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Decolonial Wellbeing Theory: Indigenous Psychology and the Return to Psychology's Spiritual Roots

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Abstract

Western psychology emerged from spiritual and philosophical traditions before taking on its present-day form as a primarily secular social science through processes entwined with colonial epistemologies. For Kānaka ʻŌiwi, this shift has shaped behavioral healthcare systems that often misrecognize Indigenous wellbeing as cultural context rather than psychological theory. This study positions Ke Ao Nōweo ʻUla (KANU) as decolonial, drawing on community-based research with Kanaka ʻŌiwi behavioral health clients, providers, and cultural practitioners. Guided by the transformative paradigm and qualitative research, the present analysis applies decolonial analytics across the domains of Being, Knowledge, and Power. Findings demonstrate that KANU functions as a coherent Kanaka ʻŌiwi theory of decolonial wellbeing grounded in spirituality, ʻike Hawaiʻi, and healing, while engaging contemporary conditions shaped by settler colonial impact. By naming KANU as decolonial, this study argues that centering decolonial wellbeing within behavioral healthcare supports Indigenous thriving and opens pathways for psychology to re-engage its spiritual roots.

Indigenization Statement

To ensure all authors were able to share their full statements and positionalities, we created a webpage; please visit https://tinyurl.com/JISDstatements or scan the QR Code in Figure 1 to read them in their entirety. Mahalo.

Figure 1

QR Code for Statements

Introduction

For nearly two thousand years, Kānaka ʻŌiwi (Native Hawaiians) governed themselves as descendants of Hawaiʻi itself (Trask, 2000). Traditional Kanaka ʻŌiwi values, as preserved through moʻolelo (oral tradition) and documented in Hawaiian scholarship, centered relationship and interconnectedness: pono (balance), aloha ʻāina (love of land), kuleana (responsibility, privilege), mālama (stewardship), and lōkahi (unity) structured a worldview in which people, land, and the divine were held in reciprocal relation (Chun, 2011; Pukui et al., 1972). A pono approach kept balance, and it meant that the gods, aliʻi (chiefly class), kahuna (healers), makaʻāinana (populace), and ʻāina (land, that which nourishes) all coexisted in harmonious balance (Silva, 2004). Their approach to agricultural resource management exemplified values of pono stewardship and pilina (reciprocal relationship, connection), whereby each ahupuaʻa (land division) was operated such that all makaʻāinana had work, no one went hungry, and no more was taken than was needed (Morishige et al., 2018). Hawaiʻi at the time of first contact with Europeans was also home to the largest population and most hierarchical and complex system of governance in the Pacific region (Stannard, 1990). Kānaka ʻŌiwi were athletic, strong, and notably well, with historical first-account documentarians consistently remarking on their lack of disease (Beaglehole, 2017). Although not all Kānaka ʻŌiwi believed in the gods or practiced religion, hoʻomana, spirituality, was a way of life, permeating nearly all activities in a typical

day, with most aspects of culture requiring a pule (similar to a prayer; Chun, 2011).

Accounts of how wellbeing was viewed in traditional Kanaka ʻŌiwi culture reflect consistent axiological themes of *relationship* and *interconnectedness* with both illness and aspects of wellbeing depicted as inevitable concerns not just of the individual, but of families as well (Chun, 2011; Pukui et al., 1972). In the case of physical and mental health, these were said to affect individuals and families, and the approach to healing involved both the individual and family members.

The Kanaka ʻŌiwi approach to being well involved using food as medicine; harnessing the spiritual power of healing rituals (as illness was often seen as having a spiritual root, resulting in a loss of mana, spiritual power); and involving a three-way collaboration between divine, people involved, and healers. The divine aspect could mean any number of aumakua (deities) related to the illness or recovery process. However, the deity of health is particularly important, Mauli Ola, and is embodied by the natural elements as reflected in the ʻōlelo noʻeau (proverb) *Ka lā i ka Mauliola*, which means, *The sun at the source of life* (Pukui, 1983, as cited in Kaholokula, 2017). In addition to family, food, mana, gods, and healers, Hawaiians believed many determinants affected one's health, including how one's piko (center) was connected to health-giving or health-obstructing people, places or things; one's given name; the way others spoke of one; the way one spoke of others; and sheer luck (Pukui et al., 1972). Articulating Ke Ao Nōweo ʻUla as a decolonial theory of wellbeing foregrounds how ʻŌiwi ways of seeing, knowing, and being have long functioned as coherent wellbeing theory, while also acknowledging and adapting to contemporary challenges produced by colonialism.

From Indigenous Wellbeing to Colonial Behavioral Healthcare in Hawaiʻi

Since the nineteenth century, the colonization of ontology, epistemology, and praxis has

unfolded globally, producing profound disruptions across social, ecological, and spiritual systems, and Hawai‘i is no exception (Goldberg-Hiller & Silva, 2015; Meyer, 1998; Silva, 2017; Trask, 2004). Following first contact in 1778, the Hawaiian archipelago experienced rapid political, legal, and cultural transformation, culminating in its status as an illegally occupied nation-state under international law (Convention (IV) Respecting the Laws and Customs of War on Land, 1907; deZayas, 2018; Trask, 1999). These transformations were not merely political, but ontological: Indigenous relationships among people, land, and spirituality were systematically disrupted through missionary influence, juridical restructuring, and racialized narratives that recast Kanaka ‘Ōiwi as deficient and uncivilized (Kauanui, 2018; Silva, 2017). The illegal overthrow and imprisonment of Queen Lili‘uokalani marked a turning point in which ‘Ōlelo Hawai‘i was banned from public education, and enforced with violence, accelerating processes of cultural suppression and epistemic violence (Trask, 1999). These colonial dynamics established the conditions under which Western institutions (e.g., education, medicine, behavioral healthcare) would emerge as dominant authorities over Indigenous wellbeing, setting the stage for the development of colonial psychology in Hawai‘i.

The enduring effects of settler colonialism and colonial psychology continue to shape contemporary health inequities for Kānaka ‘Ōiwi (Kaholokula et al., 2009; Kauanui, 2018). Kānaka ‘Ōiwi experience disproportionate behavioral health burdens, including elevated mental health challenges and substance use disparities, relative to non-Hispanic White populations (Barile et al., 2024; Subica et al., 2024). Despite these needs, Kānaka ‘Ōiwi are substantially less likely to receive mental health services, with national estimates indicating service utilization rates approximately 70% lower than those of non-Hispanic Whites (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022). Among Pacific Islander groups, Kānaka

ʻŌiwi frequently avoid Western behavioral healthcare even when clinically indicated, reflecting documented mistrust of health systems (Muramatsu & Chin, 2024; Subica et al., 2024). To address these persistent gaps between behavioral health needs, help-seeking, and outcomes, community-based research in Indigenous behavioral health contexts indicates the importance of decolonial approaches (Qinaʻau, 2024). Understanding why such decolonial approaches are necessary requires situating these contemporary impacts within the historical formation of psychology as a discipline shaped by colonial ontologies, epistemologies, and praxis.

Spiritual Roots and Colonial Branches of Psychology

To contextualize how these impacts emerged, the following section traces psychology's formation from its spiritual roots to its consolidation as a colonial social science. Psychology did not originate as a secular science but as a spiritually grounded inquiry into the nature of the soul, mind, and human wellbeing. Across global intellectual traditions, understandings of mental life were embedded within cosmological, ethical, and relational frameworks that treated psychological wellbeing as inseparable from spiritual practice, moral conduct, land relations, and collective life (Cohen & Bai, 2016; Meyer, 2001; Sargeant & Yoxall, 2023). The term *psychology* reflects this orientation, deriving from the Greek *psyche* (soul, breath, or life principle) and *logos* (study). Well into the early modern period, psychology in Europe was explicitly understood as a *science of the soul* (*scientia de anima*), situated at the intersection of philosophy, theology, and medicine (Cohen & Bai, 2016; d'Isa & Abramson, 2023; Vidal, 2006). Parallel traditions in South and East Asia articulated sophisticated psychologies grounded in contemplative practice, the cultivation of ethics, and relational balance (Bhati et al., 2025). Across these contexts, psychological knowledge functioned as praxis, guiding healing, self-

cultivation, and communal wellbeing, rather than as abstract measurement of individual mental states.

The transformation of psychology into a distinct discipline involved a gradual but consequential epistemic narrowing, shaped in part by Cartesian philosophy. René Descartes' ontological dualism redefined mind as an immaterial, internal substance distinct from the body and world, facilitating a fragmented view of humans that severed psychological inquiry from the interconnectedness of spirituality, embodiment, and land (Sargeant & Yoxall, 2023). This Cartesian reconfiguration contributed to the relocation of psychology from a holistic inquiry into human life toward a focus on individual cognition and internal mental processes, laying groundwork for its later alignment with experimental and measurement-based sciences.

As psychology professionalized in the late nineteenth and early twentieth centuries, its psychometric and classificatory methods were incorporated into colonial and state institutions as tools of population governance, including unethical practices related to eugenics (Yakushko, 2019). Psychological assessments were used to sort and manage populations, including Indigenous children in colonial schooling systems, where test results justified restricted curricula and differential treatment (Giancarlo, 2022). In medical and psychiatric contexts, psychological classifications contributed to institutional practices that framed othered populations as deficient or pathological, including within public health regimes influenced by eugenic thought (Farber, 2008; Stern et al., 2017). Concurrently, historians of psychology document that the consolidation of psychology as a secular social science involved deliberate boundary-making that excluded spiritual and Indigenous knowledge systems from scientific legitimacy, positioning them as "cultural" rather than as valid psychological frameworks (Sargeant & Yoxall, 2023; Sommer, 2013). For Indigenous populations, these dynamics constitute a form of epistemic injustice

(Fricker, 2007). Limiting expertise to White norms shaped access to education and health while Indigenous conceptions of mind, wellbeing, and relationality were marginalized or intentionally oppressed. This limited recognition of Indigenous experience as a legitimate source of psychological knowledge (Giancarlo, 2022; Sargeant & Yoxall, 2023). While this historical overview situates psychology's consolidation as a colonial social science, the following discussion examines how these formative logics continue to be reproduced in contemporary psychological theory, research, and practice.

These historical dynamics are not confined to psychology's origins but remain embedded in contemporary disciplinary norms, including dominant theories of wellbeing, research methodologies, and institutional and therapeutic practices. For Indigenous communities, psychology since the 19th century has largely emerged as a tool of colonial *epistemological violence* (Fernández et al., 2021; Teo, 2008, 2010), often carrying forward notions of gendered colonial hegemony by othering the marginalized and framing the study of the mind as individualist, ahistorical, acultural, and decontextualized (Adams et al., 2015; Bhatia, 2002; Bulhan, 2015; Dutta, 2016; Hook, 2014; Kessi, 2017; Macleod et al., 2017; Montero, 2007; Ratele et al., 2018). When contemporary epistemologies primarily reflect the views of White, Educated, Individualist, Rich, Democratic ("WEIRD") research participants (Henrich et al., 2010) and similarly WEIRD researchers, any findings not in alignment with this knowledge base are then considered a distal add-on, leading to epistemicide for the marginalized (de Sousa Santos, 2015; Mignolo, 2009b). Kanaka ʻŌiwi psychologists refer to the beginnings of this trend as the *deficit approach period* (1800s-1950s; McCubbin & Marsella, 2009), largely formed by a White supremacist view (Guthrie, 2004; Sue & Sue, 2003) positioning ethnic minorities as having deficiencies relative to the White majority (Thomas & Sillen, 1972).

While positioning the colonized as evolutionarily inferior is no longer explicitly pursued, White supremacy persists in more implicit ways today. For example, harmful biases and pathologizing of marginalized person's experiences through ongoing use of the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; American Psychiatric Association, 2013; Masuda et al., 2020); systemic racism in publishing (DeJesus et al., 2019; Guthrie, 2004; King et al., 2018; Roberts et al., 2020; Stevens et al., 2021); systemic racism in research (Miller et al., 2019; Winston, 2020); systemic racism in the selection and training process (Galan et al., 2021); and support of colonial violence in the form of torture, apartheid, and war (Kessi, 2017; Maldonado-Torres, 2016; Malherbe & Ratele, 2022; Seedat & Lazarus, 2011; Wessells et al., 2017). These examples illustrate how coloniality is reproduced across the lifecycle of psychological knowledge production and practice.

Contemporary Indigenous psychology, on the other hand, is characterized by Indigenous scholars leading inquiry grounded in Indigenous epistemologies, ontologies, and healing practices rooted in precolonial knowledge systems (McCubbin & Marsella, 2009). Indigenous psychology is part of a global decolonial movement oriented toward self-determination, relationality, and holistic wellbeing, advancing locally grounded psychologies that resist the ongoing coloniality of hegemonic psychology (Ciofalo et al., 2022). Methodologically, this work aligns with Indigenous research paradigms that emphasize relational ethics, accountability, and Indigenous data sovereignty (Chilisa, 2012; Kukutai & Taylor, 2016). In Hawai‘i, related efforts to decolonize and Indigenize research and evaluation have emerged initially within education and social work, reflecting parallel disciplinary responses to colonial epistemic constraints (Kawakami et al., 2007; Morelli & Mataira, 2010). The present study contributes to Indigenous psychology by examining Ke Ao Nōweo ‘Ula (KANU) as a decolonial Kanaka ‘Ōiwi theory of

wellbeing, demonstrating how Indigenous wellbeing functions as decolonial psychological theory within behavioral health contexts shaped by settler colonialism.

Taken together, these histories underscore psychology's potential as a site of harm, as well as a site of repair, particularly when centering Indigenous-led theories of wellbeing.

Decolonizing & Decolonialism

Across subfields of psychology, the call for decolonial approaches is resounding (Domínguez et al., 2025; Dudgeon & Walker, 2015; Johnson-Jennings & Jennings, 2023). Decolonialism offers a critical response to the social and structural determinants of wellbeing produced through ongoing coloniality. While the term *decolonizing* is sometimes met with resistance—particularly among those who benefit from colonial power relations—it names a necessary analytic orientation toward present-day systems that shape knowledge, subjectivity, and health (Maldonado-Torres, 2016; Tuck & Yang, 2012). Importantly, decolonialism is not confined to Indigenous benefit alone; rather, it offers a pathway toward more just and humane social development by confronting the epistemic, political, and psychological harms of colonial modernity. Within wellbeing research, decolonial approaches challenge dominant psychological paradigms that individualize distress while obscuring the historical, cultural, and structural conditions that produce suffering (e.g., Diener, 1984).

The foundations of a decolonial attitude in behavioral healthcare can be traced to the work of Frantz Fanon (1952/2008), whose clinical and political writings demonstrated that colonialism operates simultaneously at material, symbolic, and psychological levels (Hook, 2014; Maldonado-Torres, 2017). Fanon (1952/2008) argued that adaptation to oppressive systems constitutes harm, an obstruction to wellbeing. His work foregrounded racism as a psychopathological manifestation of colonial power, often internalized at the somatic level, and

established the necessity of analyzing psychological phenomena within their political and historical contexts. This orientation toward liberation, rather than adjustment, laid critical groundwork for contemporary efforts to decolonize psychology (Cullen et al., 2020).

Building on Fanon's legacy, Indigenous and decolonial scholars have articulated frameworks for analyzing how coloniality structures being, knowledge, and power across time, space, and subjectivity (Maldonado-Torres, 2016; Mignolo, 2010, 2011). Indigenous scholars have further emphasized decolonization as both an epistemic and relational project. Linda Tuhiwai Smith (1999, 2012) reframed research itself as a colonial instrument while simultaneously asserting that Indigenous-centered inquiry can serve as a vehicle for re-humanization, sovereignty, and epistemic recovery. Writing from a Kānaka ʻŌiwi worldview, Poka Laenui (2000) described colonization and decolonization as cyclical, overlapping processes shaping cultural continuity, identity, and wellbeing across generations. Together, these perspectives align with the *decolonial turn*—a multidisciplinary movement aimed at delinking knowledge production from colonial logics of power, hierarchy, and extraction (Maldonado-Torres, 2011). Within psychology, this turn has given rise to decolonial research orientations that center Indigenous resistance, relational accountability, epistemic justice, and the unsettling of colonial subjectivities (Adams et al., 2017; Fernández et al., 2021; Gone, 2021). The present study is situated within this lineage, advancing a decolonial approach to Kānaka ʻŌiwi wellbeing that foregrounds ʻāina (land, that which nourishes), relationality, and spirituality as foundational to social development and healing in behavioral healthcare.

The harms produced by colonial psychology necessitate alternative pathways for inquiry oriented toward healing and epistemic repair for Indigenous communities. Identifying an emergent theory of decolonial wellbeing for Kānaka ʻŌiwi clarifies how psychology may be

reoriented toward its spiritual foundations while recognizing Indigenous ontologies, epistemologies, and praxis as psychological theory rather than as ancillary cultural adaptations. Centering ontologies that understand being as holistic, relational, and spiritual has implications for behavioral health design and engagement, where healing is conceptualized not as individual symptom reduction but as the restoration of relational balance. Accordingly, the present study employs Indigenous and decolonial approaches, including the transformative paradigm, community-based participatory research, and *hoʻomana i nā leo*, to enact decolonial community-defined commitments within a discipline most recently shaped by colonial injustice.

Method

Study Approach

In collaboration with community and research partners, the lead author co-conducted the *Depression and Wellbeing in the Native Hawaiian Community (DAWN)* study using multiple decolonizing approaches to center Kānaka ʻŌiwi. The study was designed as community-based participatory action research (CBPAR) to generate an emergent theory of wellbeing among Kānaka ʻŌiwi experiencing behavioral health challenges. CBPAR redistributes power by involving communities throughout the research process and is well suited to decolonial inquiry and equity-oriented wellbeing research in Hawaiʻi (Chung-Do et al., 2016; Kia-Keating & Juang, 2022).

The study was grounded in the transformative paradigm, an Indigenous research framework that prioritizes addressing inequitable power relations across axiology, ontology, epistemology, and methodology (Mertens, 2019). This paradigm responds to the limitations of positivist and constructivist approaches rooted in colonial epistemologies (Chilisa, 2012). The study also employed an Indigenous research approach conducted by, with, and for Indigenous

communities (McCubbin & Marsella, 2009; Smith, 1999), positioning the work within Indigenous resistance efforts to decolonize clinical psychology (Adams et al., 2017; Cullen et al., 2020). Consistent with decolonial theory, knowledge generation was grounded in ʻāina and embodied experience as sites of epistemic justice (Fernández et al., 2021; Mignolo, 2011).

Participants

Data were collected between December 2020 and July 2021. Recruitment was led primarily by staff at I Ola Lāhui, a community partner and behavioral healthcare organization serving rural, predominantly Kānaka ʻŌiwi communities. Community partnership emphasized relational accountability, flexible timelines, and cultural safety (Kovach, 2021; LaVeaux & Christopher, 2009; Sherwood & Edwards, 2006). The lead researcher, a Kānaka ʻŌiwi scholar, engaged in ongoing pilina co-creation through frequent consultation with participants, the Community Advisory Board (CAB), and the community partner.

Eligibility criteria included being 18 years or older, English proficiency, and access to Zoom. To enhance credibility and triangulation (Cormack et al., 2018; Creswell & Poth, 2016), purposive sampling was used to recruit (a) Kānaka ʻŌiwi clients with depressive symptoms (n = 19), (b) mental and behavioral health providers (MBHPs) serving Kānaka ʻŌiwi clients (n = 12), and (c) Kānaka ʻŌiwi cultural practitioners or leaders (n = 10). Clients were not excluded based on comorbidities or medication use. Participants and the community partner were regarded as part of the research ʻohana to emphasize relationality and respect. After analysis, participants were given the option to be co-authors and named in the dissemination materials or remain anonymous. Participant characteristics are presented in Table 1.

Table 1

Study Participant Demographics

	Overall (n = 41)
Gender Identity	
Female	30 (73%)
Male	11 (27%)
Race/Ethnicity	
Kanaka ʻŌiwi	7 (17%)
Kanaka ʻŌiwi-mixed	29 (71%)
Non-Kanaka ʻŌiwi	5 (12%)
Highest Educational Degree	
High school diploma/GED	5 (12%)
Some college	4 (10%)
Associate degree	1 (2%)
Bachelor's degree	6 (15%)
Master's degree	8 (21%)
Doctorate degree	15 (39%)
Income Tier	
Lower tier	4 (10%)
Middle tier	24 (59%)
Upper tier	6 (15%)
Did not report	7 (17%)
Birthplace	
Hawaiʻi	34 (83%)
Other	7 (17%)
Upbringing Location	
Hawaiʻi	32 (78%)
Hawaiʻi and other	4 (11%)

Other	4 (11%)
Field of Occupation	
Professional	14 (35%)
Medical	10 (25%)
Education	7 (17%)
Service Industry	2 (6%)
Other	7 (17%)
Generation	
Gen Z	3 (7%)
Millennial	13 (32%)
Gen X	23 (56%)
Boomer	2 (5%)

Procedures and Analysis

The study was approved by the University of Hawai‘i at Mānoa Institutional Review Board (Protocol #2022-00455). A pilot focus group with three providers preceded 38 individual semi-structured interviews conducted using a culturally grounded *talk story* approach, which supports free-flowing dialogue and storytelling aligned with Indigenous oral traditions (Au & Kawakami, 1985). Interviews explored wellbeing, depression, behavioral health interventions, and visions for community futures. Interviews were conducted via Zoom and were about 90 minutes long. Participants provided verbal consent after reviewing the consent form and received $50 as a gift for their time.

Transcripts were produced verbatim and quality-checked by a second team member. Six interviews, two from each of the three categories of participants (i.e., client, provider, and cultural leader), were randomly selected and coded by two team members individually (JQ and

one research assistant) to create an initial codebook. To address the primary goal of the study and identify a theory of wellbeing for Kānaka ʻŌiwi in behavioral healthcare contexts, a five-person coding team including JQ, a post-doc, a PhD student, a postbaccalaureate, and an undergraduate student employed a flexible three-cycle, line-by-line inductive coding process (Deterding & Waters, 2021). To ensure dependability within a team-based inductive process, 67% (26 transcripts) were coded by two independent team members. The team engaged in constant comparative analysis in pairs and used analytic memos in this initial stage of coding and category identification (Chun Tie et al., 2019; Walker & Myrick, 2006). Weekly group debriefing supported analytic rigor and validation (Spall, 1998). Focused in vivo coding enhanced conceptual clarity to identify processes of the theory (Saldaña, 2013), followed by thematic analysis to develop and refine process themes (Braun & Clarke, 2006; Lochmiller, 2021). Coding and analysis integrated constructivist grounded theory (Charmaz, 2016) with *hoʻomana i nā leo*—a decolonial intersectionality method developed by the author to uplift the most vulnerable of Indigenous voices (Qinaʻau, 2024).

Reflexivity was maintained through bracketing, analytic memos, and critical theory positioning (Bourdieu, 2004). Team discussions explicitly examined positionality, assumptions, and power. Trustworthiness was addressed through credibility, transferability, dependability, and confirmability (Shenton, 2004). Throughout the project, participants and Indigenous CAB members were engaged in interpretation and dissemination to ensure the work was conducted in a pono (equitable, right) manner. Consistent with Indigenous methodologies, this analytic engagement was conducted relationally, in dialogue with community advisors and participants, and aligned with an understanding of research as ceremony, emphasizing reciprocity, relational

accountability, and spirituality as integral to ethical and decolonial knowledge production (Wilson, 2020).

To address one of four analytic questions posed by the present study—*Will participants describe a decolonial view of Kānaka ʻŌiwi wellbeing?*—the research team applied Maldonado-Torres's (2016) analytics of decoloniality to guide thematic coding in an advanced cycle of analysis. This framework attends to decoloniality across three interrelated domains: being (time, space, subjectivity), knowledge (subject, object, and method), and power (structure, culture, and subject). These deductive analytic dimensions informed focused coding and thematic refinement, supporting systematic examination of how participants articulated wellbeing in relation to colonial disruption, Indigenous ontology, epistemic authority, and structural conditions shaping behavioral health. The analytic aim was not frequency, but theoretical salience.

Results

Analytics of Decoloniality in Participant Accounts of Wellbeing

Table 2 presents frequency counts of coded excerpts relevant to articulating wellbeing as decolonial for Kānaka ʻŌiwi within behavioral healthcare contexts. Although thematic completeness rather than quantitative frequency guided the analysis, these counts are provided to support analytic transparency.

Table 2

Reference Distribution by Participant Type (Column %)

Participant Type	Being (n = 152)	Knowledge (n = 167)	Power (n = 18)
Clients	63 (41.4%)	91 (54.5%)	1 (5.6%)

Cultural Practitioners	44 (28.9%)	49 (29.3%)	11 (61.1%)
Mental and Behavioral Health Providers	45 (29.6%)	27 (16.2%)	6 (33.3%)
Total	152 (100.0%)	167 (100.0%)	18 (100.0%)

As shown in Table 2, participants across all groups articulated decolonial wellbeing primarily through ontological (Being) and epistemological (Knowledge) dimensions, with Power appearing less frequently but often with analytic clarity when foregrounded. Cultural leaders most often described wellbeing as a felt, spiritual, and place-based mode of being, grounding wellbeing in relationships with ʻāina, community, and the spiritual domain. These accounts emphasized wellbeing as lived experience rather than as an outcome or service.

Epistemological framings were especially prominent among cultural leaders and clients, who frequently questioned who defines wellbeing and what forms of knowledge are privileged in health systems. Participants highlighted Indigenous language, experiential knowing, and relational learning as central to wellbeing, often contrasting these with biomedical or institutional definitions (see Table 2).

Power emerged differently depending on participants' positionality, most strongly among cultural leaders and MBHPs, who explicitly named colonial governance, policy constraints, and institutional logics as shaping possibilities for wellbeing. Although Power references appeared less frequently as a primary analytic frame, when present they situated wellbeing within broader systemic conditions, including sovereignty, capitalism, and health system design.

Discussion

This research advances Indigenous social development and decolonial psychology in four important ways. First, this study contributes an emergent Indigenous theory of wellbeing by analytically mapping Ke Ao Nōweo ‘Ula across decolonial domains of Being, Knowledge, and Power, demonstrating how mauli ola is theorized within Kānaka ‘Ōiwi ontologies rather than derived from Western psychological models. This contribution responds to longstanding concerns that psychology's difficulty accumulating knowledge stems in part from a scarcity of coherent, integrative theory (Muthukrishna & Henrich, 2019); KANU addresses this gap by articulating Kanaka ‘Ōiwi wellbeing as a named, theoretically coherent framework rather than a set of culturally specific elements. Second, the findings reframe psychology’s spiritual roots as a decolonial resource that legitimizes Indigenous epistemologies as psychological theory, with implications for how wellbeing is conceptualized and evaluated in Indigenous communities. Third, by examining wellbeing across the analytic dimensions of Being, Knowledge, and Power, the study demonstrates how wellbeing emerges relationally and is shaped by structural conditions, underscoring its relevance for ecological health rather than individual functioning alone. Finally, these insights extend to behavioral health practice, highlighting the need for culturally sustaining approaches that address settler colonial stress (Qina‘au et al., in press), strengthen relational and spiritual dimensions of wellbeing, and support Indigenous communities’ self-determined pathways to healing.

The Analytics of Decoloniality in Ke Ao Nōweo 'Ula

In analyzing Ke Ao Nōweo 'Ula (KANU) theory, conceptions of wellbeing in behavioral healthcare contexts for Kānaka ‘Ōiwi align with decolonial analyses naming coloniality as a

matrix shaping subjectivity, knowledge, and social relations rather than as an external or episodic force (Maldonado-Torres, 2016; Mignolo, 2011). These findings extend decolonial and Indigenous scholarship by demonstrating that decolonial wellbeing centers Indigenous ways of knowing and being, articulating power as an important and less primary element. Instead, connection and healing come to the fore in KANU theory as primary mechanisms for decolonial wellbeing. Below are findings from the lens of Maldonado-Torres' (2016) analytics of decolonialism as they relate to psychology's spiritual roots.

Being (Time, Space, Subjectivity)

Findings related to *Being* illuminate how decolonial wellbeing among Kānaka ʻŌiwi with behavioral health challenges is grounded in Indigenous ontology, particularly through nonlinear time, sacred space and land, and relational subjectivity and spirituality, as described by a cultural leader:

> It's that healing is a process of many many stages and then additionally when I think about lāʻau lapaʻau in the way that I've been taught, when we gather medicine we're not just simply gathering the flower, or the fruit, or the seed, you know, we are gathering all potential futures of that flower or that seed or that fruit. So that when I take into my body the seed, maybe it's a ʻinamona from kukui, that that seed may have grown a tree, that may have produced millions of flowers and kukui nuts and millions more trees. Or this flower could have born a fruit and say this lehua flower could have created millions of little tiny seeds that would float out and create more more trees. So, I think that when I think of Mauli Ola and health and wellbeing, it really includes so many parts <laughing> both in stages of growth as well as potential futures.

Consistent with Kanaka ʻŌiwi understandings of time as cyclical or spiraled (Meyer, 1998), participants articulated wellbeing as emerging from active relationships with past, present, and future rather than from an isolated focus on the present moment. One client described wellbeing through spiritual and ancestral grounding, stating, *"*I think spiritual things. Yeah, I feel, soul, those kinds of things are really important for wellbeing … it would look like the old

Hawai‘i I guess, not just physically but how people felt with each other and the land.*”* These accounts echo Indigenous ontologies in which lineage, ancestry, and temporality shape one’s sense of self and worth.

Taken together, these accounts further demonstrate how connecting to ancestors and future generations provides an ontological anchor for wellbeing. This aligns with participants’ emphasis on genealogy (*mo‘okū‘auhau*) and ancestral knowledge as resources for healing, reinforcing Meyer’s (1998) argument that Indigenous knowledge systems situate the self within extended temporal relationships. Such ontological grounding contrasts sharply with dominant linear conceptions of time, in which elders and ancestral knowledge risk being devalued, particularly within capitalist systems that prioritize productivity over relational continuity.

Being was also articulated through relationships to space, place, and ‘āina, which participants consistently described as sacred and familial rather than instrumental, with several citing the creation story of Papahānaumoku and Wākea. Many participants underscored the connection between their wellbeing and the wellbeing of the ‘āina, with one noting, “when things start to do well with the 'āina, or things start to do well with like other pieces of what we’re connected to, then we start to thrive, or then we start to get better...” These reflections align with scholarship describing Hawai‘i as a sacred ancestor and source of mana, where land mediates relationships between humans, ancestors, and the spiritual realm (Kana‘iaupuni & Malone, 2006). Participants described ‘āina as earth mother and emphasized reciprocal responsibility (i.e., aloha and mālama (care for) land from a place of pilina as a condition for wellbeing), echoing Indigenous scholarship on land-based relationality and mana (Goldberg-Hiller & Silva, 2015; Kikiloi & Graves, 2010; Moreton-Robinson, 2020; Silva, 2017).

Finally, participants framed wellbeing through subjectivity, embodiment, and spirituality, rejecting separations between mental, physical, and spiritual domains. Behavioral health practitioners, in particular, emphasized embodied safety and presence, with one noting, “I see wellbeing when someone feels safe in their body again,” and another explaining, “It’s about grounding and presence, not just reducing symptoms.” These accounts illustrate how Indigenous collectivism extends beyond human social groups to include spiritual forces, ancestors, and the more-than-human world, offering a more holistic model than those typically described in Western psychological literature (Oyserman et al., 2002).

By centering Indigenous ontologies of time, land, and relational subjectivity, participants articulated pathways to healing that counter colonial disruptions to mauli ola and reaffirm Indigenous ways of being in behavioral health. These articulations of Being resonate with psychology’s early spiritual and philosophical foundations, prior to its fragmentation under colonial secular frameworks that separated mind, body, and spirit (Cohen & Bai, 2016; d’Isa & Abramson, 2023; Vidal, 2006). Taken together, these findings demonstrate that Being operates as a foundational dimension of decolonial wellbeing.

Knowledge (Subject, Object, Method)

Findings related to Knowledge demonstrate that decolonial wellbeing for Kānaka ʻŌiwi with behavioral health challenges is fundamentally an epistemological concern, centered on who defines wellbeing, what counts as legitimate knowledge, and how wellbeing is learned, practiced, and transmitted (see Table 2). Consistent with Indigenous wellbeing frameworks and Kānaka ʻŌiwi epistemologies, participants resisted individualistic, ahistorical models dominant in Western psychology, instead articulating wellbeing as collectively defined, culturally grounded, and relationally sustained. As one client asked pointedly, “Who gets to say what wellbeing is?

Because it's usually not us." This question foregrounds epistemic justice as a core dimension of wellbeing and echoes Indigenous critiques of epistemicide and deficit-based research paradigms (de Sousa Santos, 2015; Smith, 1999).

KANU confirms and extends Meyer's (2001) articulation of Kanaka ʻŌiwi epistemology, including the importance of place in developing knowledge, knowledge beyond empiricism, learning through the senses and relationships, and the inseparability of mind and body. Participants repeatedly emphasized that wellbeing knowledge is not abstract or expert-driven but emerges through lived experience, cultural practice, and community transmission. One cultural leader explained, "The way we know wellbeing is through doing and relationship," while a behavioral health provider noted, "A lot of what counts as evidence ignores what communities already know." These accounts underscore how dominant biomedical epistemologies can obscure Indigenous ways of knowing that are essential to mauli ola.

Participants also highlighted the central role of cultural transmission in sustaining wellbeing knowledge. Knowledge as it relates to wellbeing was described as passed through ʻohana, community, and cultural practices such as storytelling (moʻolelo), prayer (pule), chanting (oli), and reconciliation practices like hoʻoponopono. As one client reflected, "Our language already tells us what wellbeing means, if people actually listen," emphasizing Hawaiian language as a repository of ancestral knowledge and values. Language revitalization and immersion were thus framed not only as cultural preservation efforts, but as vital pathways for restoring wellbeing.

Participants described how settler colonialism produces epistemic violence, shaping how Kānaka ʻŌiwi come to know themselves. One client captured this internalized coloniality directly: "Even myself, I'm thinking like the oppressor, I'm doing things like the oppressor. So

how do I release myself?" This reflection aligns with Fanon's (2008) concept of the "epidermalization" of inferiority, where notions of low self-worth are internalized at the somatic level. Participants emphasized the necessity of "Indigenizing" knowledge: reconnecting with moʻokūʻauhau, engaging in culture, and learning within community contexts where, as one cultural leader described, "it's a kākou thing." These processes support the recovery from colonial shame and the rebuilding of self-efficacy and worth, resonating with Laenui's (2000) first stage of decolonization: recovering from feelings of inferiority. In this way, KANU challenges the colonial boundary-making through which psychology historically excluded Indigenous epistemologies, positioning ʻike not as cultural context but as psychological knowledge.

Finally, Knowledge was closely linked to processes of mourning and dreaming, which participants described as necessary for healing. Coming into contact with grief related to colonial loss, while simultaneously envisioning possible futures, reflects Laenui's (2000) decolonial processes and supports the emergence of ʻŌiwi critical consciousness. In this sense, KANU aligns with and extends Indigenous psychology by demonstrating how Indigenous wellbeing theories operate not only as cultural frameworks, but as decolonial psychological theory capable of reorienting disciplinary assumptions.

Power (Structure, Culture, Subject)

Although Power appeared less frequently as a primary analytic frame, its presence across participant accounts reveals critical insights into how decolonial wellbeing is shaped by colonial structures, governance, and sociopolitical conditions (see Table 2). The relative infrequency of Power as a dominant frame should not be interpreted as a lack of political awareness. Rather, the concentration of Power-oriented accounts among MBHPs reflects their positionality within

institutional and governance contexts, where colonial constraints become explicit through policy, funding, and service delivery. This pattern aligns with liberation and decolonial psychologies that locate wellbeing not solely within individuals, but within the structures that enable or constrain life chances (Fanon, 2008; Prilleltensky, 2008).

Participants explicitly named colonial systems as ongoing determinants of distress and wellbeing. As one client stated, "Wellbeing is hard when the system was never built for us," while another emphasized, "A lot of our stress comes from how things are set up, not from us personally." These reflections situate wellbeing within broader political and economic arrangements rather than individual pathology, echoing findings from the Native Hawaiian Study Commission Report (1983) and scholarship identifying colonialism, displacement from ʻāina, and cultural suppression as persistent barriers to mauli ola (Kaholokula et al., 2020).

KANU further suggests that social activism functions as a critical mechanism through which power is contested and wellbeing restored. This aligns with Maldonado-Torres's (2016) articulation of the decoloniality of power, in which evolving structures and cultures informed by Indigenous ontology and epistemology are necessary for healing. One MBHP described how activism offers purpose and counters despair: "Activism for some folks has become a sense of purpose… when there's this massive tide of change and globalization that objectifies Hawaiian-ness… those kinds of activities can counteract that hopelessness." Such accounts resonate with liberation psychology's emphasis on sociopolitical development and collective action as health-promoting processes (Prilleltensky, 2008), as well as with emerging work on activist purpose as a support for Indigenous wellbeing (Wilson & Hill, 2023).

Participants often emphasized that activism and political engagement are inseparable from spirituality. For Kānaka ʻŌiwi with behavioral health challenges, purposeful engagement in

lāhui-supportive efforts was described as increasing not only connection and self-efficacy, but also *mana*, or spiritual power, as participant Kumu Keola Chan notes:

> 'Why is this calling to me?' But that's what it was because it was wrapped into more than a physical place like Mauna Kea. That was 'āina to us but it was more than that, right? It was reconnecting with our spirituality again … we recognize that by engaging the spiritual realm, that's where it starts first… It is a spiritual act and simultaneously it is a physical act but one comes before the other and this is what is important to remember is one comes before the other in Hawaiian mindset. Spirituality is recognized before the physical manifestations start to happen.

Conversely, participants noted that when one's mana is strengthened through spiritual and cultural grounding, a movement toward activism may naturally follow. This intertwining of political action and spirituality underscores that decolonial wellbeing cannot be reduced to secular notions of empowerment.

Notions of ea (sovereignty) and lāhui (nationhood) emerged as critical features of the emergent theory of mauli ola. Participants expressed varied perspectives on how sovereignty should be pursued. Ranging from increased representation and leadership within existing systems to complete self-governance, these views can be understood as parallel processes within the same decolonial trajectory (Laenui, 2000). As one cultural leader asserted, "Sovereignty matters for wellbeing—without it, everything else is limited." At the same time, participants emphasized the need for lōkahi and kākou, coming together despite differences to do what is *pono* for the upliftment of the lāhui, echoing Laenui's (2000) fourth process of decolonization: commitment over time.

Participants also extended power beyond formal politics to include economic and spiritual autonomy. Economic precarity, extractive tourism, and capitalist logics were described as eroding pilina and humanity, consistent with Maldonado-Torres's (2016) and Mignolo's (2009a) critiques of capitalism as a colonial force. As one provider noted, "The system rewards

productivity, not healing." Yet participants envisioned mauli ola as including financial stability, intergenerational sustenance, and sovereignty "over our very souls," emphasizing that ea must be realized politically, economically, spiritually, and somatically.

Taken together, these findings suggest decolonial wellbeing for Kānaka ʻŌiwi is inseparable from power relations at multiple levels. Power operates both as a source of harm, through colonial structures, capitalism, and policy, and as a site of healing (e.g., through activism, sovereignty). These findings also suggest that centering Indigenous wellbeing in behavioral healthcare requires more than culturally adapted services; it demands engagement with Indigenous ontologies and epistemologies as foundational, alongside multi-level transformations that address colonial governance and power relations. In this way, decolonial wellbeing emerges not as a discrete intervention, but as an ongoing praxis of knowing, being, and resisting coloniality. Re-centering Power in this manner underscores how decolonial wellbeing not only addresses structural harm but also creates conditions for psychology to re-engage its ethical and spiritual commitments to collective flourishing.

Limitations and Future Directions

While this study provides insight into decolonial processes of *mauli ola* among Kānaka ʻŌiwi in behavioral health contexts, its findings should be interpreted in light of several limitations related to scope and analytic focus. Client participants were recruited through a community behavioral health partner, meaning they were help-seeking and willing to engage with Western behavioral healthcare. As such, the findings may not fully capture how decolonial wellbeing is conceptualized by non–help-seeking Kānaka ʻŌiwi or by those who actively avoid this type of care. Future research should engage Kānaka ʻŌiwi across a wider range of

community and non-clinical contexts to further examine how KANU is articulated and enacted in more diverse service settings.

Additionally, the analytic approach prioritized open-ended, participant-led inquiry to support Kanaka ʻŌiwi ontology, epistemology, axiology, and praxis. While appropriate for *naming KANU as decolonial*, this approach limited systematic examination of discrete detriments, states, or outcomes, and emphasized relational and interdependent processes of wellbeing. Future work should continue to refine KANU through iterative empirical research that examines how these processes interact with settler colonial conditions across contexts, while remaining attentive to the non-reductive nature of *mauli ola*. In doing so, subsequent studies can build on the present contribution by further examining how centering decolonial wellbeing creates conditions for psychology to re-engage its spiritual roots. Future research should examine the ways KANU may inform sustainability at the policy level (Qinaʻau & Antonio, 2023) and translate Kanaka ʻŌiwi wellbeing theory into measurement, as in Kukui Mālamalama, an emergent measure of wellbeing developed for use in clinical, research, and community settings (Qinaʻau et al., 2026).

Conclusion

This study positions Ke Ao Nōweo ʻUla (KANU) as a decolonial theory of wellbeing by analytically mapping Kanaka ʻŌiwi articulations of *mauli ola* across the domains of Being, Knowledge, and Power. In doing so, it demonstrates that Indigenous wellbeing theories are not cultural supplements to psychology, but theoretically complete accounts of ecological wellbeing grounded in ontologies of the spiritual, relational, and interconnected. Centering decolonial wellbeing within behavioral healthcare contexts reveals pathways for disciplinary transformation, inviting psychology to move beyond colonial and Cartesian views and re-engage

its ethical and spiritual roots. By naming KANU as decolonial, this work contributes to reimagining psychology as a field accountable to Indigenous knowledge systems and the conditions necessary for ecological wellbeing.

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