories that are elicited by being 'moved' in this way are told, the emerging 'self' takes form.

5. **Whakarata.** In the pōwhiri this is the act of physical contact, when we hongi (press noses and share breath), handshake or kiss. In former times, Durie (2001) points out, the gap between guests and hosts was large enough to enable each to 'judge the intentions of the other, without presuming the outcome was to be friendly' (p. 75). In therapy, as progress is made, any wariness of our ability to benefit each other is 'tamed' (whakarata), and our confidence (whakarata) to plan the future together flows more easily.

6. **Whakaora.** Restoring wholeness. Bruner (1990) has suggested that in these rituals of

change there are alternating sequences of action and meaning, each engendering the other. As the tangata whaiora come to terms with their new ways of being, conversation turns to what actions this may lead to in the community. Therapists may also share how this experience might affect their practice in the future. The tangata whaiora is invited to reflect on what these changes mean for him/her/them. How will relationships be different? What is healthier about these relationships? By asking who would not be surprised by these developments, the tangata whaiora is invited to reflect on people from the past who were aware of this way of being, revealing a history. Thus 're-membering' of forgotten belongings can be facilitated (the 'missing stitch' is picked up). As Durie noted, Whare Tapa Whā thinking invites us to consider mental health problems not as 'isolated areas of dysfunction but as indicators that the balance between emotions, social relationships, spirituality and the body has become distorted' (2003, p. 48).

7. **Whakaotinga.** A covenant of maintaining the new way of being beyond this pōwhiri. Epston and White (1992) describe this as the preparation for the 'reincorporation' stage, the third stage in Turner's analysis of ritual process. This is the preparation for rejoining others in a familiar social world. This involves identifying and recruiting audiences who will join in the authentication of the change, and may involve celebrations, certificates, prizegivings, news releases, letters of reference and inviting the tangata whaiora to become a consultant in therapy for others embarking on similar challenges. Inviting the tangata whaiora to become a consultant for others, or 'therapist helper', is particularly useful in allowing an opportunity for reciprocity and keeping the relationship balanced. As Durie (2001) reminds us, the primary purpose of the koha (gift) is not so much to recompense costs, but to strengthen mutual obligations. Our mutuality is also symbolised at the end of the pōwhiri through the celebration of sharing food, the whakanoa which clears us all from the restrictions imposed by the ritual.

Conclusion

While learning the 'folk psychology' of another culture, there is a risk that some therapists may lose confidence in their own skills because of an awkward awareness of their own cultural biases. A slavish adherence to any treatment protocol can result in deterioration of the therapeutic alliance (Wampold, 2001). Some researchers have suggested that rather than purposeful training in the therapeutic models of particular cultures, further training in healing factors that all models of therapy share, the 'common factors', would be more useful (Fischer et al., 1998; Frank & Frank, 1998). That way therapy can be maximally tailored to the culture in which it is being delivered.

However, if the therapist utilises the CDOI outcome and alliance tools discussed above, he or she will be warned of any deterioration of the alliance or lack of progress. I have endeavoured to show that therapy with tangata whaiora does not eschew the use of many therapeutic techniques when delivered in a collaborative manner, and the pōwhiri poutama model is one way of thinking about this. Further anxiety can be reduced if the therapist employs a 'therapist helper' or co-therapist who is more familiar with the language of the tangata whaiora.

Notes

1. A close reading of Māori Marsden's descriptions of whare wānanga teachings suggests Māori 'science' was similar to Goethe's 'delicate empiricism' (Drury, 2006; Shotter, 2005). Best (1934) and Buck's (1949) descriptions of the tohunga role suggest criteria similar to Goethe's for 'delicate empiricists'.

2. Royal Tangaere (1997) has compared the pōwhiri poutama steps favourably with Vygotsky's Zone of Proximal Development (Vygotsky, 1978). Michael White has suggested that the task of therapy is to provide scaffolding questions to assist the client across a ZPD (White & Morgan, 2006).

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