Chiropractors can move beyond the Deficit Discourse toward a Strengths-Based Approach when working with Australia's First Peoples.

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Abstract/Context

In the lands now known as Australia the health of its First People has historically been framed using the lens of deficit. While the discourse of deficit may permit the chiropractor to problem-solve issues and concerns related to neuro-musculoskeletal health, chronic disease, and related socioeconomic factors, it can become pervasive and defeatist. A strength-based approach allows the chiropractor to work with, and alongside First Peoples in a collaborative manner. It involves shared decision-making, creating proactive collaborative management and as a result, manifests a truer representation of empowered and person-centred care.

We advance the position that the chiropractic profession has a moral and social obligation to take measures that will enable a greater proportion of Australia's First Peoples to access its services. We call for inclusion of chiropractors in public health systems and Aboriginal Medical Services (AMSs).

This paper presents lessons derived from personal perspectives toward chiropractic healthcare with the First Australians and moves into a broader commentary, discussing issues of social justice, equity, and liberty in healthcare.

Keywords: *Chiropractic; Chronic Disease; Health Personnel; Indigenous Peoples; Patient-Centred Care; Socioeconomic Factors*

Note: We recognise that there is not homogeneity with respect to preferences among the original people of these lands around terminology such as 'Aboriginal and Torres Strait Islander', 'Indigenous', 'First Nations', and 'First Peoples'. Throughout this paper we respectfully (mainly) use to the terms 'First', 'Indigenous', or 'Aboriginal' hereafter when referring to the original human inhabitants of the lands now known as Australia.

Background and Context

The original peoples of Australia are collectively, Aboriginal people from mainland Australia, and Torres Strait Islander people from islands off the northern tip of Queensland. Since earliest contacts with the colonisers, Australia's First People were considered inhuman by the use of the fictitious legal term "terra nullius" (Latin: "empty land") (1-3). It was not until 1967 that these people were included in official census counts following a referendum. The Australian Government now recognises that Indigenous peoples have lived in Australia for at least 60,000 years and are considered the oldest continuous surviving culture on earth (4, 5). Understanding Indigenous identity means recognising how diverse Aboriginal peoples are and shifting away from notions of pan-Aboriginality; a concept that assumes homogeneity of Indigenous peoples (6).

The challenges facing Australian First People are well documented and form the basis of government policies formally encapsulated in 'Closing the Gap' (CTG). Australian governments are working with Indigenous people, their communities, organisations, and businesses to implement the new National Agreement on Closing the Gap at the national, state and territory, and local levels. The National Agreement has 19 national targets across 17 socioeconomic outcome areas that have an impact on life outcomes for Indigenous people. These targets cover health and wellbeing, education and employment, justice, safety, housing, land and waters, languages, and digital inclusion (7).

Many urban Indigenous people, (79% of Aboriginal people are urban dwelling, and 53% are under age 25 years), speak of a two-world construct, referring to feeling caught between an Indigenous world and the mainstream (8). Indigenous people generally have strong feelings about 'being' Indigenous; there is still a strong sense of pride, kinship, respect for Elders, families, ways of connection, connection to Country, and spirituality (9).

Deficit discourse and strengths-based approaches are two different ways of thinking about and responding to First Australian issues. Deficit discourse focuses on the problems within and beyond communities, while strengths-based approaches focus on their strengths and assets (10). Hay et al (2023) note there are compelling counter-stories told through the lens of Indigenous young people that have been largely absent in wellbeing scholarship and narratives. These stories are part of a 'strengths-based' consideration in addressing the prevailing deficit discourse of trauma-informed and medicalised mental health frameworks that dominate policy and practice approaches to Australian Indigenous discussions (1). In 2019 for example, a group of mainly Indigenous young people delivered a passionate statement named the "*The Imagination Declaration.*" This was an articulate call to education ministers, governments, and broader Australian society to listen to Indigenous young people, to expect the best from them, and to understand that they "*are not the problem, they are the solution*" (11).

> "*When you think of an Aboriginal or Torres Strait Islander kid, or in fact any kid, imagine what's possible. Don't define us through the lens of disadvantage […] Expect the best of us"* (11).

Deficit Discourse

'Deficit discourse' refers to discourse that represents people or groups in terms of deficiency, absence and lack. It particularly emphasises a narrative that predominantly situates responsibility

for problems with the affected individuals or communities, overlooking the larger socio-economic structures in which they sit (10) (Page vi).

Deficit discourse is based upon Indigenous communities having inherent problems. This discourse can be based on stereotypes and assumptions about Indigenous people, and it may lead to policies and programs that are paternalistic and disempowering (12). Continual reporting of, and focus on negativity and increased prevalence rates of poor health outcomes may actually reinforce undesirable behaviours and outcomes (13). Deficit discourse for example, is often used simplistically to explain the high rates of poverty, unemployment, and incarceration among Indigenous people. This discourse suggests that these problems are caused by people's own shortcomings. Deficit discourse can have many negative consequences. It might lead to feelings of shame and low self-esteem among Indigenous people. It can also make it difficult to develop effective policies and programs addressing the real problems facing communities. Under some circumstances, it may lead to a nihilistic view among governments and non-Indigenous people, that nothing can be done to help them, the problem is too hard, and that nothing ever works.

Strengths-Based Approaches

Alternatively, strengths-based approaches focus on the strengths and assets of Indigenous communities. This approach recognises that Australian First Peoples have a long history of resilience, wisdom, and adaptation, and it seeks to build on these strengths to create positive health changes (10).

Strengths-based approaches are predicated on the recognition that Indigenous people have intrinsic strengths and assets, and these can be used to overcome challenges. People are often more likely to thrive when they are supported and empowered. Strengths-based approaches recognise that Indigenous people have a long history of resilience and adaptation and have been stoic in a variety of settings, including education, health care, and social services (10). There is a contemporary move toward shifting the discourse from deficit to strength as this can be empowering for Indigenous people and can create a more positive and productive environment for all Australians. These approaches have been shown to improve outcomes for Aboriginal people, and to build stronger relationships between Aboriginal communities and service providers (10).

The Importance of Shifting the Discourse: Equity in Healthcare and the progression to Liberty

The language used about Indigenous Australian issues is extremely important. Improperly understood, deficit discourse may be harmful, while strengths-based approaches can be empowering. By shifting the discourse from deficit to strengths and considering the spectrum between the two, chiropractors can create a more positive and productive environment for Indigenous people who consult them. Adopting a strengths-based narrative should however, not be mistaken for calls to deflate the realities of disadvantage in the socioeconomic circumstances, or to deny the health conditions people continue to experience. Discourses of deficit occur when discussions and policy aimed at alleviating disadvantage become so mired in narratives of failure and inferiority that those experiencing the disadvantage are seen as ‘the problem’, and a reductionist vision of what is possible becomes pervasively negative. Operating only from a deficit

or 'illness-based' approach provides only one side to a complex narrative and inhibits alternative solutions or opportunities that facilitate growth (10).

Framed another way, people can discuss problems but do not offer up a reasonable solution. While understanding the premises of the strength-based literature, many Aboriginal people are reasonably and plausibly sceptical. People are often likely to change when they're able to forthrightly face their own problems in a manner of graded exposure to that which is feared most. It's the classic analogy discussed where the pain of staying the same becomes worse than the pain of change.

It is important to revisit the concepts of equality, equity, justice, and liberty as there is often confusion, especially between equality and equity. In healthcare, equality means treating all people and consumers the same way. Health equity focuses on seeking to address practices that lead to health inequities and inequality. This means addressing the ways in which poverty, racism, ableism, sexism, and other forms of oppression can make people unwell or create barriers to care (14). The stress of navigating a lifetime's worth of racism for example, has extremely damaging health effects (15). Health equity prioritises social justice by recognising that different individuals may need different levels of support to achieve the same level of health and outcomes. It goes beyond equality and aims to address systemic disparities in healthcare. The ultimate issue is justice, social justice (16). Reality is oppressive, equality is possibly unfair, equity may not address the root cause, justice aims to dismantle systemic barriers.

While equity may begin with the fair and equal treatment of individuals, it is not the ultimate concern of global health (17). Horton (2018) notes global health is influenced by power dynamics, with a few exerting power over many, leading to disparities based on race, gender, and economic status. Furthermore, associations of power are often associated with money and profit. These profits take a precedence over addressing established health inequities impacting deeply on Indigenous people (18). Chiropractors are not unfamiliar with what can manifest in the domains of large, sponsored research that favours corporations over the health of people – the pharmaceutical and food industries being prime historical examples. Beyond equity, the defining objective of global health for many is *liberty* – the realisation of self-determination, freedom, and health and well-being sovereignty. All these are concepts close to the heart of the Chiropractic profession. Everyone deserves the right to access Chiropractic care.

To quote Horton directly for context:

> *"Global health is about the power of the few over the many. The power of the rich over the poor. The power of the advantaged over the disadvantaged. Equity certainly matters to be sure. But equity is not directly concerned with power. Indeed, the very idea of equity itself risks perpetuating disempowerment and injustice by disregarding the forces that damage and distort our lives, our communities, our ecologies. If equity is not the defining objective of global health, then what is? The answer is liberty. Liberty is anterior to equity. Fairness can never be achieved unless each of us has realised our aspiration for self-determination. Liberty is necessary to enable any kind of association on equal terms" (Horton, 2018)*(17).

What does this mean for Chiropractic?

The world views of First Peoples are complex, fluid, nuanced and evolving. Yunkaporta (2023 p.22) describes the term 'Dreaming' as being simplified for Western understanding as '*supra rational interdimensional ontology endogenous to custodial ritual complexes'* (19). Chiropractic thinking is also complex and grounded in systems thinking, reflecting the complexity of living systems, as illustrated in '*General Systems Theory*' (20, 21). Thinking that is primarily geared toward problems with two variables connected by linear causation in one direction, (such as the biomedical model) has difficulty handling complicated multivariate phenomena (22).

Chiropractic is a healthcare profession that focuses on helping people with neuromuscular syndromes, with an emphasis on spinal disorders (23, 24). One of the key reasons why chiropractic is a compatible with Aboriginal world views is that as a sustainable form of healthcare, is that it is a non-invasive, non-surgical, drug-free approach to health. Chiropractors embrace the World Health Organisations definition of health, *'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'* (25).

Contrary to previous assumptions, chronic low back pain (CLBP) is profoundly disabling for many Aboriginal people and should be a priority health concern (26). Chronic low back pain (CLBP) is a complex issue to manage in primary care and is under-researched in Aboriginal populations. Thus, it is critical that chiropractors and other allied health practitioners become conversant with strategies facilitating optimal care provision for Indigenous people, beginning with communication. Evidence shows good communication between practitioners and Indigenous patients is essential but difficult to achieve. Barriers to communication relate to content and the use of technical medical terms and jargon. Enablers related to communication style include 'yarning', a two-way dialogue, and having good listening and conversational skills (27). These are all skills embedded in the education of chiropractors, however becoming skilled when working specifically with Indigenous people is also in our view an essential attribute (28). The acquisition of these contextualised skills will require cultural sensitivity and awareness (29).

Whilst it is a historical reality that the Chiropractic profession has faced political exclusion (30) and ongoing criticism, the existential challenge is to address barriers and identify opportunities for expanded future roles, including in Indigenous settings.

Some of the most important work so far evaluating chiropractic services in Australia among Aboriginal people has been carried out since 2004 by Vindigni and his collaborators. In 2009 they identified Aboriginal Medical Services (AMSs) as the main portal of health care for Aboriginal communities, particularly in rural and remote areas. They also confirmed a disproportionately high prevalence of musculoskeletal (MSK) conditions in Aboriginal people compared with non-Aboriginal Australians, noting that chiropractors can impact substantially on the quality of life experienced by Aboriginal Australians. Chiropractors primarily (31, 32) manage MSK conditions (33). Vindigni notes there exist important philosophical similarities between healthcare as traditionally practised in Aboriginal communities and tactile therapies such as chiropractic. They developed a community-based chiropractic program, delivered in Aboriginal Community Controlled Health Services, informed by a community advisory group (34). Follow up data indicate that people had a significant change in their symptomatology due to chiropractic care (33).

The group subsequently successfully used a normalisation model (35) to consider ways to promote chiropractic services, to enhance relationships and interactions between clinicians and

procedures within Aboriginal health services, and to avoid disruption of the existing services. They identified ways in which chiropractors can become trusted team members with recognised knowledge and skills. They also developed strategies that could result in chiropractors finding a place within a complex occupational web, by being seen as similar to other well-known professions (36).

Meanwhile, Aboriginal scholars, led by Fogarty et al provide the foundational narrative about deficit discourse and interestingly devote a significant proportion of their seminal work to the topic of '*salutogenesis*'. Their analysis of the literature found there is a growing and emergent interest in salutogenesis as a conceptual underpinning based in strength. Salutogenesis—meaning "giving birth to health or, the origin of health"—is a term coined by sociologist Aaron Antonovsky over forty years ago and used extensively by Fogarty and others in their strength-based narratives (10). The concept is well known and used within the chiropractic literature (37).

Salutogenesis is closely associated with the positive psychology movement embodied in the works of Seligman (38), Maslow, May, Martin, Rogers and many others (39, 40). Antonovsky recognised that because a person was 'successfully treated' for medical conditions didn't necessarily mean that they were healthier or well (41-43). Salutogenesis is a '*scholastic focus on the study of the origins and assets for health, rather than disease and risk factors'* (42). It conceptualises a health/dis-ease continuum that is in contrast to the dichotomous classification of health or illness as pathology (42). Salutogenesis is concerned with optimising health and asks 'what makes people healthy?' (41). Rather than focusing on risk factors, it highlights 'salutary factors that actively promote health', and when working with communities and individuals it looks holistically at a person and their life (42). An ongoing critique of current Indigenous health research is that it is conducted mainly within a pathogenic paradigm that only highlights the 'problems' of Indigenous communities. This involves focusing on illness related gaps and needs, and the risks and vulnerabilities for Indigenous ill-health (44). A salutogenic approach is a progressive theoretical foundation for emerging strengths-based perspectives.

The elements Antonovsky termed 'environmental generalised resistance resources' are considered because they are within the purview of design practitioners to influence. Generalised Resistance Resources (GRR) as coined by Antonovsky (1979, 1987) comprises the characteristics of a person, a group, or a community that facilitate the individual's abilities to cope effectively with stressors and contribute to the development of the individual's level of a 'sense of coherence' (SOC) (45).

Idan et al explain that the GRRs refer to, "Phenomena that provide one with sets of life experiences characterized by consistency, participation in shaping outcomes and an underload-overload balance" (Antonovsky, 1987, p. 19). Such resources may include; (1) material resources (e.g., money), (2) knowledge and intelligence (e.g., knowing the real world and acquiring skills), (3) ego identity (e.g., integrated but flexible self), (4) coping strategies; (5) social support, (6) commitment and cohesion with one's cultural roots, (7) cultural stability, (8) ritualistic activities, (9) religion and philosophy (e.g., a stable set of answers to life's perplexities), (10) preventive health orientation, (11) genetic and constitutional GRRs, and (12) individuals' state of mind (41, 43, 45, 46).

While Antonovsky's work became focused on an aspect of salutogenesis he termed 'sense of coherence' (SOC), he actively encouraged exploration of additional aspects. Mazzi (2020) subsequently proposed an expanded definition of salutogenesis that includes five aspects of

environmental GRR that can address or alleviate specific causes of stress— sense of coherence' (SOC), biophilia (the human tendency to interact or be closely associated with other forms of life in nature), relaxation response, self-empowerment, and prospect and refuge (47).

According to Jonas (2014):

> *"Salutogenesis takes a different lens in healthcare. Instead of looking at just simply stopping the pathology, we can look at reversing pathology by enhancing our own inherent healing capacity*" (48).

This perspective toward salutogenesis is something with which many chiropractors, even those who adopt a so-called 'mechanistic' paradigm, can identify. There is an 'essentiality', something almost primal about chiropractic. '*All one needs to practice Chiropractic is one's hands and the ground'* (attributed to JW Parker 1920-1997). Australia's First Peoples have been on this ground, this 'country' now called Australia, by most robust estimates for at least 60,000 years. They have much to teach the wider Australian community about this country.

So, when working respectfully with Indigenous people there are several strategies that have been identified as important to guide practice. 1) Commit to building relationships by relinquishing control and try build your own awareness of Aboriginal and colonial history. 2) Learn about and use yarning in communication (49, 50). 3) Be flexible, humble, honest, and persistent using reciprocity, reflection, and reflexivity as these are cornerstone strategies from which many other strategies naturally follow (29, 51).

How and what can non-Aboriginal people learn from Aboriginal ways of communicating?

Spending time together and 'yarning' is important in Indigenous culture. Aboriginal scholar Yunkaporta explains that in Aboriginal culture, pronouns for example, mean things that are often different to non-Aboriginal people. There are social groups where everything is distributed throughout the group, including decision-making, governance, and power. To Aboriginal people, yarning is vibrant and overlapping.

> *"The aim of the yarn is to build a loose consensus out of many different points of view, so you've got an accurate picture of the reality from as many different points of view as possible because that is more approximating the truth"* (19, 52).
> *"I have built on … oral exchanges with people who make me feel uncomfortable. I yarn with those people because they extend my thinking more than those who simply know what I know"* (19)(p15).

Evans, a distinguished professor of linguistics, notes in the realm of knowledge of nature, biology, ecology, there's an accumulated observation of thousands of generations about the natural world that is transmitted through the words of Indigenous languages (53). Words are connections between people and country and environment including in health settings (54). For example, some Indigenous languages don't have words for 'left' and 'right', rather they use words that situate the person with respect to direction, (east, west etc) on country. Kinship relationships are different, respect for Elders, uncles and aunties have different collective importance than for non-

Aboriginal people (54). This complex view of human relationships and the universe resonates with chiropractors who recognise the nature and importance of complex systems (55-57).

According to Pat Anderson as chair of The Lowitja Institute (2014), to address the root causes of the ill health of First Nations people, more than prescriptions and treatments are needed. Aboriginal people need to have a sense of agency in life, that they “are not stray leaves blowing about in the wind”. In a Andersons’ view that word is ‘empowerment’ (46) (pv).

All these concepts are central to a move beyond the power differential of practitioner (powerful) and patient (less powerful) which is intrinsic to working with Indigenous people. When the practitioner approaches the clinical encounter from a perspective of curiosity and humility in an attitude of being a conduit of healing, both may benefit as they build a shared reality (29).

The disparities in access to chiropractic services in our communities are a fundamental matter of social justice that must be a high priority item for member organisations in advocacy, regulators, and educational institutions. Access to quality healthcare, including chiropractic, is a basic human right as recognised by the World Health Organisation (58). The profession must be advocating effectively so that barriers to access are addressed whether they be based on financial, socioeconomic, regulatory, or for pragmatic political reasons. This begins with the most fundamental of healthcare dynamics, that of practitioner and consumer. As practitioners, we must corporately seek to acquire the skills required to provide care in a culturally safe and nurturing environment. Then, structural barriers can and must be challenged. These barriers include chiropractors not presently being widely situated in public health settings, hospitals, community health centres or Aboriginal Medical Services in Australia.

Conclusion and Call to Action

Health is connected to liberty, as ill-health and diminished well-being restricts freedoms and opportunities. To address global health challenges, when working with Indigenous people, we advocate for a deeper understanding of a strength-based approach, focusing on cultural, economic, professional, and political rights to foster Indigenous peoples’ and communities’ rights in the chiropractic context. The chiropractic profession has since its inception advocated for social justice, health equity and access to services for the entire community. This existential challenge remains.

Just as the overall health of any society is determined by the health and well-being of its least advantaged people, collective health is predicated on our encompassed sense of well-being. Caring for each other is everyone’s responsibility, and in all our best individual and collective interest. Chiropractors have a key role to play in adopting person-centred care to facilitate, co-design and embody its original principles of holistic care for the world’s oldest living culture.

About the authors

Bill Hayward: Providing Primary Chiropractic Contact for Aboriginal People.

It is believed that Dr William (Bill) Hayward was the first chiropractor in Australia, (graduation 2008) who identified as Aboriginal (Noongar), making him an Elder in the profession. He was also the first chiropractor employed at an Aboriginal Medical Service (AMS) in Western Australia when

he commenced practice at Derbarl Yerrigan in 2009. Derbarl Yerrigan Health Service (DYHS) is an Aboriginal community-controlled health organisation which was established in 1974. 'Derbarl' provides holistic and integrated primary health care services to Aboriginal people living in the Perth metropolitan region and currently employs 127 staff across four locations (59). The Murdoch University undergraduate placement program was proposed by Dr Hayward while he was a student at the university and active as the Indigenous Guild representative.

Dr Hayward highlights that successful communication is at the heart of the clinical consultation, however communication between Aboriginal patients and practitioners is often a barrier to the successful delivery of health care. He uses humour and yarning as resources to put people at ease during the clinical encounter. 'Clinical yarning' is a person-centred approach that integrates Aboriginal cultural communication preferences with biomedical understandings of health and disease. Lin et al (2016) describe clinical yarning as consisting of three interrelated areas. The social yarn, in which the practitioner aims to find common ground and develop the interpersonal relationship; the diagnostic yarn, in which the practitioner facilitates the patient's health story while interpreting it through a biomedical or scientific lens; and the management yarn, that employs stories and metaphors as tools for patients to help them understand a health issue so a collaborative management approach can be adopted (50). There is cultural and research evidence that supports this approach (49, 50).

Troy Walker: Taking Lifestyle Medicine to Aboriginal People. Nyini Health & A2B Personnel

Troy is a proud Yorta Yorta man, an experienced chiropractor and strength and conditioning coach working in the clinical health, wellbeing, nutrition, and physical activity domains. He is active in - and passionate about - nutrition research and practice, clinical pain management, Aboriginal lifestyle health, social and emotional wellbeing, and neuromusculoskeletal rehabilitation (60-62). He is an active research professional affiliated with Deakin and Monash Universities with a master's degree in human nutrition having particular focus on Australian Aboriginal strength-based approaches. This is especially as it relates to nutrition, physical activity and sarcopenia prevention in older adults and includes regular publication, delivery of lectures, workshops, and presentations at seminars on these topics (63).

Troy is a dedicated member of the Australian Chiropractors' Association (ACA), the Australian Society of Lifestyle Medicine (ASLM) and an elected member of the diagnostic taskforce for the Australian and New Zealand Society for Sarcopenia and Frailty Research (ANZSSFR) and the Monash University Nutrition and Dietetic Course Advisory Board for ongoing tertiary education. He has obtained Clinical Fellowship in Lifestyle Medicine with the ASLM. He works in his local Aboriginal community with the young and old, and among his family in health and clinical care, especially in mentorship, coaching and assisting age-related muscle and bone loss prevention and general lifestyle-based health outcomes through multi-modal care delivery.

Lyndon Amorin-Woods: Murdoch University chiropractic placement program manager

Lyndon is a Wadjela (white person, as far as he knows) living in Perth (Boorloo), Western Australia. He has a Master of Public Health (MPH) and has been manager of the Murdoch University Chiropractic Rural & Remote Placement program since 2019. The Murdoch University chiropractic program has conducted clinical immersion placements in the Kimberley, Pilbara, Gascoyne, and Mid-west regions since 2006. Collaboration has been with Rural Health West (RHW), the Western Australian Centre for Rural Health (WACRH), and Majarlin Kimberley Centre

for Remote Health, and the WA Country Health Service (WACHS). The placements have been variously situated in Aboriginal Medical Services; hospitals; nursing posts; and community open spaces. The placement program has received substantial financial support from the Australian Chiropractors' Association (ACA) for many years.

The program's outreach teaching clinics offer Aboriginal people and others who live in remote communities, health screenings and chiropractic services to which they otherwise may not have access at no charge. The services are greatly appreciated and strongly supported by people of the communities they serve. The discipline has also pro-actively instituted Aboriginal and Torres Strait Islander cultural awareness and competence training for all students. Since 2015 compulsory cultural awareness training has been embedded in the curriculum. Students receive both online and 'face-to-face' training contextualised for non-metropolitan placements (29). The chiropractic program is the only health professional program in Western Australia that requires all students to complete a non-urban clinical immersion placement in their final (5th) year of study.

Over the years, students have provided around 20,000 health checks and treatment visits corresponding to approximately $1 million in opportunity cost value. While this project primarily involves the treatment of spinal pain and other physical problems, it also encourages healthy living and health promotion, thus addressing quality of life for disadvantaged people. The program has been found to increase the likelihood that graduates will return to practice in the country by up to five times (64).

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