Te Wetekina — The Loosing

When Strongholds Block the Autophagy Process:

A Kaupapa Māori Framework for Releasing Covenanted Patterns

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Abstract

This article presents the theoretical and clinical foundations of Te Wetekina — a precision protocol within the Dimensional Autophagy programme of Te Poutama Ora (TPO) for releasing patterns that resist the standard four-phase autophagy process. Where Dimensional Autophagy addresses five foundational dimensions of wellness across five months, Te Wetekina addresses a specific sub-category of pattern that the four-phase model alone cannot clear: the stronghold.

A stronghold, as the term is used within this framework, is a covenanted pattern — one that entered through a specific moment of wounding, survival decision, or ancestral transmission, and that has been maintained through a structure of implicit covenant rather than mere habit or conditioned response. Strongholds resist willpower, cognitive intervention, and cathartic expression because their root is not behavioural but covenantal: they require not better strategies but the dismantling of the altar through which they are sustained.

This article articulates the stronghold as a distinct clinical category, distinguishes it from adjacent constructs in trauma, attachment, and behavioural psychology, and presents Te Wetekina as a kaupapa Māori protocol that operates simultaneously at psychological, somatic, ancestral, and spiritual registers. The article draws on Māori spiritual epistemology, epigenetic transmission research, family systems theory, somatic psychology, and the psychology of religion to position Te Wetekina within and beyond existing clinical frameworks. It argues that some patterns — specifically those that entered through covenant and are maintained through ancestral altar structures — require spiritual authority as a primary clinical tool, not as supplementary to psychological intervention but as the mechanism through which the loosing becomes possible.

Introduction: The Gap the Four Phases Cannot Close

The Dimensional Autophagy programme moves participants through five dimensions of wellness across five months. For many patterns encountered — inherited relational dynamics, conditioned emotional responses, shame-driven beliefs, and accumulated somatic tension — the four-phase model of Recognition, Breakdown, Metabolisation, and Release is sufficient. The participant names the pattern, sits in the discomfort of dissolution, extracts whatever wisdom the pattern carried, and moves forward changed.

Clinical practice reveals, however, a consistent subset of patterns that do not respond to this process. The participant can name the pattern precisely. They have done the recognition work. They hold clear intention to release it, and they return to it regardless — at the same moment, in the same form, with the same pull. The pattern is not unconscious. It is not unnamed. It is covenanted, and covenanted patterns require a different clinical response.

Te Wetekina — from the Māori: wetekina, to loosen, to unbind, to free from bondage — is the protocol developed within TPO to address precisely this category. It is not a general wellness practice. It is a precision intervention, applied at the specific trigger moment of a specific stronghold, engaging spiritual authority as its primary mechanism. This article provides the theoretical and clinical foundations for understanding why Te Wetekina is necessary, what makes it distinct from adjacent frameworks, and how it operates across the five autophagy dimensions.

Theoretical Framework

The Stronghold as Clinical Category

The concept of a stronghold has theological history (cf. 2 Corinthians 10:4, Aramaic Peshitta tradition) but requires clinical translation if it is to function as a precise therapeutic construct. Within the TPO framework, a stronghold is defined as: an ingrained pattern of thought, behaviour, or relational dynamic that has become fortified over time — through generational repetition, spiritual wounding, or the repeated covenanting of survival responses — and that resists standard intervention through a mechanism deeper than habit or conditioned response.

The distinction from ordinary conditioned patterns matters clinically. Conditioned patterns — the habits, emotional responses, and cognitive loops addressed through cognitive-behavioural, somatic, and mindfulness-based approaches — respond to awareness, intention, and consistent practice (Siegel, 2010; Doidge, 2007). The neural pathways that sustain them are plastic: with sufficient repetition of new patterns in changed conditions, they are replaced. Strongholds do not behave this way. They demonstrate what clinicians sometimes describe as ego-syntonic rigidity: the person is not simply unaware of the pattern; they are, at some level, invested in its continuation, because the pattern entered through a moment in which it offered something — comfort, protection, belonging, or the relief of familiar pain — and that offer has never been formally withdrawn.

Attachment theory provides a partial framework. Bowlby (1969) and subsequent attachment researchers demonstrate that early relational templates — the internal working models developed in response to primary caregiving — are extraordinarily resistant to change, precisely because they were formed in conditions of high arousal and survival necessity. The stronghold concept extends this understanding: it is not only attachment templates but any pattern that entered through a moment of survival necessity and was covenanted into the person's operating system at a level below conscious intention.

The clinical significance is operational: if a pattern is understood as a stronghold rather than merely a conditioned habit, the intervention changes. Cognitive restructuring addresses the thought. Somatic work addresses the body-held residue. Neither addresses the covenant. Te Wetekina addresses the covenant.

Covenant as Transmission Mechanism

Covenant — in the clinical sense used within this framework — describes the implicit agreement through which a pattern is established and maintained. When a person first adopts a coping behaviour in response to genuine threat, they are not merely forming a habit. They are entering into an arrangement with the pattern: it will provide relief, safety, or belonging; they will sustain it. This arrangement is rarely conscious. It is inscribed in the nervous system, in the emotional memory, and in the relational templates that govern subsequent choices.

Family systems research provides empirical grounding for understanding how such covenants transmit across generations. Bowen's (1978) concept of multigenerational transmission identifies how emotional processes, relational patterns, and coping strategies move through family systems across multiple generations. Minuchin's (1974) structural family therapy documents how roles, triangulations, and homeostatic pressures are maintained across time in ways that individual-level intervention cannot address. The TPO framework extends this understanding: what transmits through the family system is not merely behaviour but covenant — the implicit arrangement that the pattern made with those who carried it, passed forward to those who inherit it.

Epigenetic research adds biological grounding. Yehuda and colleagues' (2016) demonstration of intergenerational epigenetic transmission in descendants of Holocaust survivors confirms that trauma responses can be biologically transmitted across generations, altering stress hormone regulation and threat-response systems. The participant presenting with a stronghold may be experiencing not merely their own nervous system's history but that of their parents, grandparents, and great-grandparents — a covenant established in the lineage long before their birth.

This has direct clinical implications. A pattern understood as personally formed can be addressed through personal intervention. A pattern understood as an inherited covenant — one that entered the lineage through a specific wound and was transmitted forward through biological and relational mechanisms — requires a genealogical response. Te Wetekina is that response: the conscious, authoritative closing of a door that was opened in the whakapapa, not merely in the individual.

The Ancestral Altar: Clinical and Theological Construction

The language of altars is used deliberately within this framework and requires clinical justification. An altar, in the sense used here, is a structural site of maintenance: the practice, habit, belief, or relational pattern through which the stronghold's covenant is regularly renewed. Every stronghold has an altar because every stronghold requires ongoing energetic investment to sustain. The person who returns to alcohol at 4pm every day is not merely following a habit — they are, consciously or otherwise, re-offering something at the site through which the pattern entered. The person who repeatedly chooses unavailable partners

is not merely repeating a conditioned attachment — they are renewing a covenant that entered through the whakapapa's relational wounding.

The clinical utility of altar language is that it makes visible what contract language, and habit language cannot: the ongoing maintenance cost of the stronghold, and the specific site at which that maintenance occurs. When the altar is named, the intervention becomes precise. Te Wetekina does not address the pattern globally. It addresses the specific altar: the specific time, the specific trigger, the specific renewal moment at which the stronghold makes its bid.

Māori spiritual epistemology provides a coherent framework for the altar concept. In te Ao Māori, tapu — sacred restriction — and noa — the lifting of that restriction — operate as structuring principles of spiritual and relational life (Durie, 1998). A stronghold, understood through this lens, is a site of misaligned tapu: a sacred structure that was established through wounding or survival and that has not been lifted. Te Wetekina is the noa practice — the deliberate lifting of the restriction, the closing of the site, the restoration of flow where the tapu has created blockage.

Spiritual Authority as Clinical Concept

The most distinctive claim of the Te Wetekina framework is that spiritual authority — the engagement of te Ao Wairua and te Atua as co-agents in the loosing — is not supplementary to the clinical process but primary to it. This claim requires careful positioning.

The psychology of religion provides an empirical basis for the clinical efficacy of spiritual engagement in behaviour change. Koenig (2012) documents extensive evidence for the relationship between religious and spiritual practice and psychological resilience, recovery from addiction, and regulation of chronic health conditions. Pargament's (2011) research on religious coping identifies spiritual surrender — the explicit handing over of what cannot be managed by personal effort alone — as among the most effective coping strategies in situations of genuine helplessness. Te Wetekina operates in this register: it is not the invocation of divine assistance as a bypass of personal responsibility, but the recognition that some covenants extend beyond the individual's personal authority to dissolve.

More precisely: if a stronghold entered through an ancestral wound and has been covenanted across generations, the authority to dismantle it is not merely personal. The

person who carries it did not establish it. They inherited it. The loosing of an inherited covenant requires an authority that exceeds personal will — and within the kaupapa Māori framework of this programme, that authority is te Atua, engaged through karakia, through the Inoi a te Ariki, and through the deliberate invocation of divine intervention at the specific trigger moment.

This is consistent with Māori understandings of mana as a dynamic, relational, and spiritually-grounded concept. Walker (1990) and Marsden (2003) articulate mana as the authority that flows through whakapapa connection and spiritual alignment: it is not generated by personal effort but received through right relationship with te Ao Wairua. The reclamation of mana — which is precisely what Te Wetekina facilitates — is therefore not a psychological achievement but a spiritual one, grounded in whakapapa and activated through karakia.

Te Wetekina in Māori Epistemology

Te Wetekina draws on a specifically Māori epistemological tradition: the understanding that healing operates simultaneously at the human, ancestral, and spiritual registers, and that interventions that address only the human register are incomplete. This understanding is articulated across Māori health scholarship (Durie, 1998; Pihama et al., 2014) and is the foundational epistemological claim of the Te Poutama Ora framework.

Smith's (2012) decolonising methodologies framework provides the epistemological grounding for asserting the clinical validity of Māori knowledge systems alongside and in conversation with Western therapeutic frameworks. Te Wetekina does not claim to supersede cognitive, somatic, or attachment-based approaches. It claims to address what those approaches cannot address: the covenanted, ancestral, spiritually-maintained dimension of stronghold patterns. This is not a gap in Western therapeutic frameworks — it is a domain they do not enter by design, because their epistemological commitments exclude the spiritual register as a clinical category.

Within kaupapa Māori, the spiritual register is not supplementary. Wairua is, as Durie (1998) establishes, load-bearing: without it, no other dimension of wellbeing is fully available. Te Wetekina's insistence on spiritual authority as primary is therefore not a theological addition to an otherwise secular clinical framework. It is the epistemologically consistent expression of a framework in which wairua is foundational.

Distinguishing Te Wetekina from Adjacent Frameworks

Te Wetekina occupies a distinctive clinical space that is clarified by distinguishing it from several adjacent frameworks with which it shares partial territory.

Cognitive-behavioural approaches address the content and structure of thought patterns and the behavioural habits that maintain them. They are effective for conditioned patterns that respond to awareness and intentional practice. They do not address covenanted patterns because they operate at the level of thought and behaviour, not at the level of the implicit arrangement through which the pattern is sustained. Te Wetekina does not replace cognitive work; it addresses what cognitive work leaves untouched.

Somatic approaches (Levine, 2010; Van der Kolk, 2014; Porges, 2011) address the body-held residues of trauma and conditioned nervous system states. They are essential for releasing what the body has stored. They do not address the ancestral covenant dimension: the somatic pattern may be released in session and reconstitute itself through the whakapapa transmission mechanism if the covenant has not been named and dismantled. Te Wetekina and somatic work are complementary, not competing: the somatic release is completed when the covenant is closed.

Family systems approaches (Bowen, 1978; Minuchin, 1974) address intergenerational transmission of relational patterns and the systemic maintenance of dysfunction. They share the most theoretical ground with Te Wetekina. The distinction is the spiritual dimension: family systems approaches understand transmission as emotional and relational but do not engage the ancestral and spiritual registers within which Te Wetekina operates. For Māori participants, the whakapapa dimension of transmission is inseparable from the spiritual and ancestral; a framework that addresses only the relational is, from a kaupapa Māori perspective, incomplete.

Deliverance ministry within Christian traditions addresses spiritual strongholds through prayer, renunciation, and spiritual authority. Te Wetekina shares the recognition that some patterns require spiritual authority for their release. It differs in its clinical grounding, its kaupapa Māori epistemological foundation, its integration with psychological and somatic frameworks, and its precision focus on the specific trigger moment and altar structure. Te Wetekina is not deliverance ministry with a Māori aesthetic. It is a clinically scaffolded,

epistemologically grounded protocol that holds the spiritual register without abandoning clinical rigour.

Spiritual bypassing (Welwood, 2000) — the use of spiritual frameworks to avoid psychological work — is what Te Wetekina is not. Spiritual bypassing uses the divine to skip the metabolisation process. Te Wetekina uses spiritual authority to complete the metabolisation process when psychological tools alone cannot. The distinction is directional: bypassing moves away from the wound; Te Wetekina moves through it.

The Five-Question Diagnostic

Te Wetekina is not applied to every difficult pattern in the Dimensional Autophagy programme. It is a precision protocol, applied when specific indicators confirm that a stronghold — rather than an ordinary conditioned pattern — is present. The five-question diagnostic serves this function.

The five questions — What is the pattern? When does it make its bid? When did the door open? What was promised and what was delivered? What altar has been established? — are not merely reflective prompts. They are a clinical assessment tool that maps the stronghold's structure with sufficient precision to make Te Wetekina's intervention targetable.

The second question — when does it make its bid? — is clinically essential and distinguishes stronghold identification from general pattern recognition. Strongholds are not diffuse. They are precise. They surface at a specific time, in a specific relational or environmental context, with a specific affective quality. The precision of the trigger moment is both a diagnostic indicator (strongholds have addresses; conditioned habits are less specific) and a treatment parameter (the counter-covenant must be established at the exact trigger moment to be effective).

The third question — when did the door open? — requires clinical sensitivity. Some participants can identify the personal moment of entry clearly. Others cannot, because the covenant was established in the whakapapa before their birth. In these cases, the kaiārahi's task is to hold the participant in the recognition that a door they did not open is nevertheless one they have the authority to close — and that the closing is a genealogical act, not merely a personal one.

The Loosing Protocol: Clinical Architecture

Te Wetekina's five-step protocol — Name the covenant; Dismantle the altar; Establish the counter-covenant; Engage te Ao Wairua as co-agent; Mark the crossing — constitutes a clinical architecture that operates across four registers simultaneously.

The psychological register: naming the covenant makes the implicit explicit, removing the tacit power of the unnamed. The counter-covenant provides a competing neural pathway at the specific trigger moment, consistent with neuroplasticity principles (Siegel, 2010).

The somatic register: the specific, time-anchored nature of the counter-covenant practice engages the body's conditioned responses at their precise activation point. The karakia practice at the trigger moment begins the recalibration of the nervous system's conditioned response to that cue (Porges, 2011).

The ancestral register: the explicit naming of the whakapapa root — the moment or generation through which the covenant entered — and the conscious act of closing that door reclaims tino rangatiratanga over the inherited pattern. This is the genealogical dimension of the work: not merely personal change but lineage change.

The spiritual register: the engagement of te Atua through karakia, through the Inoi a te Ariki, and through explicit divine invocation at each trigger moment constitutes the spiritual authority dimension. This is not supplementary. For patterns whose covenant is ancestral and spiritual in its maintenance, the spiritual authority is the mechanism of the loosing. Gratitude expressed at each resistance is not sentimentality — it is the neurological and spiritual reinforcement of the new covenant over the old.

The fifth step — marking the crossing — has both neurological and relational significance. Narrating the shift to a trusted person or kaiārahi consolidates the new pattern through social witnessing (Siegel, 2010), while simultaneously acknowledging the genealogical significance of what has occurred. When the crossing is a generational one — when the door that has closed was open in the whakapapa for longer than the participant has been alive — the marking is not merely personal celebration. It is the acknowledgment of an act of intergenerational healing.

The next morning, I woke feeling different. Like I had crossed generations. — ……. Te Wetekina practice, Whakapapa Autophagy Month

Te Wetekina Across the Five Dimensions

Te Wetekina is available at any point in the five-month programme, in any dimension, whenever the stronghold indicators are present. Its application has dimension-specific features that the kaiārahi must hold.

Taha Whakapapa

Strongholds in the whakapapa dimension are ancestral covenants — relational patterns transmitted through the family system across generations. The epigenetic and family systems research cited above provides the empirical grounding for understanding these patterns as genuinely ancestral rather than merely personally formed. The specific clinical challenge in this dimension is the participant's tendency to either over-personalise the pattern (taking full responsibility for what was inherited) or to externalise it entirely (placing all responsibility on the lineage). Te Wetekina holds both: the pattern is ancestral in origin, and the closing of its door is the participant's personal and genealogical act.

Taha Wairua

Strongholds in the wairua dimension are spiritual covenants — shame-based beliefs, religious wounds, or the closing down of the spiritual life in response to colonial spiritual assault. Religious trauma (Marlowe, 2019) and spiritual bypassing (Welwood, 2000) both contribute to the formation of wairua strongholds. The specific feature of this dimension is that Te Wetekina finds its deepest expression here: karakia is not merely the mechanism of counter-covenant, it is the primary clinical tool. The authority to dismantle a spiritual stronghold belongs to te Atua, and the loosing is, in this dimension, most directly and most necessarily a spiritual act.

Taha Tuakiri

Strongholds in the tuakiri dimension are identity covenants — the agreements made with institutional environments hostile to authentic self. Decades of code-switching and colonial

performance create what the framework describes as fortified identity structures: performance selves that reassert under pressure long after the environment that required them has changed. The clinical challenge is that the identity stronghold often feels like protection — the participant is reluctant to dismantle it because the institutional environment that made it necessary is still, in some form, present. Te Wetekina in this dimension requires explicit naming of the specific moment the identity covenant was established, and the reclamation of an identity that was always theirs but never given permission to exist.

Taha Hinengaro

Strongholds in the hinengaro dimension are thought and emotional covenants — patterns of anxiety, shutdown, self-diminishment, or rumination that have become the nervous system's default. These are rarely primary wounds. As the framework establishes, hinengaro strongholds are frequently the fortified residue of unmetabolised whakapapa, wairua, and tuakiri wounding. If Te Wetekina applied to a hinengaro stronghold does not produce the expected shift, the kaiārahi should look upstream: the primary wound, and the altar that sustains it, may not yet have been located.

Taha Tinana

Strongholds in the tinana dimension are somatic covenants — the body's habituated holding of what was never metabolised across all dimensions. Chronic pain, addictive physical behaviours, and persistent nervous system dysregulation that returns despite intervention are the presenting forms. Te Wetekina applied in this dimension works at the intersection of somatic and spiritual authority: the body holds what the spirit has not yet been given permission to release. Levine's (2010) somatic experiencing framework and Porges's (2011) polyvagal theory both support the understanding that the nervous system's conditioned states can only be recalibrated when the conditions that established them are addressed. Te Wetekina provides the spiritual dimension of that recalibration.

The Tūāpapa Trinity in Te Wetekina

The Tūāpapa trinity — Recognition, Reclamation, Restoration — operates in Te Wetekina with specific content that distinguishes it from its application in the standard four-phase model.

Recognition in Te Wetekina is the naming not merely of the pattern but of the covenant: what was promised, what was delivered, what altar has been established, and what door remains open in the whakapapa. This recognition is more precise than general pattern awareness, and its precision is what makes the loosing targetable.

Reclamation is the active closing of the door and the dismantling of the altar: the exercise of tino rangatiratanga over the inherited covenant, through spiritual authority, at the specific trigger moment. Reclamation here is genealogical: the person is not merely changing their own behaviour but reclaiming sovereignty over their whakapapa's future.

Restoration is what becomes available when the stronghold's door is closed: the mana that was flowing into the maintenance of the covenant is now available for the creation of what was never there. The counter-covenant is the seed of restoration — the first practice of the new pattern in the exact site the old one occupied.

Discussion: Limitations and Clinical Considerations

Several limitations and clinical considerations require explicit acknowledgement.

First, Te Wetekina is a precision protocol, not a general practice. Applied indiscriminately to patterns that are not strongholds, it may produce confusion rather than clarity: the participant who has an ordinary conditioned pattern labelled as a stronghold may experience the spiritual and ancestral framing as unnecessarily heavy or may feel that a simpler tool has been replaced by a more elaborate one. Kaiārahi's must assess carefully, using the five-question diagnostic, whether a stronghold is genuinely present before introducing Te Wetekina.

Second, the spiritual authority dimension requires that kaiārahi's have genuine personal engagement with their own wairua dimension. A facilitator who is uncomfortable with spiritual language, who has not navigated their own cave season, or who treats the karakia dimension as culturally decorative rather than clinically essential cannot adequately hold participants through the Te Wetekina process. The wairua dimension is the most personally demanding of the five dimensions to facilitate; Te Wetekina demands the most from it.

Third, where strongholds are connected to acute trauma, the Te Wetekina process must not precede adequate stabilisation. The naming of an ancestral wound and the invocation of

spiritual authority at a trigger moment can surface acute material in participants who are not yet regulated enough to metabolise it. The clinical principle of the broader framework applies here: stabilisation before transformation. Kaiārahi's must assess readiness for the depth of Te Wetekina work and ensure appropriate support is available.

Fourth, the claim that spiritual authority is the primary mechanism of loosing for ancestral covenants is an epistemological claim grounded in kaupapa Māori. It is not universally shared by all clinical frameworks, and the practitioner working with participants for whom te Ao Wairua is not a living concept will need to hold the protocol's spiritual dimension carefully, finding the equivalent register within the participant's own spiritual or philosophical framework rather than imposing a specific theological form.

Conclusion

Te Wetekina addresses what the four-phase Dimensional Autophagy model cannot address alone: the patterns that entered through covenant, are maintained through altar structures, and resist standard intervention because their root is ancestral and spiritual rather than merely habitual or conditioned. These patterns are real. They are clinically identifiable. And they require a response that operates at the full register of human experience — psychological, somatic, ancestral, and spiritual — simultaneously.

The contribution of Te Wetekina to the clinical landscape is the precision it brings to the spiritual register. It is not spirituality as a general wellness resource. It is karakia as a clinical tool, applied at a specific trigger moment, invoking divine authority over a specific covenant, in a specific dimension of a specific person's whakapapa. That precision is both its distinctive feature and its clinical power.

When the door that was opened in the whakapapa — sometimes generations before the participant was born — is finally and intentionally closed, what the participant reports is consistent with what the framework predicts: not merely personal change, but the sensation of something shifting in the lineage. The crossing of generations. The closing of a door that has been open too long.

That is Te Wetekina. That is the loosing. And in the fullest sense of the kaupapa Māori framework within which it operates: that is mana restored.

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