



Value-Full: A Theoretical Analysis of the Speech-Language Pathology Positionality

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Article Information

Article editor: Kristen Abrahams
Article type: Research article
Review type: Double anonymized
Submitted: 1 August 2022
Revised: 29 November 2022
Revised: 11 April 2023
Accepted: 14 September 2023
Published: 20 December 2023

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DOI:

https://doi.org/10.48516/jcscd_2023vol1iss2.11

Published by:

Adelphi University Libraries

(<https://www.adelphi.edu/libraries/open-access/digital-publishing/>)



Citation: Brouse, H. (2023). Value-Full: A theoretical analysis of the Speech-Language Pathology Positionality. *Journal of Critical Study of Communication and Disability*, 1(2), 6-27.
https://doi.org/10.48516/jcscd_2023vol1iss2.11

Abstract

In a culture built by settler colonialism (e.g., the United States), colonial values are perpetuated in cultural knowledge (e.g., its language use). Standard language practice replicates these values unless language professionals consciously work to refuse them. This paper argues that language interaction in this context cannot be value-neutral but is inherently value-full. While prior research addresses the culturo-linguistic realities of speech-language pathology clients, little work in the United States addresses the context and positionality of speech-language pathology clinicians, not only obscuring their values from view but their impact on clinical practice from scrutiny. This research conceptually framed the colonial values inherent in dominant United States culture. Using this framing as a conceptual tool, this qualitative study completed a textual analysis comparing three documents from the American Speech-Language-Hearing Association to two colonial value hierarchies, investigating how and to what extent colonial values are inherent in the field.

Keywords

Colonialism, speech-language pathology, culture, clinical practice, cultural values, power.

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Positionality Statement

Audre Lorde wrote, “I am not free while any woman is unfree, even when her shackles are very different from my own.” Coloniality appears to be related to every power system oppressing my communities and those beyond me. As long as colonialism is unrecognized and unchallenged, I am not free. Dr. Adriana Ramirez de Arellano instilled in me the conviction that praxis requires love to take hold. I believe in a world outside coloniality. I love its potential for creation. My own positionality and values undergird my work. I benefit from the very colonial constructs I critique. Objectivity, I argue, is impossible — my responsibility instead is to expose the value-full inner workings of my research to their necessary checks. Coloniality cannot be resisted without first the understanding and acceptance of the responsibility to do so. Every question I ask of SLP requires first this current research. By uncovering the existence of colonial values in the U.S. SLP field, my hope was to support work against them. I welcome all responses to this research and refuse to accept financial reward from any publication of it, now or in the future.



Language and culture are interconnected realities that express each other. Interaction with language, then, cannot be value-neutral, but rather is fully situated within the context of cultural values (Duranti, 2011, Freire, 1970/2017). The knowledge produced by a given culture acts on its values through either replication or resistance; in a settler colonial context such as the United States (U.S.), colonial values are embedded in U.S. cultural knowledge (Abrahams et al., 2019, Quijano, 2007). The field of speech-language pathology (SLP) in the U.S. emerged from this colonial context and its clinical practice acts on standards of “normal” and “abnormal” language practice. This research aimed to analyze the colonial values embedded in texts from the U.S. SLP field at the national level in 2021. The research included developing a critical framework of colonial value hierarchies and using it to analyze American Speech-Language-Hearing Association (ASHA) texts for evidence of coloniality.

Culture and Coloniality

Culture and language exist symbiotically, making it impossible to access one without the other (Duranti, 2011; Saussure, 1915). As a created reality, culture contains the social constructs of a given group (e.g., history, customs, identity, power dynamics; Sardar & Loon, 1999). Cultural participants use shared language to define, express, and maintain these constructs that create their culture. This cycle exists due to the shared reality of culture, which relies on communication to exist (Emmitt and Pollock, 1997). Change in the language, then, leads to change in culture, and vice versa.

Cultural contact between distinct languages and cultures takes a multitude of forms, including the forceful exertion of power. Settler colonialism (one such system of domination) describes the method through which one culture seeks to destroy and replace Indigenous peoples’ cultures, bodies, and languages (Sayles, 2010; Spit Justice, 2018; Veracini, 2010; Wolfe, 1999; Wolfe, 2006). Given the interrelationship of language and culture, the erasure, replacement, and/or

disconnection of language is a settler colonial method of exerting this power (Fanon, 2004; Grosfoguel, 2011; Mignolo, 2012). This domination, once established, must be continuously maintained through coloniality: the erasure of pre-existing Indigenous and other cultural values and the normalization of the dominating cultural values over all other occurring constructs (Grosfoguel, 2011; Maldonado-Torres, 2007; Quijano, 2010; Veracini, 2010; Wolfe, 1999). Settler colonialism is the foundation of the United States. U.S. residents are positioned within a dominant culture not only built by colonialism to destroy, erase, and replace the cultural values and practices (e.g., languages, genders, philosophy) of Indigenous nations it colonized, but maintained by coloniality to uphold its domination over all other values. To act in – without deviating from – a colonial culture is to perpetuate colonial values (Mignolo, 2012; Quijano & Ennis, 2000). The colonization of the North American continent established hierarchies which empower a eugenicist white supremacy (e.g., ideas, people, experiences) over everything and everyone else (Grosfoguel, 2011; Quijano, 2010; Quijano & Ennis, 2000). Puerto Rican sociologist Ramón Grosfoguel (2011) theorized these hierarchies place cultural constructs either inside or outside of a “zone of being.” Within the zone, constructs are viewed as both standard and superior to others; the others, outside the “zone of being,” are both sub-human and inferior (Grosfoguel, 2011; Maldonado-Torres, 2007; Quijano, 2010; Quijano & Ennis, 2000). I use the term “positive value” to refer to cultural constructs in the colonial “zone of being” of a hierarchy and the term “negative value” to refer to cultural constructs and hierarchies disempowered by them. I use these terms not in support of this valuation but in description of its application. Coloniality as a system of power perpetuates

what it positively values and erases and replaces what it does not, thereby regulating what is standard or “normal” in a colonial culture.

Positioning the Speech-Language Pathologist

The American Speech-Hearing-Language Association (ASHA) is the nationally credentialing body for speech-language pathologists in the United States. As a national association, it empowers and supports the SLP profession as well as the interests of the clinician-researchers and clients (ASHA, n.d.). Under ASHA’s description, the scope of SLP includes prevention, assessment, (re)habilitation, and scientific investigation of communication (e.g., speech, language) disorders through both professional practice and service delivery domains (ASHA, 2016). The SLP profession uses the World Health Organization’s International Classification for Functioning, Disability, and Health (WHO-ICF) as a framework for service delivery under this scope (ASHA, 2004, 2016). ASHA emphasizes the importance of evidence-based practice across the practice of SLP “to the extent possible” (ASHA, 2016).

Current evidence for best practice in the SLP field recommends restructuring clinical practice for multicultural clients, particularly Indigenous clients, whose cultures, bodies, and languages the settler colonial project of the U.S. attempts to erase and replace (Berman, 1976; Huer & Saenz, 2003; Neff & Spillers, 2008; Pillay, 1997; Pillay & Kathard, 2018; Ross, 2016; Ukrainetz et al., 2000; Westby, 2013). Yet adjusting clinical practice implies both that change is needed and that standard practice does not satisfy this need. Even the term “multicultural” itself collapses a disparate array of experiences into a lump group of “other” which is then implicitly

excluded from standard clinical practice. This othering is a process through which one side of a binary is defined in opposition to the “other” (Bauman, 1991; Beauvoir, 1949; Said, 1979; Spivak, 1985). For example, traditional, standard SLP practice should be restructured for the undefined group of “multicultural” clients, this “other” against which standard clients are implicitly defined. Little research within the U.S. investigates its SLP field (or SLP practitioners) for what underlying values are defined against the exclusion they create, which requires such a restructuring.

Current evidence for best clinical practice in SLP recommends considering the three components of client values, clinical expertise, and external/internal evidence (ASHA, 2005). This recommendation seems to emphasize the perspectives that both clients and clinicians bring to therapeutic work. Yet little research within the U.S. investigates the positionality of clinicians or of the SLP profession itself within power structures (Pillay & Pillay, 2021). When the positionality of the individual speech-language pathologist and the SLP profession at large are excluded from clinical considerations, their impacts on clinical practice are likewise excluded from scrutiny.

The colonial value hierarchies are the foundation of dominant U.S. culture and perpetuated in its constructs. It follows that U.S. cultural values persist in its production of knowledge. Speech-language pathologists in the U.S. assess, (re)habilitate, and investigate clients’ communication (e.g., speech, language) in a colonial context, which inherently involves interaction with the colonial value hierarchies through either replication or refusal (Abrahams et al., 2019). The interplay between colonial values and clinical practice has been critiqued by clinician-researchers in other countries and cultures (Bird, 2020; Penn et al., 2017; Pillay & Kathard, 2018; Pillay & Pillay, 2021; Staley et al., 2022; Watermeyer &

Neille, 2022). Yet, within the U.S. context, the SLP profession is slow to acknowledge this interaction. Without realization and reaction to this reality, the field perpetuates violence and maintains power systems that oppress the clients (and clinicians) for whom we otherwise profess support in quality of life (ASHA, 2015; ASHA, 2016; ASHA, n.d.; Grosfoguel, 2011; Mignolo, 2012; Quijano & Ennis, 2000).

The interaction between SLP and language inherently cannot be value-neutral. The traditional framing of speech-language pathologists, their education, and the field of SLP itself as value-neutral ignores that neutrality is an illusion obscuring the unique construction of position in relation to history, identity, experience, culture, and other constructs (Duranti, 2011; Filippakou, 2022; Freire, 1970; Giroux, 2020; Haraway, 1988; Yanow, 2006). These gaps in the research considering the values inherent to the SLP position in U.S. practice are addressed in part by SLP researcher-clinicians holding identities traditionally marginalized in the field, within and beyond the U.S. and by fields of related study such as disability studies, critical race studies, gender and sexuality studies, colonial studies, and cultural studies (Batterbury et al., 2007; Bauman & Murray, 2017; Berman, 1976; Campbell, 2001; Crenshaw, 1989; Davis, 1995; Eckert & Rowley, 2013; Davis & McKay-Cody, 2010; Grosfoguel, 2011; Hill, 2017; Huer & Saenz, 2003; James et al., 2020; Lane, 1999; Markotic, 2001; Neff & Spillers, 2008; Penn et al., 2017; Pillay & Kathard, 2018; Ross, 2016; Ukrainetz et al., 2000; Westby, 2013). Yet despite the ongoing colonial violence in the U.S., despite published evidence that those affected by that violence require change in clinical practice, and despite structural change generated by persons in the field and related disciplines, the SLP field in the U.S. does little to recognize its own positionality. Standard practice continues to

remain falsely value-neutral rather than to investigate what I term, in direct contrast, our “value-full” position.

Language and culture are interconnected in their expression. When engaging in the communication of a cultural context, we are able to understand its values. U.S. cultural values are replicated in its production of knowledge at sites such as the SLP profession. In order to analyze the values inherent to the U.S. SLP field, I chose to engage with its texts – to engage with the production and communication of the cultural knowledge of ASHA.

To analyze the values embedded in the 2021 U.S. SLP field and their relationship to the colonial values embedded in dominant U.S. culture, I asked: how does current practice in the 2021 U.S. SLP field as exemplified by the American Speech-Language-Hearing Association’s documents of Preferred Practice Patterns, Certification Standards, and Code of Ethics compare to two colonial value hierarchies?

Method

The above literature review of critical theory (e.g., postcolonial theory, feminist theory, critical race theory) formed my understanding of coloniality. Based on the reviewed literature, to identify colonial values embedded in texts produced by the 2021 U.S. field of SLP and analyze their relationship to the colonial values of dominant U.S. culture, I created the framework of colonial value hierarchies below. This framework summarizes the manner in which two colonial value hierarchies interact with cultural constructs by normalizing and empowering them or othering and disempowering them. I then conducted textual analysis of three ASHA texts (Preferred Practice Patterns, Certification Standards, and

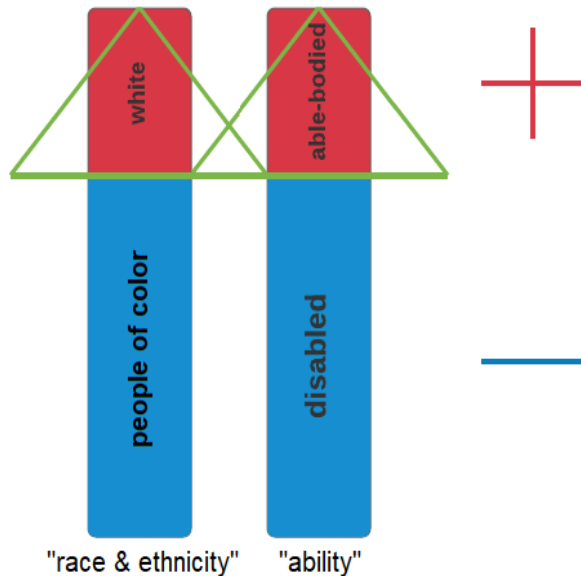
Code of Ethics) using the colonial value hierarchy framework to identify values embedded in texts, compare them to the colonial value hierarchy framework, and analyze their relationship.

Colonial Value Hierarchy Framework

I selected two colonial value hierarchies for analysis in SLP from those maintained in dominant U.S. culture: race, ethnicity, and ability. The form and evolution of my research inherently impacted the number of hierarchies chosen in ways that are acknowledged in my limitations. My own familiarity with the colonial values at work in the U.S. varies across disparate arenas and inherently impacted my choice in ways that are described in my limitations and positionality. I chose the selected hierarchies for their impact on the field. The institutionalization and routinization of medical care, including SLP, is part of an ongoing colonial power structure that legitimizes forms of knowledge produced in alignment with the settler colonial values of the United States. The social constructions of race and disability and the understanding of community history represented in ethnicity are critical to this undertaking. As discussed in the literature review, the dominant values in a society are replicated in the standard practice of its institutions; given that the field of SLP was developed in a white supremacist and eugenicist settler colonial society, it follows that those would be the values encoded in the institutions. To visualize my selected colonial value hierarchies, I created the following diagram (Figure 1).

Figure 1

Two colonial value hierarchies



Each hierarchy I investigated is represented with an upright pillar. Constructs positively valued and empowered by coloniality are at the top in red, a position maintained by disempowering the negatively valued constructs denoted in blue. These pillars are divided into the binary of “positive” or “negative” by a green line representing their inclusion or exclusion from the “zone of being.” This reductive inclusion/exclusion binary masks a complex range of experiences – all constructs outside the colonial zone of being are unified solely by their othering, despite potentially having nothing else in common (Bauman, 1991; Said, 1979; Spivak, 1985). Thin green lines connect the top of each pillar to the green line of the zone of being and to each other. These lines indicate the pillars’ interconnectedness and joint effort to uphold the colonial system.

The framework visually describes the colonial value hierarchies of dominant U.S. culture. When conducting textual analysis

research as described in the methods, I used this framework to identify, compare, and analyze values embedded in ASHA texts for evidence of coloniality. Each pillar of the framework is described below.

Colonial Values of Race & Ethnicity

The first pillar in the framework (white/non-white) allowed for analysis of race and ethnicity as cultural values in the U.S. which affect communication. Race is a fluid perceptual construct that relies on cultural constructs of blood lineage, phenotype, segregation, privilege, law, and geographic location (Collins, 2020; Crenshaw, 1989; Delgado, 2013). Ethnicity is the self-identification of a group in recognition of a shared politicized past (Anzaldúa, 1987; Collins, 2020; Nagel, 1994). Though race and ethnicity are independent constructs that operate uniquely among power systems, for the purpose of this analysis, I consider them in relationship with each other as they are othered by constructs of whiteness, which is positively valued by U.S. coloniality. Under white supremacy as a dominant power system in the settler colonial project of the U.S., white American constructs are positively valued by coloniality and normalized in colonial culture. The binary of the colonial value hierarchies collapses all positions outside the colonial zone of being, defining them by their exclusion. Wherever possible, in my research, I refer to the race and ethnicity of people involved specifically. When referring to the broad group of those the colonial value hierarchies negate in contrast to whiteness, I use the term “people of color.”

An example of using this colonial value hierarchy to analyze language would be to investigate the terms “minority” and “majority” in the context of race. In texts such as internet articles or casual spoken conversations, a person may use the word “minority” to refer to

Black people in the U.S. or their local Hispanic community. The word minority may refer to a statistical concept, but it also carries the import of a power differential (Wirth, 1945). It is othered in contrast to an undefined majority: whiteness. The social definition of racial minority, once investigated, is described as a disadvantaged and disenfranchised group regardless of whether that group is actually a numerical minority in the context of the text (Healey et al., 2019; Wirth, 1945).

Colonial Values of Ability

The second pillar in the colonial value hierarchy framework (able-bodied/disabled) allowed for the investigation of ability as represented, used, and accessed in U.S. language practice. Ability as a construct encompasses physical, cognitive, emotional, embodied, and social realities and is considered in this research as it is defined as “normal” and able-bodied (i.e., positively valued in a colonial hierarchy due to the capacity to perform labor which can then be extracted) versus “abnormal” and disabled (i.e., negatively valued in a colonial hierarchy due to lack of legible capacity for the same). Under ableism and eugenics as a dominant power system in the settler colonial project of the U.S., able-bodied constructs are positively valued by coloniality and normalized in colonial culture. The binary of the colonial value hierarchies collapses all positions outside the colonial zone of being, defining them by their exclusion. Wherever possible in my research I refer to the abilities/disabilities of people involved specifically. When referring to the

broad group of those the colonial value hierarchies negate in contrast to able-bodied, I use the term “disabled.”¹

An example of using this colonial value hierarchy to analyze language would be to investigate normalized cultural language practice for children who are d/Deaf. In the U.S. it is preferable for deaf (i.e., profound hearing loss)/Deaf (i.e., participants in Deaf culture) children to learn spoken English rather than American Sign Language (ASL) regardless of success rates or difficulty (Batterbury et al., 2007; Markotic, 2001). Sign languages are predominantly used by and associated with d/Deaf cultures, which are distinct from dominant U.S. culture in their hearing ability (Batterbury et al., 2007; Bauman & Murray, 2016; Lane, 1999). Even the term “hearing loss” emphasizes a perceived lack on the part of d/Deaf persons by non-deaf culture. Language practices associated with perceived disability (i.e., hearing loss is perceived as a disability by dominant U.S. culture) are disempowered.

Colonial Value Intersection

Though I consider these hierarchies independently for the ease and clarity of research, every colonial value hierarchy interacts. Every person within a colonial context is perceived in relation to every colonial value simultaneously as either inside or outside of the zone of coloniality. Co-occurring identities, then, compound. While both a white disabled person and a disabled person of color experience negation (and with it, violence, dehumanization, and erasure) on

¹ I use the identity-first terminology “disabled” rather than the person-first language of “person with a disability” (Back et al., 2016). It is common practice in medical and therapeutic fields to use person-first language, which responds to the historical dehumanization of people with disabilities by emphasizing their personhood (Haller et al., 2006; Michaelakis, 2003). However, disabled communities problematize person-first language as distancing disability from lived reality and framing it as an abnormal, personal experience (Ladau, 2014; Liebowitz, 2015). Instead, members of disabled communities advocate for acknowledgment and inclusion of their lived experiences in a disabling society as part of their identity through identity-first language (Haller et al., 2006; Ladau, 2014).

the axis of disability, the constructs of one are positively valued (e.g., humanized, protected) on the axes of race while all constructs of the other are negated (Crenshaw, 1989; Grosfoguel, 2011). This interaction between experiences is referred to as intersectionality by Kimberlé Crenshaw (1989) or entanglement by Grosfoguel (2011).

Textual Analysis of ASHA Texts

The values of a culture are carried in its knowledge production (e.g., cultural constructs, history, philosophy, ethics), either in replication or resistance. This knowledge is passed on through sedimented language in texts such as published documents or living texts such as conference proceedings and classroom syllabi (Duranti, 2011; Scholes, 1982). To investigate the values embedded in U.S. SLP knowledge, I conducted a textual analysis of three of its texts. Textual analysis is critical reading. The words we use, the way we use them, the punctuation, and the placement – these all have meanings that are clearly defined and culturally meaningful. Textual analysis is a method of reading in which a researcher engages with the potential meanings of a text based on some kind of cultural context – the culture in which the text was written, the culture in which the text is read, or a framework created from cultural understanding (Arya, 2020; Frey et al., 1999; McKee, 2003; Miller, 1984; Rockwell, 2003).

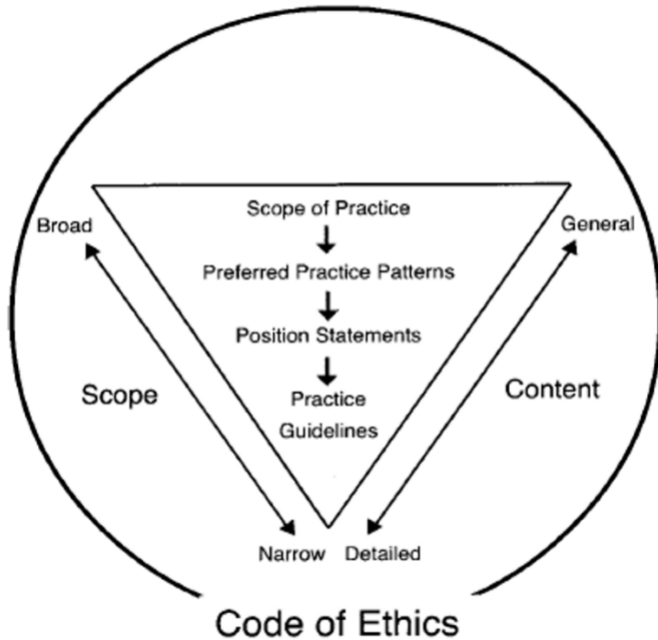
Textual analysis as a research method considers the message in a text by analyzing its content, structure, and function(s) in comparison to known structures (in this case, the colonial value hierarchy) to describe and interpret the text's characteristics by rhetorically arguing its constructed knowledge (Frey et al., 1999; Miller, 1984; Rockwell, 2003). Two types of textual analysis are common: analysis of the text (i.e., an in-depth qualitative study of a particular text and all

ideas contained) or an analysis using the text (i.e., approaching the text with a particular framework and investigating key details; Frey et al., 1999; McKee, 2003). In order to investigate the SLP profession at multiple levels (i.e., individual, educational, national) using the above framework, I completed an analysis using my selected texts (Arya, 2020; McKee, 2003; Scholes, 1982).

ASHA maintains a resource called the practice policy documents designed to inform and shape “best practices and standards in the profession [of...] speech-language pathology” (ASHA, 2004). These documents and their relationships are summarized in Figure 2.

Figure 2

ASHA's practice policy documents



Note. From *The Preferred Practice Patterns for the Profession of Speech-Language Pathology*, American Speech-Language-Hearing Association, 2004, p. 3 (<https://www.asha.org/siteassets/publications/pp2004-00191.pdf>).

The pictured documents outline the standards of clinical knowledge and practice that ASHA certifies in its speech-language pathologists. I selected two texts from this body of literature and one text from ASHA's clinician resources for textual analysis. These texts each represent the SLP profession at one of three levels: the individual practice of the SLP clinician, the educational practice of academic bodies training SLP clinicians, and the national associative (ASHA) practice of maintaining clinical and association quality. The Preferred Practice Patterns (PPP) address the individual level of SLP practice as the "informational base for providing quality patient/client care and a focus for professional preparation, continuing education, and

research. (ASHA, 2004)" The Certification Standards address the educational level of SLP practice as the requirements SLP graduate students must meet through their graduate school education and following clinical fellowship to be certified by ASHA as an SLP (ASHA, 2020). Finally, the Code of Ethics addresses the national associative level of SLP practice as the ethical standard to which all ASHA members are held and against which misconduct is identified (ASHA, 2015). Each text informs speech-language pathologist experience, from educational requirements to professional practice to ethical expectations. As well, each text is developed and maintained by the national association of U.S. speech-language pathologists. By selecting texts that address distinct aspects of the SLP profession, I allow for a balanced analysis of the embedded values of the SLP profession.

Sources of data collected during the analysis of ASHA texts included the texts themselves, procured from ASHA's website as PDFs. The data points were moments within the text inflected with language reflecting one of the three criteria in the colonial value hierarchy, explicated above. Quotations were pulled from whole documents and analyzed in comparison to the known structure of the colonial value hierarchies.

In conducting textual analysis of each document, I completed a close reading of the text to analyze its messages and meanings in comparison to the colonial value hierarchies for explicit mention of their contents (i.e., race and ethnicity, ability) or implicit connection to the same. When I found examples of either perpetuation or resistance of these colonial values, I extracted quotations from the text and rhetorically described their representation of the text's constructed knowledge, connection to the indicated hierarchy, and implications for the SLP profession.

Results

During close reading of the three ASHA texts (Preferred Practice Patterns, Certification Standards, and Code of Ethics), I found examples in each document explicitly or implicitly related to each of the colonial value hierarchies. I selected quotations for each example and rhetorically analyzed them below in comparison to the colonial value hierarchies. I used the colonial value hierarchy of race and ethnicity to explore the messages and meanings in the selected ASHA texts and found examples of colonial values in each. The Preferred Practice Patterns' use of the WHO-ICF indicated race as a personal experience divorced from related power structures. This document also recommended inclusion of CLD considerations through adjusted clinical practice, defining standard practice by othering CLD populations. The Certification Standards explicitly normalized English as the standard of professional quality and implicitly normalized whiteness in the use of English. The Code of Ethics indicated awareness of intersectionality but also explicitly normalized settler colonial languages as standard language practice.

I used the colonial value hierarchy of ability to explore the messages and meanings in the selected ASHA texts and found examples of colonial values in each. The Preferred Practice Patterns supported improved inclusion of the client-based outcomes in SLP but continued to uphold the speech-language pathologist in their role in deciding what is normal and abnormal language practice. The Certification Standards also upheld the role of the clinician in evaluating, deciding, and maintaining normal language practice. The Code of Ethics defined normal, standard clinician existence, behavior, and clinical practice by othering disability.

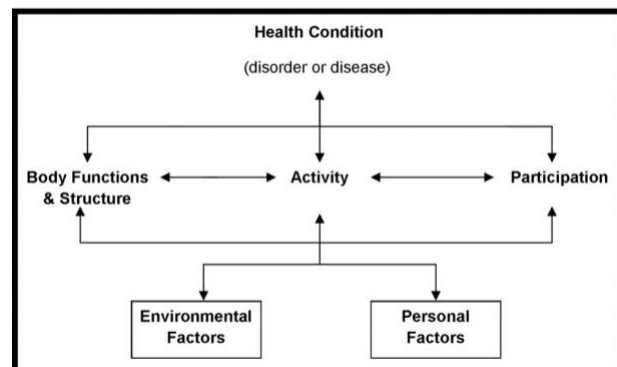
I analyze and rhetorically describe the results in full below. The existence in each document of colonial values, in resistance to or replication thereof, indicates a relationship between the SLP profession and the cultural context from which it was formed.

Textual Analysis: Race & Ethnicity

In the PPP's sections on fundamental components and guiding principles, the World Health Organization's International Classification of Functioning, Disability, and Health (WHO-ICF) framework is defined as an operational framework for treatment. Its visualization is presented in Figure 3.

Figure 3

WHO-ICF Framework



Note. From "Figure 1: Interactions between the components of ICF (WHO 2001:18)," by the World Health Organization, *The ICF: An Overview*, p. 2 (https://www.cdc.gov/nchs/data/icd/icfoverview_finalforwh_o10sept.pdf).

Two of its components for assessment and intervention are "contextual factors, including personal factors (e.g., age, race, gender, education, lifestyle, and coping skills) and environmental factors (e.g., physical, technological, social, and attitudinal)" (ASHA, 2004, p. 4). This framework goes on to

describe using these contextual factors in clinical practice: “[i]dentify and optimize personal and environmental factors that are barriers to or facilitators of successful communication” (ASHA 2004, p. 4). Racialized physical constructs such as skin color do not in themselves affect an individual’s ability to communicate. Racialized social contexts such as the perception and interpretation of an individual’s skin color by a communication partner do affect their communication. By placing race within personal factors such as age rather than with environmental factors such as other social concepts, the WHO-ICF linguistically positions it outside of a social power construct. The rhetorical move of including race as a personal experience without addressing related power structures indicates the maintenance of colonial value hierarchies.

Furthermore, the above is the only explicit mention of race or ethnicity in the PPP. The remainder of the document uses the phrase “culturally and linguistically diverse” (CLD). Positioning race as a personal, biological factor related to ethnicity, culture, and diversity before using it within the WHO-ICF framework and the remainder of the PPP document as an environmental, cultural consideration supports the analysis that race, ethnicity, and culture are tied together as socially constructed, racialized experiences. All racial considerations are CLD, but the term CLD includes experiences outside race and ethnicity. For example, according to the PPP, speech screenings should be “sensitive to persons from all culturally and linguistically diverse backgrounds,” while materials and approaches should be “appropriate to the individuals [...]socioeconomic, cultural, and linguistic backgrounds” (ASHA 2004, p. 69, p. 109). These recommendations include no mention of personal or environmental factors, only those that impact client outcomes.

Through the PPP, ASHA recommends that best practices adjust therapy approaches and materials to account for clients’ CLD, which includes racialized experiences. As mentioned in the introduction of this research, the concept of restructuring clinical practice to meet a client’s need implies that standard clinical practice does not meet that need. CLD values of race and ethnicity are rhetorically positioned as “outside” standard practice – the recommendation of their inclusion through adjusted clinical practice comes without any investigation of why their exclusion first occurred. This framing obscures the value-full position of both individual clinicians and national recommendations in favor of emphasizing clinical practice as a value-neutral tool to tailor to clients with “CLD” constructs.

In the Certification Standards, standard language values are both explicitly mentioned and implicitly defined through the “other:”

[T]he applicant must have demonstrated speech and language skills in English, which, at a minimum, are consistent with ASHA's current position statement on students and professionals who speak English with accents and nonstandard dialects. In addition, the applicant must have demonstrated the ability to write and comprehend technical reports, diagnostic and treatment reports, treatment plans, and professional correspondence in English. (ASHA 2020, p. 5)

Explicitly, English is valued as the standard (e.g., established rule for the measure of quality) which all applicants must meet. English competency at a master’s degree level is required for applicants to be certified by ASHA and for SLP educational programs to appropriately train students for application. This document and associated webpage are

provided in English only, further reifying a settler colonial language from Europe as standard language practice. This certification standard excludes student applicants and their clients who do not speak English. Implicitly, this criterion describes dialects/accents as nonstandard in opposition to an unspecified standard (e.g., well-established, familiar) English dialect, likely Standard American English (SAE; Gleason, 2001; Speicher & Bielanski, 2000). Applicants are not disallowed certification for using these dialects and/or accents, but they are disempowered. They are othered, grouped in definition solely by their exclusion from the standard. SAE as a dialect is based on white Midwestern English, emphasizing that undefined, culturally legible language use is based in white racial, ethnic, and cultural constructs. Not only does this criterion make explicit the normalization of a European-sourced language as the standard of professional quality, but it also implicitly normalizes whiteness in the use of English, no matter the dialect, accent, or language used by clinicians and their clients. This is unambiguous evidence of interaction with the colonial value hierarchy: constructs associated with whiteness and Europe are both explicitly and implicitly maintained over all other constructs as the positively valued standard and superior practice. No mention is made of the values underlying the construction of this criterion, obscuring its value-full position (Bauman, 1991; Beauvoir, 1949; Said, 1979; Spivak, 1985).

In the Code of Ethics, we again see this prioritization of European-sourced languages: it is offered on ASHA's website in either English or Spanish. The United States has no official language – language use is not mandated but chosen (United States Government, n.d.). The 2019 language data collected in the American Community Survey (ACS) by the U.S. Census Bureau indicated

that 241,032,343 (78.05%) of the 308,834,688 households in the U.S. speak only English at home, while 67,802,345 households spoke another language at home (US Census Bureau, 2021). Of households that spoke another language, 41,757,391 (61.58%) spoke Spanish or Spanish Creole (US Census Bureau, 2021). I do not assume that ASHA chose to produce the Code of Ethics in English and Spanish to explicitly perpetuate coloniality – I assume they produced this document in the two most spoken languages in ASHA's associated nation. However, as described above in relation to the Certification Standards, the existence, and use of English in the U.S. is the result of settler colonialism and represents the ongoing colonial project of the U.S. Similarly, Spanish was used in Spain's colonization campaigns to replace and erase Indigenous languages and cultures and to establish colonial power systems. Its inclusion alongside English in common use in the U.S. and by ASHA/its speech-language pathologists is evidence of colonial culture(s) maintaining their existence and values through normalization of them. Yet the dominance of English is maintained – Spanish is negatively valued by the U.S. colonial value hierarchies of race and ethnicity through its use by Latine, Hispanic, and Mexican people. The language choices ASHA and speech-language pathologists make in personal and professional use are inherently tied to colonial values.

Textual Analysis: Ability

The Preferred Practice Patterns (PPP) use the WHO-ICF framework to emphasize the importance of therapeutic outcomes that benefit SLP clients. These outcomes are described through the clients' own body structures and function, activities and participation in those activities, and contextual factors (ASHA, 2004, Figure 3). The

framework seeks to empower clients to share their perspective on their experiences and define and habilitate their abilities alongside the clinician. However, as problematized by clinicians in practice already, the speech-language pathologist's opinion of their client's abilities maintains a primary role (Heerkens et al., 2017. Mitra & Shakespeare, 2019). Delineation of body structure and function still requires the role of a speech-language pathologist. Pathology is in the very title of SLP; the medicalization and definition of normal and abnormal ability is a part of the SLP institution. Coloniality normalizes its dominating cultural values over all other occurring constructs (Grosfugel, 2011; Maldonado-Torres, 2007; Sayles, 2010; Quijano, 2010; Quijano & Ennis, 2000; Wolfe, 1999). The very ability to define what is normal and abnormal ability is power. The PPP introduces the WHO-ICF as part of its fundamental concepts and guiding principles and goes on to list other such concepts: service providers, expected outcomes, clinical indications and processes, clinical setting, equipment specifications, safety and health precautions, and documentation. Conspicuously missing are clients. Rather, under clinical indications the following guidelines are presented:

Screening services are used to identify individuals with potential communication or swallowing disorders. [...] Assessment services are provided as needed, requested, or mandated or to rule in or out a specific disabling condition. [...] Intervention and consultation services are provided when there is a reasonable expectation of benefit to the patient/client in body structure/function and/or activity/participation (ASHA 2004, p. 5).

The PPP emphasizes use of the WHO-ICF to prioritize client position and benefit, yet criterion for clients accessing intervention or succeeding in any benefit depends on the clinician's judgment of disability and disorder. Such judgment is made according to the speech-language pathologist's education, understanding, and position on SLP professional standards of normal and abnormal ability – not the experience of the client. Even then, the positionality of the field training and certifying the individual clinician is obscured, as is the importance of the positionality of the individual clinician. So too, then, are the impacts of their values hidden from view.

In the PPP, the power of pathologizing language in the U.S. – defining what is “normal” and able-bodied and what is “abnormal” and disabled – is placed in the hands of the speech-language pathologist. This is continued in the Certification Standards, where I identified requirements related to normal and abnormal human development across the lifespan. The first quotation I selected is the requirement of applicants to “integrate information pertaining to normal and abnormal human development across the life span” (ASHA, 2020, page 3). The current conceptualization of “normal” in dominant U.S. culture is recent, tied to advances in Western science and statistics as means and averages became standard tools of measurement and description (Davis, 1995). Arenas of medicine and public health picked up these tools, applying norms and averages to the human body, while French statistician Adolphe Quetelet formalized this connection to suggest a physically and morally average man (Davis, 1995, 2010). This progression defined normal as a baseline expectation of function rather than middle of a variable range and came with a positive value for being “normal” (Davis, 2010). This positively valued perceived

normalcy perpetuates eradicating negatively valued abilities, now perceived explicitly as disability, to be “normal.” Pathologizing – defining and deciding normal and abnormal human behavior – is the explicit maintenance of colonial value standards. Perpetuating this is required for ASHA certification.

The second quotation of interest I identified in Certification Standards is that applicants are required to demonstrate their own ability in outlined skills. For example, “the ability to integrate information pertaining to normal and abnormal development across the life span” or “the ability to relate research to clinical practice” (ASHA, 2020, p. 3, p. 5, p. 9). There is no criterion in the document for measuring these abilities. This decision is implicitly left to graduate programs staffed by clinicians who have previously met these standards and continue to perpetuate standard SLP knowledge and clinical practice. The colonial act of pathologizing in a colonial culture without investigation of the colonial values involved is here entwined with the standardization of SLP ability.

The Code of Ethics begins with listing definitions of specific terminology. I identify two quotations of particular interest. The first is the definition of diminished decision-making ability: “[a]ny condition that renders a person unable to form the specific intent necessary to determine a reasonable course of action” (ASHA, 2015, p. 3). The language used in this definition creates an implicit othering. No definitions are provided for a dis-abling condition or for reasonable decision making. Both terms are explicitly related to ability across physical, cognitive, emotional, embodied, and social realities (e.g., condition is sometimes used when referencing neurodivergence such as attention deficit disorder or physical disability related to use of a wheelchair; reason is sometimes used when referencing neurodivergence such as autism

spectrum disorder). Colonial value hierarchies positively value the capacity of a person’s body across the aforementioned realities to perform expected social roles and labor. The language used surely allows room for interpretation by individual practitioners, involved legal bodies, and ASHA as a governing body. The language used also implicitly others disabled experiences by describing them as diminished and defines ASHA’s value of the normal (i.e., not diminished) condition of a clinician and their decision-making as able-bodied in contrast. Varied decision-making skills and their fluctuations may be important for therapeutic practice, but the values underlying ASHA’s description and evaluation of those skills are obscured.

The second quotation I identified for further analysis is the definition for an impaired practitioner: “any individual whose professional practice is adversely affected by addiction, substance abuse, or health-related and/or mental health-related conditions” (ASHA, 2015, p. 3). Here a personal dis-abling is defined by a person’s ability to professionally perform labor – the sentence construction removes the disability and its impacts from the humanity of the clinician by emphasizing the buffer phrase of “professional practice.” Two broad categories describe the impacts: by substances and by health. No mention is made of trauma, extraneous life circumstances, or workplace environment. Health is made distinct from mental health and any indication of addiction as a (mental) health issue is left out entirely. This definition implicitly others disabled experiences by constructing ASHA’s value of the normal (i.e., not impaired) existence of a clinician as able-bodied in contrast. Further, the normalized clinician is dichotomous in their practice; their embodied existence is personal and does not affect their professional practice.

The Code of Ethics sets and maintains the standard of conduct for ASHA-certified SLPs. Yet in both above examples, there is no indication that the values set forward are considered in contexts of power systems (Pillay & Pillay, 2021). Though the terms and concepts involved are analyzed as linked to the colonial value hierarchy of ability, to systems of health and well-being in the U.S., to the pathologizing inherent to the field, their value-full position is not acknowledged.

Discussion

The results of my research as a whole question the values of pathologizing speech, language, and communication in a colonial culture. SLP practice as it stands is demonstrated to be defining normal and abnormal human behavior within a context that seeks to normalize certain behavior to the disempowerment of other people. It remains unclear in this research if SLP necessitates the maintenance of colonial values or if it can exist in refusal of them. What this research has made clear, however, is that the very concept of speech-language pathology is in relation to colonial values and violence. The SLP profession at large and its texts, educational programs, and individual clinicians are engaged with their cultural context. The values of this positionality cannot continue to be obscured. Speech-language pathology is not a value-neutral practice of objective clinicians but a value-full practice of agents in a colonial context. The knowledge constructed and perpetuated by the profession at large is in conversation with coloniality. Beyond this research, conversations are already happening to address this reality – in oppressed communities within the U.S. (e.g., Indigenous clinicians, transgender clinicians), beyond the U.S. (e.g., South Africa, New Zealand), and

beyond the SLP field (e.g., occupational therapy, education, sociology, women and gender studies, critical race theory). The goal of my research was to indicate clearly the colonial values underlying the context and construction of SLP in the U.S. The conversations that must address these values, either through replication or refusal, are beyond its scope. That such acknowledgement and action must happen is without question.

Limitations

My work is inherently limited by my knowledge and contexts. I am a part and product of the very colonial culture I herein problematize. I benefit from its maintenance and instinctively resist dismantling its power structures because of that benefit. My own marginalized identities are still cultural identities from a colonial culture. My experiences of marginalization and violence raised my consciousness, made me aware of systems of power affecting and controlling me beyond what I even experienced (Freire, 1970/2017). I have required explicit education on or direct experience of the described power structures to even become aware of their operation, much less resist and refuse them. This is an immense privilege and a purposeful product of coloniality, and it is certain to have limited the depth and reach of my research. All of this exists as an explicit limitation of my research.

Limitations in my framework include colonial value hierarchies considered. Hierarchies of economy, war, and religion were not included as their relative complexity and material manifestation are beyond my background as a researcher and my capability in this format.

Limitations in my research question include scope and document selection. Investigation into individual clinical practice

through survey research and educational practice through genre analysis of graduate school syllabi were considered pre-publication. Analyzing every ASHA document was beyond the scope of this project; the three documents included were chosen specifically for their importance and constant relevance in the field. While the document selection may be limited, the implications of this analysis are not. Further research could include a narrow rather than broad textual analysis of each of these documents to highlight the nuances of each complete document. This study, however, purposefully focused on the broad implications of these documents and their effects on the field, and the scale of analysis reflects that. I completed this research as a master's level thesis in 2021 and therefore experienced limitations as to time and resources. Future research on this topic will expand the colonial value hierarchy to include the above-identified categories and explore related topics.

Future Research

The scope of this project required inherent restriction. For combined reasons of scope, length, and rhetorical force, I cut considerations of individual and educational SLP practice from the text of this research for publication. Both of these areas of SLP practice deserve their own research into their relationship with coloniality. Only two colonial value hierarchies were chosen for analysis in this research, which is not a summation of colonial values. I considered these hierarchies in relative isolation for ease of research, obscuring their intersections and interactions. This research should not be considered a definitive statement of what shapes coloniality takes. I explicitly ask that future research endeavors address the aforementioned and other colonial values on their own and in relation. It is the nature of this work to explore

themes and broad commonalities to begin what must become a deeper, richer understanding of the topic of coloniality and the resistance and refusal of its values.

Conclusion

Language and culture are interconnected realities that express each other (Saussure, 1915). Given this, interaction with language cannot be value-neutral, but rather is value-full (Duranti, 2011; Friere, 2017). The knowledge produced by any given culture carries its values, and in a colonial context such as the United States, colonial values are embedded in that cultural knowledge (Abrahams et al., 2019; Friere, 2017; Quijano, 2007; Veracini, 2010). Speech-language pathology as a field defines what is "normal" language practice by othering what it defines as "abnormal" from a colonial context and evidence of colonial values (i.e., what is considered "normal," "typical," "superior," "human," or not) is reproduced in its practice (Said, 1979; Scholes, 1982; Spivak, 1985).

The two colonial value hierarchies I have discussed (European/able-bodied/white) are embedded within current standard speech-language pathology practice in the United States at the level of its governing body. These hierarchies are indicated even in implicit support (e.g., pathologizing human experience, prioritizing English only; Scholes, 1982; Quijano, 2007). The U.S. SLP field acknowledges differences in its clients. But is acknowledgment enough? The foundation of knowledge used by clinicians and certified by ASHA is still embedded in colonial values. Acknowledging and including a diverse range of differences does not resist coloniality – after all, the colonial value hierarchies have room for all, so long as certain (European, white, able-bodied) constructs continue to be

normalized as standard and superior. Acknowledgment of difference in the maintenance of dominant normalcy cannot be enough – SLPs must understand their position in relationship to the coloniality that enmeshes them and their field to truly resist it. It is the responsibility of the field at large, from the individual to the educational to the national level, to recognize their colonial context and investigate their practice and knowledge for evidence of colonial values. Resisting coloniality requires explicit understanding of colonial systems and refusal of power structures.

Culture is a simple word that summarizes a complex reality. It contains untold constructs and shapes futures. It is inextricable from language. As clinicians who investigate, assess, treat, and support language in a colonial culture, it is impossible to uphold the false idea of value-neutrality. Rather, it is our responsibility to take place in what Paulo Freire (1970/2017) calls “conscientization” -- the ending of silence around oppressive structures within which we are entrenched, the ongoing realization of our role as an object and actor in these structures, and the action to end their perpetuation. We are full of values, knowingly and unknowingly. What happens next is a choice.

this knowledge. In personal gratitude, I thank the following people who have made my research possible: Dr. James McCann, Dr. Yvette Hyter, Dr. Kristen Abraham, Dr. Sanyukta Jaiswal, Dr. Myrriah Gomez, Dr. Andrea Mays, Rachel Nevins, Clair Willden, Anna Skarr, and Janna Haider.

Acknowledgements

The knowledge on which my research is built – critiques of colonial power systems, the ability to remember and create life outside coloniality – belongs to the people coloniality seeks to erase, such as the nations whose stolen land I occupy to write this. I am a settler colonizer benefiting from the shared knowledge of indigenous and colonized peoples in my education, and even in application of my research I have no claim to

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