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Elizabeth Usher memorial lecture 2024: Speech-language pathology practice in Aboriginal spaces: A journey of learning and unlearning

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Abstract

In this paper I describe learnings gained from 15 years collaboration with Aboriginal colleagues in Australia, in endeavours to improve rehabilitation services for Aboriginal people with brain injury and their families. Colleagues include Aboriginal researchers, clinicians, and people with communication and other disorders associated with brain injury and their families. My research journey in this field has been made possible through the work, mentoring, and support of these colleagues who introduced me to Aboriginal ways of knowing, being, and doing. My journey has involved challenging and un-learning some widely accepted Western tenets of speech-language pathology practice in order to explore culturally acceptable practices. The notion of learning, while at the same time unlearning and relearning is discussed in this paper along with several crucial ingredients of working cross-culturally in an Aboriginal *space*. These include ongoing relationships, collaboration, and the concept of cultural security. Clinical yarning as a method to be employed in both clinical and research contexts is also discussed as it has been applied to particular projects undertaken to date. The paper encourages the unpacking of aspects related to evidence-based practice, accepted research methodologies, and assessment and treatment processes in brain injury rehabilitation and in speech-language pathology, generally.

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Background to the paper and positionality

From the outset, I want to acknowledge the Aboriginal mentors and colleagues who have guided the cultural journey that I have followed now for several years as part of combined efforts to pursue better ways of providing meaningful and accessible rehabilitation services for Aboriginal and Torres Strait Islander peoples after brain injury. While the work I will discuss has been collaborative and my learnings — and unlearnings— are many and ongoing, I want to be clear from the outset that my comments in this paper are made from a wadjela (whitefella) perspective and, as such, I won't be defining or confirming the cultural security of a particular set of processes or ways of doing things. I am hoping, however, that this paper may contribute to a still small but growing body of work within the discipline of speech-language pathology and related disciplines, in encouraging and challenging speech-language pathologists (SLPs) to examine their current practices to enable ways forward with the goals of increasing inclusivity, access, and relevance of our services. This applies both to Aboriginal and Torres Strait Islander peoples and to peoples of other cultures that may be different from the therapist's own. While coming largely from an adult neurological and brain injury perspective, I hope that some of the learnings conveyed will resonate with SLPs across the range of practice. I also want to emphasise that *learning* is not just a cumulative process and that to *learn*, one also often has to sometimes *unlearn* previous beliefs/tenets and leave space for new learning and re-learning. In this discussion paper, I will highlight some of the perspectives and concepts that have been part of my

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journey, working with Aboriginal and non-Aboriginal colleagues over a number of years.

I'd like to position myself as a White woman who grew up in the north-western suburbs of Sydney, largely unaware that I was living on Wallamedegal country (the land of the Dharug nation) at the time and knowing very little about Aboriginal and/or Torres Strait Islander peoples (respectfully and predominantly referred to as Aboriginal people from here on as the majority of my experience has been with Aboriginal communities) or cultures. Despite my living through Stolen Generation policies (Lavarche, 1997) and during a time when Aboriginal people in Australia didn't have the vote, it wasn't really until my post-school days that I started becoming more socially aware of what was happening within Australia and the struggles of Aboriginal and Torres Strait Islander peoples (a case of classic white privilege). My cultural awareness was raised and continued to grow in pockets or moments of learning such as occasional culturally-centred workshops or the reading of articles. However, even when I went on to work as the head of the speech-language pathology department at one of the largest hospitals in Sydney at the time, located right next to what was the largest Aboriginal community in Sydney, I still wasn't doing anything with this awareness in my clinical practice. I certainly never visited the first Aboriginal Medical Service in Australia located at Redfern (Foley, 1991; Marles et al., 2012) which stood almost next door to the hospital, I didn't know if Aboriginal Liaison positions existed in the hospital, I didn't explore whether there were Aboriginal people on our caseload, nor investigated measures that might increase a feeling of cultural safety for Aboriginal patients in the hospital. Ultimately, it was my postgraduate study of sociolinguistics and associated readings, followed by active seeking out of Aboriginal colleagues which highlighted my need to reflect on my practice and speech-language pathology practices in general, when working in an Aboriginal context and to do something with those reflections.

Since that time, I've had the privilege, largely through my research work, to experience a wide diversity of Country[1] within Australia as well as a diversity of Aboriginal cultures. While brain injury and rehabilitation have been at the centre of much of my research, I've also been involved in curriculum development, organising teaching for speech-language pathology students about Aboriginal cultures and language differences across paediatric and adult speech-language pathology client populations and contexts, and have also had the privilege of being an ex officio member of the Speech Pathology Australia Aboriginal and Torres Strait Islander Advisory Committee until recently, representing a university curriculum perspective.

But my journey in the research field, in particular, has been made possible through the work, mentoring, and support of many wonderful Aboriginal and non-Aboriginal colleagues but in particular Aboriginal researchers, clinicians, and people with communication and other disorders associated with brain injury and their families—who introduced me to Aboriginal ways of knowing, being, and doing. In particular, I'd like to acknowledge all the wonderfully generous and committed individuals named at the end of this paper (and many who aren't) who are committed advocates for their peoples and who have shared their knowledge and wisdom with me and others in our team over a number of years.

Introduction

At the current time, there is much discussion of diversity, inclusion, and equity, with social movements seemingly going forward at times and backwards at others in terms of achieving social justice. Economic/resource pressures, political pressures, systemic influences, and racism influence health, education, and other related services, with speech-language pathology being very much a part of, and being impacted and shaped by, these systems and influences. In a colonised country, with colonial systems still in place and resultant inequities still high in many Indigenous communities (high incidence rates of a variety of diseases, social disruptions, lower life expectancy than non-Aboriginal Australians), non-Aboriginal SLPs often report struggling to engage with Aboriginal communities and/or provide services which meet the needs of those communities (Hersh et al., 2015). Many Aboriginal people want such services but report difficulties accessing them due to factors including geographical remoteness, competing family and community demands, and the lack of cultural security of the services offered (Armstrong et al., 2021).

The aim of this paper is not to offer solutions, but to elucidate the context of speech-language pathology in relation to both historical and current political influences to assist SLPs to reflect on their services, acknowledging the ongoing effects of these powerful influences. In order to approach the reconciliation work needed to successfully begin to meet Aboriginal clients' and their families' expectations and needs, it is essential that SLPs know their own history on which current frameworks are built. In a cross-cultural *space*, self-reflection is key to finding solutions. Efforts to simply gain knowledge about the *other* often masks the importance of reflecting on one's own personal and professional worldview and practices built around this particular set of values and experiences. A brief discussion of the notion of *worldview* is included below.

Acknowledgment of the richness and strength of Aboriginal languages, protocols, spirituality, families, and communities is also key for our field for whom a primary focus is language. For many years, and similar to many disciplines, both speech-language

pathology research and clinical practice involving Aboriginal communities and related health issues have been built on a deficit model. Such a model places a focus on illness, social dysfunction, disadvantage, and disconnection (Bullen et al., 2023) and has reinforced a negative narrative surrounding Aboriginal people and cultures, also typically drawing comparisons with non-Indigenous people (e.g. as is also evidenced in *the gap* terminology; Fields et al., 2024). This is especially evident in relation to work surrounding language and literacy development in Aboriginal children. Scholars are beginning to *call out* this model. It was called out in the disability sphere many years ago—both in terms of failing to acknowledge the role of colonisation in creating this gap and all that it entails, and failing to acknowledge the rich history, culture, practices, and strong kinship systems of Aboriginal people/communities. Scholars are increasingly promoting strengths-based and Indigenist approaches that include studies on language revitalisation (Bracknell, 2020), health, and wellbeing (Garvey et al., 2021) and *flourishing* (Bullen et al., 2023).

This discussion paper alludes to the above issues as well as raises key concepts such as cultural security, clinical yarning methodology, and the importance of relationships and collaboration in both undertaking research involving Aboriginal peoples and in providing clinical services. But firstly, a necessary brief historical perspective is provided.

Influence of origin of speech-language pathology as a profession: The political context

When we look at the history of speech-language pathology as a profession globally, we see that it originated in Europe and the UK, and had its roots in elocution, medicine, linguistics, and education. Speech-language pathology spread to the USA, Canada, Australia, and later Africa; then more recently to Asia, the Middle East, and South America—largely adopting and adapting existing ideologies/frameworks from the original ones. More recent developments have increasingly acknowledged the need for local collaboration and cultural contextualisation/adaptation (Staley et al., 2022), yet theoretical frameworks and treatment programs often remain familiar and activities such as translation of long-existing assessment tools persist.

In recent articles and books on speech-language pathology history and its positioning politically, there has been increasing acknowledgment of the role of colonisation (e.g. in Aotearoa [New Zealand], South Africa, Australia) and exploration of where speech-language pathology sits in terms of redressing linguistic, cultural, and educational inequities in its practice (Abrahams et al., 2019; Penn et al., 2017; Pillay et al., 2024; Nair et al., 2024). In other allied health disciplines, discussions are significantly expanding on rehabilitation models, for example, with occupational therapy in particular contributing valuable and innovative insights and initiatives (e.g. Meechan et al., 2024) and psychology focused on decolonisation principles for several years now (Dudgeon & Walker, 2015).

The role of elocution in speech-language pathology's history is a significant one in that it reflects an assumption that there is a *correct* way to speak. While many of us today may like to distance ourselves from elocutionists, there are some clear ramifications of this beginning for a profession in which language is core. For example, there are now many forms (or dialects/variations) of English: American English, African American English, Singaporean English, Australian English, Aboriginal English. I would challenge us as SLPs, as to whether we view all these variations as equal. There's evidence that this isn't the case. For example, there are specific *rules* for what is accepted as *academic English* in universities, *standards* of report writing in speech-language pathology professional practice and journal article writing, and there is ongoing evidence of misdiagnosis of language disorder in children who may speak a variation of English from a clinician's own variety (Gould, 2008; Armstrong et al., 2019). While our profession is now discussing some of these issues, we still have a long way to go in incorporating linguistic diversity into our practice.

In order to be theoretically comprehensive, the discussion of language and communication must be situated not only in the scientific, medical, and linguistic realms, but in the political realm, as well (Abrahams et al., 2019). Language has long been acknowledged as a powerful tool for political control within different societies. This includes making some languages more powerful than others by prioritising their use in legal, educational, and health systems, often excluding speakers of other languages from equitable access to such systems (Malcolm, 2018). Forbidding the use of speakers' first languages, which happened in Australia with colonisation, is of course the ultimate in an attempt to control a population and was a clear initiative in this case to extinguish Aboriginal cultures. If not familiar with history in relation to language policies or not sufficiently cognisant of the role of language in construction of identity or centrality to culture, SLPs are particularly vulnerable to perpetuating colonial attitudes and practices. Canadian researchers St Pierre and St Pierre (2018) reflected on how SLPs can become gatekeepers of dominant language forms:

> The **therapeutic** industry of speech-language pathology has become the dominant mode of approaching speech variation. The way we understand voices that stray beyond codified linguistic and temporal boundaries is widely assumed to be medical and scientific, not political. Part of this depoliticization stems from the fact

> that expert knowledges of speech disability have gone uncontested. (p. 151).

Medical and scientific analysis/characterisations of language that speech-language pathology predominantly uses, have typically been prioritised over social and linguistic theories that explain language difference/s. This has tended to pathologise language difference (Gould, 2008). For example, complex phonological and grammatical adaptations made by Aboriginal speakers to European languages and regional European accents introduced into Australia by colonial settlers (i.e. Aboriginal English) have often been categorised as *pathological* or erroneous uses of those languages. This has failed to acknowledge the rich linguistic processes involved in the development of these adaptations or variations (Malcolm, 2018) and automatically relegates Aboriginal English to a lower status rather than acknowledging it as a language in its own right. Readers are referred to Malcolm (2018) for a detailed analysis of the development of Aboriginal English including principles of dynamic adaptation, restructuring of English, and ultimate ownership of English through the establishment of a distinct form of English used by Aboriginal people. Calls for Aboriginal English to be used in legal, educational, and public service settings are currently being made (Malcolm, 2018); with Aboriginal English being increasingly used but still on a limited basis, in classrooms. As Malcolm highlights, "If Aboriginal English is to be accepted as a legitimate vehicle of communication in the Australian context, there are important implications for the ways in which services needed to be provided" (p. 185).

As a profession that's focused on communication and language, interaction with these issues is highly political and sensitive, but totally necessary.

Colonisation and its effects

The effects of colonisation and indeed colonial practices are ongoing within Australia (Watego, 2021). In summary, *colonisation* involved displacement of Aboriginal and Torres Strait Islander peoples—communities and families—through the Stolen Generations where children were removed from families (Lavarche, 1997), the taking of land, the suppression of Aboriginal and Torres Strait Islander languages, the suppression of cultural practices, the denial of access to health services, the restriction of freedom of movement, incarceration, and imposition of Western educational, cultural, spiritual, and political frameworks. The impact of these acts included many languages being extinguished and socioeconomic inequities—poverty, poor housing, food insecurity, unemployment, high mortality rates, multiple disease comorbidities, intergenerational trauma, with Aboriginal people being largely disenfranchised. Aboriginal peoples did not get to vote until 1962, and were only included in the national census in 1967. In 2024, the Voice to Parliament Referendum, asking the Australian public to vote for the establishment of a federal advisory body made up of Aboriginal and Torres Strait Islander people to represent the views of Indigenous communities on Aboriginal and Torres Strait Islander matters resulted in a resounding "no" vote.

While the above are often seen to be historical in nature, ongoing colonisation is evident in many systems and practices today as noted above (Watego, 2021). SLPs diagnosing language difference as disorder is an example of ongoing colonisation within speech-language pathology itself (Gould, 2008). This exemplifies a certain type of language use being prioritised over another, thereby disadvantaging the speaker of the non-standard form and relegating that speaker to a less powerful position of someone who needs assistance or whose language needs fixing. In this case Standard Australian English is the language of power—note the term itself highlights the issue in that one form is considered *standard* when another is *non-standard*, used by a minority of people and is often equated with *sub-standard*. Another example of ongoing colonisation in the general health service context is the use of systems which inherently disadvantage a particular group. Many health services are located at a great distance from rural and remote populations; in addition, hospitals are perceived by many Aboriginal patients and families as unwelcoming or challenging (Armstrong et al., 2021). Although seen as necessary for many good reasons, rules about who can visit, times allowed for visiting, autonomy of patients (e.g. moving around the hospital, going outside the ward), discharge planning often excluding significant others in a person's community, and lack of opportunity to communicate in one's first language do not allow room for cultural protocols to be followed, often cumulatively having significant effect on patient and family autonomy. SLPs using standardised tests and programs as part of an evidence-based practice framework often fail to take into account the populations used in the background research of these tools and programs for validation. This can lead to misdiagnosis and ill-directed treatments that are not appropriate for the population at hand. While co-design and consensus statements are currently promoted in the research field, with increasing emphasis on consumer engagement in these processes, White middle-class, SLPs often still dominate the development of clinical guidelines. Speech Pathology Australia has taken up this challenge and its Aboriginal and Torres Strait Islander Advisory Committee and Aboriginal membership have generated new frameworks and guidelines that will influence practice in the years to come, for example, the Culturally Responsive Speech Pathology Practice Framework (Speech Pathology

Australia, 2024a), with current work focused on dissemination and implementation of these through the Association's Reconciliation Action Plan (Speech Pathology Australia, 2024b). Even further developments have been undertaken in Aotearoa with multiple documents and practices introduced, for example, Towards Equity for Maori: A guide for Speech Language Therapists working in Aotearoa (New Zealand Speech-language Therapists' Association, 2022). Brewer's work with Maori (e.g. Kohere-Smiler et al., 2024), and collaborative international work (Brewer et al., 2019; Penn et al., 2017) provide excellent analysis and models for speech-language pathology practice with First Nations peoples.

Learning, unlearning, and re-learning

On my cultural journey, I have found the model of learning, unlearning, and re-learning to be a very useful one. It was futurist Alvin Toffler in 1970 (although sometimes debated) who is credited with the famous quote, "the illiterate of the 21st century will not be those who cannot read and write, but those who cannot learn, unlearn, and relearn."

In order to move forward, reflection on what we've learned and where that comes from, is essential. When we talk of unlearning, we're not talking about rejecting or throwing out these practices/theories/principles—we need to be able to critique them, let go of some of them, and/or modify them so we don't stagnate. We then leave room to re-learn from a different perspective, being able to incorporate new knowledges. This notion is important when addressing the cross-cultural domain, as noted by Grogan et al. (2023) in relation to student absorption of cultural learnings within an Indigenous Studies unit at university, and by George (2024), another non-Aboriginal researcher exploring Indigenist methodologies. Grogan et al. (2023) observed the importance of assessing students' prior knowledges in order to be able to "constructively build upon what is already known, which in turn assists students to effectively link their prior knowledge with the newly presented knowledge, and the educator to alert students to further learning or troubling misconceptions for unlearning" (p. 1934). In her own cultural and transformational journal, George uses a weaving metaphor to describe how she "reflected on the significance of unravelling before I could weave in new knowledge" (p. 741).

Below I outline key concepts that have informed my new learnings, then contextualise them in terms of research our team has undertaken to date.

Worldview

What does the term *worldview* mean and how is it relevant to speech-language pathology? In some ways, it may be considered a simplistic way of explaining different cultural perspectives as, in fact, worldviews are frequently modified, influenced, and changed. Nakata (2007) refers to this issue when discussing the *intercultural space* and in particular the way/s in which colonised peoples have had to navigate different worldviews. Another useful definition of worldview is, "a collection of attitudes, values, stories, and expectations about the world around us, which inform our every thought and action. Worldview is expressed in ethics, religion, philosophy, scientific beliefs, and so on" (Sire, 2004 in Gray, 2011).

Worldview is often characterised through conceptualisations, for example, the notion of *disability* is a largely Western one. The Aboriginal scholar, Scott Avery (2018) provides a comprehensive discussion of how this is framed in Aboriginal cultures/languages and why approaching such a conceptualisation cross-culturally/cross-linguistically is problematic. A systematic review by Puszka et al. (2022) further highlights how the notion of disability, framed initially from a biomedical model, continues to perpetuate colonial domination through "disability support services that often exclude many Indigenous people [and] … frequently fail to encompass Indigenous values and social practices, and in some cases, services are experienced by Indigenous people as hostile environments" (p. 1).

Cultural conceptualisations involve mental images that organise a speaker's view of the world (Sharifian, 2017). Some simple examples of the same words eliciting different images between Aboriginal and non-Aboriginal speakers taken from the work of linguists, Ian Malcolm, Glenys Collard, and Patsy Konigsberg in the South West region of Western Australia (Malcolm, 2018) include items such as *supper*, in Aboriginal English typically referring to the main evening meal at home, while potentially referring to a snack before bedtime in Australian English; or *picnic* referring to a large gathering involving the outdoor cooking of food in Aboriginal English, whereas in Australian English, the word can refer to any group of family/friends in the open eating food prepared beforehand (cooking not necessarily involved).

Broader examples of a particular worldview, familiar to adult therapists and often used in speech-language pathology clinics, include the commonly used language test pictures such as the Cookie Theft picture from the Boston Diagnostic Aphasia Examination (Goodglass et al., 2001), and the picnic scene from the Western Aphasia Battery (Kertesz, 2006). The Cookie Theft picture depicts a middle-class family of mother, father, and two children in a suburban home with one parent mowing the lawn and another washing dishes. The WAB picnic picture contains a couple sitting on a rug by a lake with a picnic basket and a bottle of wine, someone flying a kite, and a yacht on the lake. While the cultural, linguistic, and socioeconomic bias of such commonly used

pictures has been repeatedly noted (e.g. Steinberg et al., 2022), they continue to be widely used.

An example of an Aboriginal worldview of speech-language pathology from an Aboriginal person flown from a rural to a metropolitan area for treatment after suffering a stroke is exemplified in the following quote (unpublished to date) from a participant in our Missing Voices project (Armstrong et al., 2015):

> "When we're talking about speech, we got to understand that Australia … we got a people still here that speak their own language and you get flown out to a city and expect to … to speak with, you know, really little office, this pretty … pretty girl with blonde hair and blue eyes, you're in culture shock … (Stroke Survivor, Missing Voices project, Armstrong et al., 2015).

As just mentioned, worldview informs everything we do and all of our attitudes. Our personal worldview comes from our upbringing—our childhood experiences, our language, attitudes of parents, schools, peer groups. Our professional worldview is informed by all of these elements plus institutions in which we work, the broader society in which we operate, and the professional learnings that come through our education—school, undergraduate, and postgraduate training.

Figure 1 is an attempt to capture what an SLPs professional worldview might look like. At the centre are some general activities and some principles commonly involved and accepted as best practice in aphasia practice. The next outlying circle depicts some general categories that capture principles of practice which SLPs largely abide by, including the notion of evidence-base which is currently pervasive. There are general notions of assessment and treatment principles, research methodologies, ways of writing and talking professionally, that all increasingly depend on rationales from our growing evidence base.

Speech-language pathology currently proclaims itself as an evidence-based profession and exists within a climate of the need to justify clinical and research practices with solid rationales and evidence. Clearly, evidence is an important concept as peoples' wellbeing, including ultimate mortality in some cases, and use of resources, including huge financial resources, are involved in today's health and education services. SLPs have an ethical responsibility to know what we're doing and have good support for doing it. In reflecting on speech-language pathology practice, however, a critical reflection on the dominant professional worldview including its view of the construct of evidence is crucial to include. What is the nature of the evidence that currently forms the basis of many of our practices? Where does that evidence come from in terms of cultural, philosophical, and methodological worldview? Is that evidence appropriate in particular contexts only with particular populations? Could it be damaging or dangerous to employ outside the context in which it was gained?

Sprague (2001) cited in Dudgeon et al. (2020) questions the Western methodologies often used in research undertaken by non-Aboriginal researchers with Aboriginal people, "from whose lives, needs,

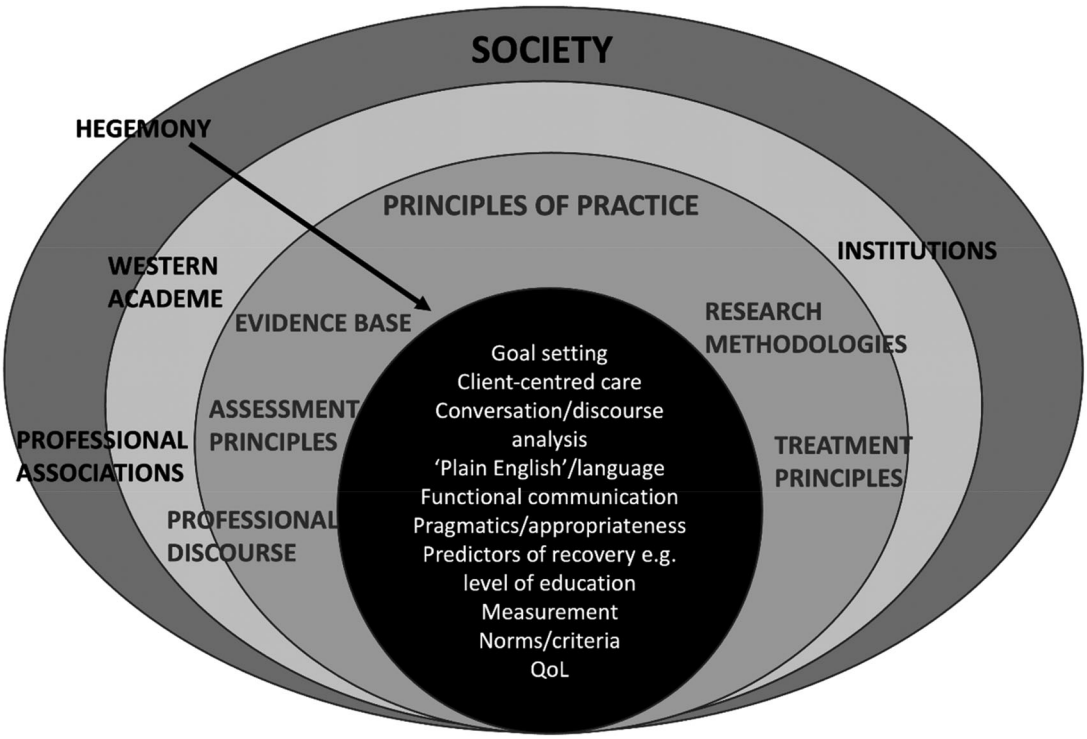

Figure 1. Example of factors influencing a speech-language pathology worldview.

and interests do we begin; whose ordering of experience do we take seriously; to whom are we responsible to communicate; when has a question been adequately answered?" (p. 534).

While communication-focused therapies rarely have fatal consequences, in a cross-cultural environment, where language both shapes and reflects identity and where control of language has been a powerful and destructive political tool for attempting to destroy generations of peoples' identity (as occurred in the Aboriginal context in Australia), it is possible that our clinical practices could have very significant consequences. The current speech-language pathology evidence-base is centred around certain Western research methodologies and rarely acknowledges other methodologies such as Indigenist methodologies or knowledges. For many years, the latter have often been cited from the so-called grey literature. *Grey literature* is work not published in traditional academic journals and is not typically peer-reviewed in the traditional sense. However, this situation is changing with the emergence of Indigenous-focused research undertaken by Indigenous scholars (Watego et al., 2021). Indigenist methodologies provide a broad range of tools and principles that not only surround research but can inform clinical practice. Principles include Aboriginal leadership and consultation with community, acknowledgment of the diversity of Aboriginal peoples, acceptance of colonisation as a social determinant of disability, and use of the local language in all endeavours (Gilroy et al., 2013). I would refer readers to Aboriginal scholars such as Professors Chelsea Watego (Watego et al., 2021), Scott Avery (Avery, 2018), Martin Nakata (Nakata, 2007), John Gilroy (Gilroy et al., 2013), Pat Dudgeon (Dudgeon & Walker, 2015; Dudgeon et al., 2020) for discussions of Indigenist methodologies as well as the ongoing colonial practices which continue to prevent widespread dissemination of alternative worldviews and methodologies.

Hegemony

Beyond speech-language pathology principles of practice (see the third outlying circle in Figure 1), we are influenced by the values, structures, and power of institutions in our professional sphere, for example, our clinical workplace (hospitals, community centres, schools, not-for-profit organisations, private practices, schools), our educational institutions, our professional associations. All operate on particular philosophies that are enacted through such things as clinical guidelines, codes of ethics, professional competency frameworks, employment practices; and that serve to influence, monitor compliance with, and maintain certain tenets on which disciplines are based. The outer circle in Figure 1 represents broad societal influences and ideals. While Australia has indeed become multicultural, it retains the predominantly British systems of law, education, government, and English (Standard Australian English [SAE]—terminology noted above) prevails in all of those systems.

Hegemony is a term that encompasses all of the above influences. It describes the various ways in which one group in a society has dominance over another. Hegemony can be cultural, economic, political, military, or informational. While many of these apply in an Aboriginal context here in Australia, we will focus on the cultural one where language is the primary hegemonic tool employed in speech-language pathology contexts. Readers are referred to the book 'Hegemony of English' (Macedo et al., 2015)—particularly relevant for a discipline that deals in language—for an overview of influences at play in promoting, for example, English as a/the world language. Of relevance to speech-language pathology in Australia, linguistic hegemony is reflected in speech-language pathology university entrance examinations requiring a high level of SAE of international students; journal standards for academic writing in English typically involve Standard Australian, American or British English forms; published systematic reviews (e.g. 60% of aphasia reviews include English only; only 14% unrestricted language inclusion; Jagoe & Isip, unpublished); numerous texts used in speech-language pathology student education contain guides for professional report writing that promote standard forms of English only; there is ongoing discussion of confusion between disorder' vs difference' in non-native English speakers or speakers of various dialects of English (apart from SAE); pragmatic features of English are often considered the norm, for example, use of narrative story structures seen as universal (e.g. Clinical Evaluation of Language Function 5th Edition – Wiig et al., 2020).

As noted previously, many speech-language pathology assessment tools represent a certain worldview, with few challenges to this dominance, such as the type of pictorial representations as noted above, as well as numerous assessment tasks based on a Western worldview. Examples of tasks include the explanation of idioms (e.g. "butterflies in the stomach", "turn over a new leaf", "fly off the handle", "hit the nail on the head"), or verbal reasoning tasks such as, "life is better in the city than in the country, give me a reason to support this statement, now give me an argument against it," and "give two reasons why people like to eat in restaurants" (Mt Wilga High Level Language Test, Simpson, 2006 – revised 2nd edition). Such tasks disadvantage speakers who are not familiar with these expressions, have never lived in the city, have a life experience that does not include eating at or familiarity with restaurants, or who are not familiar with a question/answer format involving decontextualised language tasks. In addition, they are often not standardised or validated on many of the populations they are used with and, in the case of Aboriginal peoples, these tasks have definitely not

been validated. Hence, the chance of poor scoring and misdiagnosis is high. This can lead to misguided treatment and management, as well as alienating the person being assessed.

Despite concerns having been expressed about culturally-biased assessment tools, SLPs continue to use many of these tools, often citing lack of alternatives. Ethical concerns come into play in this context. Tools and guidelines developed from Aboriginal and Torres Strait Islander perspectives – developed with and by Aboriginal and Torres Strait Islander peoples—remain few, although efforts outside of speech-language pathology in allied areas are of relevance, particularly in the areas of quality of life and mental health (e.g. Gilchrist et al., 2023; Westerman, 2012)—both areas being relevant to speech-language pathology. Language tests remain few (e.g. the Gumerri Assessment, developed by Aboriginal SLP Tara Lewis and described in Lewis et al., [2017] is one of the few). Creative and culturally-responsive therapists around the country are creating/co-designing different tools, but our formal evidence-base still insists that *real* tools must meet certain criteria for validity and reliability in order to be used for formal reporting, for funding purposes, etc.—hegemonic pressure, in fact. I would encourage creative therapists to continue to co-design and use tools created with their local community and consider dissemination where appropriate.

Deficit discourse

Hegemonies are often reinforced and maintained through language use and styles. As mentioned, language is a powerful tool, and the way we as SLPs use language professionally both reflects and constructs our philosophy. Discourses of deficit have been described across numerous contexts (e.g. law, healthcare, education, management) for several years (Candlin & Crighton, 2011). In the largely biomedically driven Western health context, deficit discourse has been dominant as Western medicine is largely underpinned by the principle of describing, diagnosing, and fixing health problems (Bryant et al., 2021). In an Indigenous context, Bryant et al. argue that, "as a result, biomedicine not only holds the power to narrate the 'truth' of Indigenous ill health and deficit, but also serves to hide Indigenous ways of knowing and Indigenous concepts of health and wellness" (p. 1406).

Highlighting disability as a social construct, rather than a state of being involving inherent deficit (Oliver, 1990), has changed the narrative somewhat in the disability field for health practitioners and for society in general, although there is still a way to go (Gilroy et al., 2013). Both clinicians and the general public/institutions have been encouraged to take a strengths-based attitude and approach to enabling all members of the community to reach their maximum potential, provide maximal opportunities for both social and occupational activity, and ensure equitable access to community resources. Indigenous scholars continue to argue for a similar approach to narratives surrounding Indigenous health still often characterised by a deficit framed discourse. In the introduction to a paper exploring the notion of *flourishing* in Aboriginal communities, Bullen et al. (2023) emphasise the importance of a strengths-based focus rather than a continued focus on disadvantage and fixing what is wrong:

> While the impact of trauma on Aboriginal Australians is well documented, a pervasive deficit narrative that focuses on problems and pathology persists in research and policy discourse. This narrative risks further exacerbating Aboriginal disadvantage through a focus on 'fixing what is wrong' with Aboriginal Australians and the internalising of these narratives by Aboriginal Australians. While a growing body of research adopts strength-based models, limited research has sought to explore Aboriginal flourishing. This conceptual paper seeks to contribute to a burgeoning paradigm shift in Aboriginal research, seeking to understand what can be learned from Aboriginal people who flourish, how we best determine this, and in what contexts this can be impactful. (Bullen et al., 2023, p. 1).

In terms of speech-language pathology specifically, in 1999, Dana Kovarsky, Judy Duchan, and Marilyn Maxwell edited what was quite a revolutionary book at the time called 'Constructing In-competence'. In that book, authors employed a social disability model (Oliver, 1990) through which they challenged the way/s in which SLPs make judgements about communicative competence/incompetence of their clients and often create clinical interactions which are inherently disempowering for clients, highlighting things that they can *not* do, and assuming client behaviours and attitudes always come from a deficit perspective, instead of acknowledging and facilitating success. In a chapter on report-writing in this book, Duchan highlighted the often negatively-skewed language of speech-language pathology assessment reports, resulting from the primary purpose of the report typically being to identify disorder and provide support for this diagnosis, with background information on the client being interpreted relatively negatively in order to again support the diagnosis. Progress reports, on the other hand, tended to be more positive, where the report purpose was focused more on reflecting change that had occurred as a result of treatment and included more positive recommendations. In a more recent study of speech-language pathology professional report writing focused on exemplars from texts devoted to promotion of best practice in speech-language pathology report writing,

O'Malley-Keighran (2016) highlighted the ongoing deficit focus of SLPs. They found a focus of terminology surrounding *deficits, disorder, and difficulties*, with terms such as "adequate … within normal limits … within functional limits" describing performance of individuals across a range of communication and swallowing tasks (p. 226).

Starting out publishing in the area of Aboriginal health, one of the aspects I have attempted to unlearn, despite many external pressures encouraging the opposite, is the use of a deficit approach in journal publications and grant writing. One of the first things often encouraged at an institutional/systemic level in both is an up-front description of the *problem* and how your study is going to/has addressed the problem. Of course how the problem is framed is crucial, but in much research undertaken with Aboriginal communities, often by non-Aboriginal researchers, the problem typically has been located within the Aboriginal population itself, with little acknowledgment of who determined the problem, whether the context described was actually determined a problem that needed a solution by the population described, and the broader context of this problem in terms of both the strengths and challenges of the community involved. A typical example of this is taken from one of our own journal articles from 2017:

> "Stroke and traumatic brain injury occur up to three times more frequently in Aboriginal and Torres Strait Islander (hereafter referred to as Aboriginal) Australians when compared to the non-Aboriginal Australian population … although figures are thought to underestimate the true incidence." (Armstrong et al., 2017, p. 297).

With greater Aboriginal input, journals, fortunately, are beginning to recognise this and demand attention to this, recommending a more strengths-based or explanatory approach representing Aboriginal agency. The following studies demonstrate alternatives to the above in their introductions, "the First Peoples of Australia (Aboriginal and Torres Strait Islander peoples) are richly diverse in terms of culture, language, experiences, and geography." (Cochrane et al., 2024, p. 149) … "Aboriginal and Torres Strait Islander peoples are less likely to use mainstream health services due to the previous negative experiences associated with institutional racism, fear of hospitals and the ongoing impact of colonisation and intergenerational trauma (Sheehan et al., 2024, p. 711) … "Every Wednesday people come to an Aboriginal led community center that operates as a community hub in a suburb of Perth, Western Australia, and gather for the Brain Injury Yarning Circle." (Armstrong et al., 2024, p. 2).

Learnings contextualised in our research to date

My learning and unlearning have taken place over a number of years now as part of ongoing collaboration with Aboriginal and non-Aboriginal colleagues around rehabilitation services. In the following section of this paper, I will outline further concepts I have encountered in this journey and how we've attempted to embed them in specific projects we've undertaken.

With a program of research that has lasted over 15 years, one of my biggest learnings has been the importance of sustaining the focus of research over

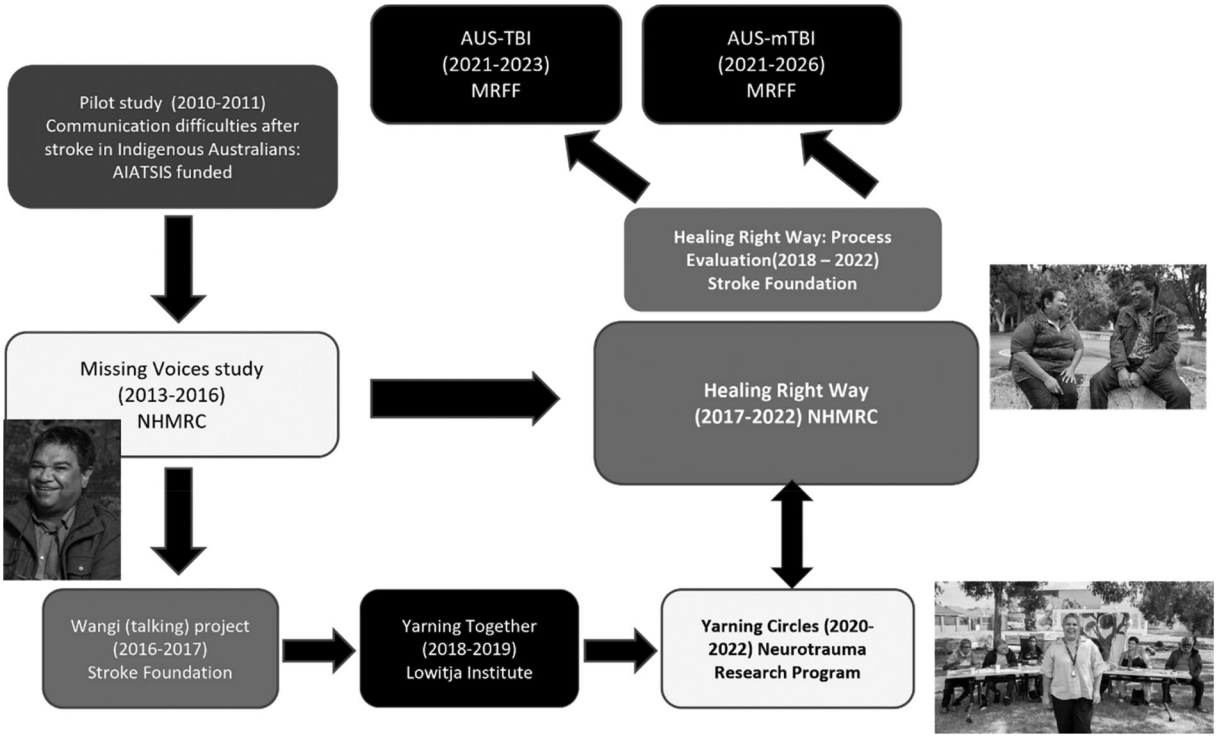

Figure 2. Program of research 2010 to date.

time – see Figure 2. Sustaining research focus has involved the ongoing building of relationships and partnerships, most particularly with Aboriginal community organisations, Aboriginal research colleagues, Elders and people with lived experience of brain injury, with learnings deepening over time.

Partnerships and relationships

When we started this work, I first approached my university's Centre for Aboriginal Research and Teaching and asked the Director for advice on how to start such research and whether there were any Aboriginal colleagues interested in collaborating or anyone interested in being a research assistant. He was forthcoming with personal recommendations which I followed up through many formal and largely informal face to face meetings. With attendance at Aboriginal-led conferences, relationship building with multidisciplinary partners in and outside of the university and mainstream health and education services, and the mentoring and assistance of the people mentioned initially and many more, I'm privileged to say that I'm now connected with Aboriginal researchers nationally. I'm currently the only non-Aboriginal Chief Investigator on a national team of seven Chief Investigators exploring concussion in Aboriginal communities, with an Aboriginal Project Manager Kerri Colegate coordinating the national project initiative.

Our recently completed Healing Right Way project demonstrates the culmination of partnerships developed in many ways (Armstrong et al., 2021a; Armstrong, et al., 2021b; Armstrong, McAllister et al., 2023; Katzenellenbogen et al., 2024). Based on the recommendations from Aboriginal participants in our previous projects, Healing Right Way was a clinical trial undertaken in Western Australia in 2017–2022 to improve rehabilitation services and, ultimately, health outcomes for Aboriginal people after stroke and TBI. The project involved four metropolitan and four rural sites across the state.

We recruited 108 Aboriginal people to the study who had recently been admitted to hospital for either a stroke or traumatic brain injury and followed them up for six months after their injury. During that time they received the services of an Aboriginal Brain Injury Coordinator (ABIC) who provided advocacy, support, information, and education to the person and their family (Armstrong et al., 2021). We employed nine ABICs throughout the project who acted as a statewide network to support participants. We also provided cultural training workshops to 250 hospital staff.

Partnerships and relationships were crucial throughout. The research partnerships included university-based researchers and clinicians (Aboriginal and non-Aboriginal), Aboriginal people with lived experience of brain injury and their families, Aboriginal Community Controlled Health Services (ACCHS) throughout the state – mostly the same partners as in previous projects, some of whom had been involved since the outset of our research endeavours. It was the statewide network established for the project and the strength of relationships developed amongst the research team, including the strong network of ABICs (who provided each other with valuable peer support), the ACCHS, and the hospitals (Katzenellenbogen et al., 2024) that enabled participants with brain injury to be successfully followed up over a six-month period.

Cultural security

There are numerous terms used to describe both feelings of Aboriginal clients (e.g. cultural safety, cultural security) and aspirations of health service providers (e.g. cultural humility, cultural competence, cultural responsiveness). In relation to brain injury rehabilitation and as part of the Healing Right Way cultural security training program (Armstrong et al., 2019), Aboriginal colleague Professor Juli Coffin defined cultural security as:

> Cultural security in brain injury care for Aboriginal people refers to ensuring that Aboriginal cultural values, world views, and ways of working are incorporated at each level and stage of the care of the Aboriginal person with a brain injury and that services will not compromise the legitimate cultural rights, values, and expectations of Aboriginal people.

I can't write about what cultural security necessarily looks like, as only the Aboriginal client/family can judge whether a service is culturally secure or not. However, an example of what it doesn't look like, often cited to me by Aboriginal colleagues, is being the only Aboriginal person on a committee or at a meeting, sitting listening to the wadjelas (whitefellas) discuss Aboriginal health and rarely being given the floor or asked for input.

Coffin (2007) provided a framework (see Figure 3) which describes the layers of cultural safety

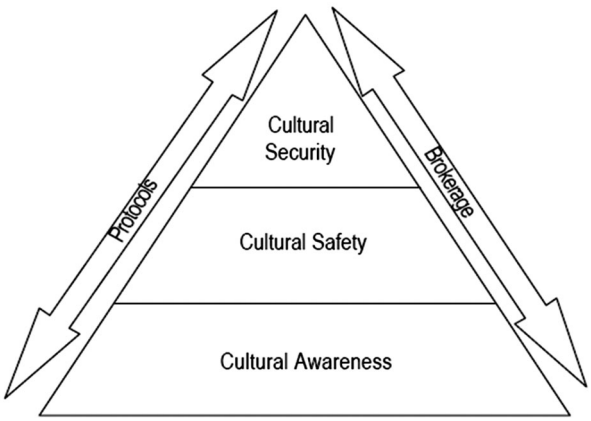

Figure 3. Cultural security hierarchy. Reprinted from Coffin (2007) with permission of author.

"There is somebody that you can yarn with about that stuff, cause not a whole lot of people really understand the impact of someone having an acquired brain injury and how it changes their life" (carer of son with TBI)

"I know what X is capable of so I sort of stand on the side and say things and do things to encourage him on…So it's my little job in the meetings (male with stroke)

"With other Aboriginal people here, expectations and image doesn't matter – it's great you know you're accepted for who you are as a person. That's really valuable" (male with TBI)

Figure 4. Quotes from brain injury yarning circle participants.

Figure 5. Brain injury yarning circle community: Community members including elders, carers, yarning circle facilitators, university-based researchers, sponsors.

and security. Coffin talks about cultural security being related to both individuals and organisations and it builds over time. It begins with cultural awareness with people reading about culture, learning about kinship for example, languages, and protocols. It then develops into skills that are put into practice. For example, you might be aware of extended family networks in Aboriginal cultures, you start being more flexible and inclusive in your practice, you include various people in consultations and therapy sessions, and acknowledge different roles within families and communities. You might acknowledge some of the difficulties people may have in getting to appointments for example, and organise transport, or change appointments as needed. Cultural security is when this is really guaranteed across an organisation so that it doesn't just depend on one person's knowledge or responsiveness but is part of the organisation's sustainable philosophy and practices.

While I don't claim that all of our projects have been a gold standard of cultural security, I think the Brain Injury Yarning Circles (BIYC) project (Armstrong et al., 2022; Armstrong et al., 2024) comes very close. BIYC involved the running of community support groups for people with brain injury based in Perth and a regional centre in Western Australia. The groups were led by Aboriginal facilitators and were located in local community centres. The facilitators were local and had strong community connections. The centres were meeting places for Aboriginal people prior to the establishment of the BIYC, with the Perth-based centre being a large centre where Elders already regularly met, food security programs were in place, social activities took place, and Aboriginal children from the local schools

visited on a regular basis to meet with Elders and engage in cultural activities. Other complimentary local council and government services (e.g. doctor, social services) also were available at the centre on a visiting status. In this environment, both yarning circles provided a culturally safe space for participants, focusing on empowering participants by engaging in educational, fun and meaningful activities such as music, sharing and practicing of language, art, yoga, trips on Country, self-care activities such as having hair and nails done, as well as discussion surrounding their brain injury stories.

The targeted cultural support offered at BIYC very much reflected an acceptance of people without judgement, with explicit acknowledgment of their cultural backgrounds (in terms of where they were from, language, family connections) and acknowledging the intersectionality involved—multiple identities related to their Aboriginality/cultural connections, disability/medical condition, living arrangements, Elder status for some (Armstrong et al., 2024). It provided an inclusive environment and a good example of what McDermott (2019) termed "meeting people in their own reality", and indeed provided a good model to be emulated in community-based clinical practice (p. 254). Some reactions of participants that support the evaluation of BIYC as being a culturally secure context (taken from Armstrong et al., 2022) are provided in Figure 4 below.

The photo in Figure 5 shows the community surrounding the BIYC and the sense of cultural security involved in a local Aboriginal community space, with the BIYC facilitated and organised by Aboriginal community members. It was taken at the Perth launch of a video that members of the metropolitan BIYC participants produced to encourage community members with brain injury to re-engage with their lives and discover a *new self* after brain injury. The launch was attended by over sixty people including centre workers, carers, Elders, and non-Aboriginal supporters.

Clinical yarning

Yarning was central to the BIYC project, of course (i.e. the two-way sharing of stories within a culturally safe space). Yarning is defined as, "a conversation that is two way and inclusive of both speakers. To have a yarn is not a one way process but a dialogical process that is reciprocal and mutual" (Bessarab & Ng'andu, 2010, p.38).

The notion of clinical yarning has also been developed by Lin et al. (2016) which is described as, "a patient-centred approach that marries Aboriginal cultural communication preferences with biomedical understandings of health and disease" (p. 377).

A big lesson that I've learned in the yarning sphere is not around the talking, but around listening. I think SLPs often consider themselves to be good communicators and listeners. However, I think we also know that we're very good, and frequent, talkers. The aphasia research literature contains numerous papers about the domination of assessment and therapy sessions by clinicians (Brogan et al., 2020). Listening may therefore be an area worth further exploration within speech-language pathology practice. The Aboriginal term *dadirri* (Ungunmerr-Baumann et al., 2022; a word that belongs to the language of the Ngan'gikurunggkurr peoples of Daly River in the Northern Territory) – but with similarities throughout the country – refers to the following:

> Dadirri is the art of being present, being still, connecting with yourself and the environment in such a profound way that it creates space for deep relationships. Dadirri encourages cyclical, deep listening, and reflection. Through Dadirri, relationships are built on trust and respect, which provides opportunities to create the co-directional sharing of knowledge and privileges Indigenous voices. Ungunmerr-Baumann et al., 2022, p. 96.

Of course there's listening to the words that someone says and there's listening for the meaning behind them. With deep cultural and worldview implications, cross-cultural listening is often challenging, as what a person from one culture hears when listening to a person from another cultural talking may be different to what that person is meaning. This is because of the multiple factors that come into cross cultural communication——assumptions about the other person, attitudes, self-perceptions of your role (perhaps professional role) in the interaction, worldview, and numerous power differentials.

As noted above, participants attending the BIYC yarned together across numerous activities. Sometimes story-telling was enmeshed in the other activities, for example, participants' experiences and feelings were expressed and captured in music and art forms, with a strong focus on adjustments of living with a brain injury towards positive wellbeing. Yarning was facilitated in these ways, with group facilitators assisting participants with communication problems, for example, and with participants helping each other. Listening to each person's story, shared understandings of cultural contexts, silences as appropriate, all played a role in creating a culturally secure space.

The notions of cultural security and yarning also were key in the planning and implementation of the Healing Right Way project. One of the most important factors related to the cultural security of Healing Right Way included the fact that the ABICs provided a shared worldview with the participants that made yarning easier, as the ABICs understood the person's context regarding aspects involving family, community, cultural protocols, any shame felt. This often meant that follow-up was possible and wanted, including by people located in rural and remote

"...knowing that someone was there throughout their journey, and just building that relationship, having that rapport with them, I think they really enjoyed it. And we've also experienced it from the initial contact, let's say when they're in hospital, and following them through that, throughout their journey, like what you grow together with that new client, you know, their shame at the beginning, but as time goes on you yarn, and, you know, you link up family"

"...keeping hold of our clients and being persistent and trying and trying, you know, we have a bit more of a positive outcome. Whereas if anywhere else, they might say, Oh, we've tried twice. That's it, you know, couldn't get a hold of them. Yeah, back to the bottom of the list."

Figure 6. Quotes from Aboriginal Brain Injury Coordinators in the Healing Right Way project.

settings. We achieved 80% follow up at 6 months through the cultural security of the project which is very different from the challenges many clinicians often cite in following up many Aboriginal clients.

Figure 6 contains quotes highlighting reflections from the ABICs themselves on their work and the importance of relationships and yarning.

Conclusion

In my journey of learning, unlearning, and relearning, I've had to reflect (and still do of course) on where I've come from and where my values have come from—both personally and professionally, and how these affect other people. I've had to look at our profession's evidence-base differently. My learning and unlearning have occurred through different processes of reflection, collaboration, listening, cultural immersion, yarning, and reading about Indigenist methodologies. My relearning has incorporated new knowledges sometimes alongside the old. For example, I always acknowledged the importance of family and networks surrounding the clients I worked with, involved family in therapy where possible, and explored family interactions and therapies in my research. However new insights into Aboriginal kinship systems, interactional styles, rules of Aboriginal English and yarning, and Aboriginal partnerships have given me reason to see possible new ways forward in working with Aboriginal families (and *conversation partners* as is current terminology in aphasia research). At the very least, I have an awareness of what evidence to date may *not* be applicable in an Aboriginal family context, an awareness of the depth of cross-cultural differences in communication, and the significance of language both culturally and from a specific historical context. I've used my ever-increasing awareness of the nuances of implicit deficit discourse along with my existing linguistic knowledge to alter my written discourse (although with ongoing editing from Aboriginal colleagues!).

I know there are varying personal and professional journeys for both Aboriginal and non-Aboriginal SLPs. But for many who are just starting on their professional journey in particular, I would encourage going outside of speech-language pathology for cross-cultural and multidisciplinary perspectives. In particular, I would recommend pursuing opportunities where the SLP can learn from Aboriginal Elders, academics, and community members. There is much to be learned outside of often siloed discipline-based knowledges. Attending Indigenous conferences (e.g. the Lowitja Conference, the Indigenous Allied Health Australia Conference) can be invaluable. Visiting the local Aboriginal Community Controlled Health Service, and making connections there is critical. School and hospital based SLPs need to develop strong relationships with Aboriginal Liaison staff. University based academics all have access to their University's Aboriginal and Torres Strait Islander research and teaching centres and could ensure attendance at seminars offered, participate in co-teaching opportunities, as well as establish meaningful personal connections.

To conclude, the following quote from Bullen et al. (2023) aligns with the notions of learning, unlearning, and relearning; and articulates the

urgency of change required in disciplinary perspectives on deficit that still prevail within speech-language pathology, particularly in an Aboriginal context. I hope my reflections above encourage readers to explore their own philosophies of clinical practice from a critical perspective and assist in the development of culturally secure speech-language pathology services into the future:

> We reiterate the urgent need to push back against and/or expand upon the predominant focus on individual and community deficit and dysfunction within many disciplines. We also reiterate calls to investigate the potential benefits and utility of integrating Aboriginal ways of knowing, being, and doing and Western positive psychology methodologies (i.e. strength-based social science). We suggest this offers a unique and potent means of reflecting on the current status quo and enables new perspectives to shift the dial on seemingly intractable problems in our society (p. 15).

Note

1. "Country is the term used by many Aboriginal peoples to describe the lands, waterways and seas to which they are connected. The term contains complex ideas about law, place, custom, language, spiritual belief, cultural practice, material sustenance, family and identity." AIATSIS, 2025.

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