

# **A Critical Theory Response to Empirical Challenges in Report-Writing: Considerations for Clinical Educators and Lifelong Learners**

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## **Purpose**

Audiologists working with/in school settings write reports, communicating assessment results and recommendations. Yet there is a gap in education and professional development regarding report-writing and the effects reports can have on children and interprofessional relationships. This article highlights the ways that the linguistic and visual construction of reports affect possibilities for children and inter-sector collaboration among clinicians, school-based professionals, and families.

## **Methods**

We began with two main problems stemming from report-writing, as identified in a larger research study of the clinic-school interface. We employed a critical social science theoretical framework to generate three considerations for report-writers to ameliorate the two problems.

## **Results**

Two main issues were generated from a secondary examination of the empirical dataset: 1) clinicians advocate by proxy, through written reports brought to schools by parents, thereby precluding dialogue among clinicians and school-based professionals; and 2) parents place importance upon clinicians' reports, which contributes to the exclusion of parent and child perspectives. The three considerations to address the issues were: 1) include dialogic language in report-writing to invite direct communications amongst families, clinicians, and school-based professionals; 2) develop awareness of how language actively shapes and impacts children's identities and opportunities; and 3) format written reports based on visual rhetoric to invite and represent family-clinician-school dialogue.

## **Conclusions**

Applying a critical social science perspective to report-writing enables us to provoke change in recurrent, problematic practices at the clinic-school interface. This article is not meant to be a prescription; rather, it is an opportunity to question assumptions and engage in more sensitive and informed practices for and with children, families, and other professionals.

## Introduction

Reports have been described as “the tickets of safe passage for patients traveling to seek further care, and they are the visible currency of sanctioned co-operation among healthcare providers” (Lingard, Hodges, MacRae, Freeman, 2004). Indeed, health professionals frequently create and receive written reports, detailing assessment results and recommendations (Angell & Solomon, 2014; McConnellogue, 2011; Ng, Fernandez, Buckrell, & Gregory, 2010; O’Keeffe & McDowell, 2004; Oberklaid, 1988; Schryer, Gladkova, Spafford, & Lingard, 2007). Importantly, these reports may be the primary communication method between clinical and educational professionals (Ng et al., 2013a). Yet reports may not always serve as “tickets of safe passage” in actual practice. Problems in supporting children with school-based health needs are well documented, and often stem from a breakdown in the communication and collaboration between clinicians (e.g. audiologists in clinical practice) and school-based professionals (e.g. teachers, principals, educational audiologists and speech-language pathologists) (Ng et al., 2013a; Roberts, Price, & Oberklaid, 2012; Villeneuve, 2009).

There is a dearth of literature to guide the education of audiologists toward creating meaningful, sensitive, and useful reports for a school-based audience (Baxley & Bowers, 1992; English, 2006; Gozenbach, 2000; Pannbacker, 1975). This gap exists in spite of the established importance of written communication in representing, reinforcing, or resisting professional boundaries (Schryer, Lingard, & Spafford, 2007). These boundaries are linked to the notion of ‘discourses.’ According to the critical social sciences, any field, including biomedical sciences, operates within and through particular ‘discourses,’ which are language- and text-mediated systems of meaning and truth (Greenhalgh & Wieringa, 2011; Wodak & Meyer, 2009).

A critical social science perspective on report-writing could thus shed new light on the matter by challenging commonly and tacitly held discursive (discourse-based) assumptions. Specifically, in report-writing, critical social sciences let us ‘deconstruct’ the linguistic and visual construction of reports, in order to identify and thus change unintended negative practices. Therefore, the critical social sciences are crucial for the realization of report-writers’ intents, by uncovering taken-for-granted routine practices and their discursive and social influences. Further, the language and texts (texts include documents and other visual representations) that audiologists and other professionals use to describe and discuss children is influential in the shaping of children’s identities (Phelan, Wright, & Gibson, 2014; Phelan & Kinsella, 2009). Therefore, one must be conscious and sensitive in writing about children and their needs (Phelan et al., 2014).

In this article, we use the broad theoretical framework of critical social sciences to encourage audiologists to create written reports that are as helpful as possible and unlikely to cause harm. We will also draw upon visual rhetoric to offer some practical, theoretically-informed strategies to meet this challenge. A starting point for audiologists new to the critical social sciences is to appreciate that language is an active, constitutive force in the shaping of actions, identities, knowledge, and opportunities. Language, in this view, is not merely a neutral mechanism that enables humans to

communicate. Rather, language is a social act that carries intended and unintended meaning, reproduces or resists social norms, structures society, represents and constitutes ideology, and actively shapes individuals’ identities and possibilities (Phelan et al., 2014; Stooke, 2010; Wodak & Meyer, 2009). We suggest that while this article may, at times, challenge commonly held assumptions about knowledge and practice, it is precisely the bridging of audiology with the critical social sciences that will enable the field to see and practice differently if it so chooses.

The rationale for this article is to respond to empirical evidence, from the authors’ and others’ research of the types of problems that written reports can create, and the role they play, in helping children and families access appropriate school support (McConnellogue, 2011; Ng et al., 2013a; Rix & Matthews, 2014). The authors are interdisciplinary social science scholars with a health professions education and practice research focus. They have practice backgrounds in audiology, library science, professional communication, and occupational therapy. The considerations proposed may be useful to the educators of audiologists (clinical supervisors and academic faculty members), and to practicing audiologists who seek change and emancipation from social structures insidiously governing practice. In creating this article, we drew from the programs of research of the first and last authors (Ng et al., 2013a, 2010; Phelan & Kinsella, 2013; Phelan & Ng, 2014; Phelan et al., 2014; Phelan, 2011; Phelan & Kinsella, 2009), and the research projects of two Master of Professional Communication scholars (VB and EM), all which focus on various aspects of the clinic-school interface for children with disabilities.

The clinic-school interface serves as the context of this article, and refers to any interaction – among families, clinicians, and school-based professionals – occurring when a child with disability requires access to school-based health support. The article structure is as follows. Two overarching theoretical orientations inform this report and are introduced herein: critical social theory and semiotics. Within these broad theoretical domains, we focus specifically on critical sociology, critical disability studies, and visual rhetoric. We begin with a summary of common problems related to written reports at the clinic-school interface, derived from the dataset of the authors’ ongoing program of research. Next theoretical frameworks are used to generate considerations to ameliorate these problems. Suggestions for change include more thoughtful language practices, with an awareness of language as social action, and attention to the visual construction of written reports.

## Method

This article is not a primary research paper. Instead it re-analyzes an empirical dataset that was derived from a long-term qualitative program of research that began in 2011 and continues today. This program of research aims to understand what ‘work’ occurs at the clinic-school interface to support children with disabilities, and what coordinates or influences this work. Work, in this context, is broadly defined to include both official paid work and unofficial unpaid work (Quinlan, 2009; Turner, 2006). An example of the latter type of unofficial work is a mother bringing reports from a clinician to the school. The dataset that we draw

upon for this paper included three types of data from 27 informants: interviews with parents and professionals, observations of school meetings, and an archive of texts. The textual archive included forms, reports, protocols, and policies at the clinic-school interface, as well as related news media reports. Interviews were recorded and transcribed verbatim; the researchers performing observations typed up their fieldnotes, and the document archive was compiled digitally.

The analytic process involved a qualitative analysis of data, conducted by the first author, with use of qualitative coding software to assist with data organization (QSR International Pty Ltd., 2008; SocioCultural Research Consultants LLC, 2014). First, data were labeled (coded) based on the work processes that were occurring. Next the work processes were categorized according to common and routinized work processes across the dataset. Associations were made between the identified work processes and related documents from the textual archive. It became apparent that the texts and documents (e.g. professional discourses, policies) served as social coordinators of the work processes; that is, the documents affected how clinicians performed their work (e.g. report-writing). This analytic process is consistent with the institutional ethnography approach – an approach rooted in critical social science – that was employed for the larger study (Ng et al., 2013a; Smith, 2006). In qualitative research, data are not numeric but rather textual. Therefore, findings do not tend to take the form of graphs and statistics, but rather of textual representations such as diagrams or written explanations.

In generating the considerations included in this article, we started with two key problems identified in our prior research, shared in the following section. Then we turned to critical and semiotic theory to examine how the challenges identified at the clinic-school interface could be ameliorated through more attentive discursive and visual construction of written documents. The aim of introducing these theoretical considerations to the practice of report-writing is to enable genuine collaboration amongst families, professionals, agencies and systems, toward enablement of children to achieve their self-determined goals.

### **Findings: Two Relevant Issues**

Two main issues were derived from two main work processes identified in the empirical dataset. The two work processes were previously reported by the team of investigators conducting the larger study (Ng et al., 2013a; Ng & Lingard, 2014; Ng et al., 2013b; Phelan & Ng, 2014). We summarize the work process findings here to situate them within the audiology / educational audiology context. The two main work process findings were: 1) clinicians from our dataset were often advocating for children to gain school support through written reports; in so doing, clinicians were advocating by proxy and 2) clinicians were often navigating a complex terrain (school context) without a map (contextual awareness and understanding) of the education system's structure. These two work processes, in turn, resulted in two problematic issues: 1) conflict can be instigated and perpetuated by clinical reports, and 2) parents and children can be inadvertently excluded or silenced by clinical reports. These issues are explored next, as the basis for this article.

### **Issue 1: Conflict can be instigated and perpetuated, to the detriment of children and families**

Clinicians were advocating by proxy, using written reports in an attempt to secure school support for children. Indeed, all of the clinician participants espoused advocacy as a key function they served, yet they described their advocacy as taking the form of a written report handed to a parent or sent to a school (Ng et al., 2013b). While this work occurred with good intent, it often created problems in which conflicts or confusion about the content of the reports were not always communicated back to the clinician. For example, educators described how written reports may contain unrealistic or infeasible recommendations; yet, there was no standard mechanism for clinicians and educators to discuss such recommendations. Therefore, clinicians may not be informed or aware that some recommendations were perceived as inappropriate in the school context. Without a communication channel between clinicians and school-based professionals, the clinician's practices (e.g. report writing) may fail to become more effective over time, and may perpetuate conflicts within the education context, hindering rather than facilitating children in receiving school support. Written reports cannot fully speak for themselves nor respond to questions, and they are often translated into other forms, including being excerpted, in direct quotation or paraphrased form, on Individual Education Plan (IEP) documents. In contexts where an educational audiologist (or other intermediary) is present, this situation may be ameliorated. But educational audiologists in our dataset reported facing similar challenges in trying to mediate between clinicians and school-based professionals.

### **Issue 2: Parents and children can be excluded through written reports**

Some clinicians demonstrated savvy and had built relationships with school-based professionals, enabling them to work effectively with and for families. Other clinicians – particularly those unfamiliar with the education system – were struggling. This clinician-professed naivety was concerning because parents often put significant weight on the content of reports. We even witnessed parents wielding reports in school meetings in an attempt to accrue and establish more authority in their advocacy attempts. Not all clinicians were fully aware of the role(s) of written reports, or of how reports were used and interpreted by parents, educators, or school-based health professionals. Without contact between clinicians and school-based professionals, the written report was often perceived as the only tool available for parents to use as 'proof' in acquiring support for their children. Therefore, clinicians may have affected the behavior of parents by consciously and unconsciously guiding parents to use written reports to advocate. In this way, parents' and children's voices were rendered somewhat peripheral in the process of determining support at school. That is, parents and children may be involved in meetings, and parents may use reports to advocate, but in some respects, the report-writing practices reinforce their backseat role relative to the professionals who create and supply the 'official' knowledge of documents and records. We saw, in our dataset, instances of considerable time and effort exerted in pursuit

of one support (e.g. technology) at the cost of other forms of support. Meanwhile, actual desires and voices of parents and children were sidelined as the focus became the pursuit of, resistance to, or resolution of conflict about the object of a written report.

These two issues, presented above, are not identified as the faults of clinicians; systems are complex and practices are influenced by many social factors. For example, the classification discourse, represented and mediated by the Diagnostic and Statistical Manual and other diagnostic standards, leads to the creation of reports that identify or diagnose children with disabilities or disorders (Wang, 2012). This classification discourse pervades medical and educational settings. In educational settings, classifications and categorizations of children are documented in IEPs, through which needs and support can be outlined. Although there may be instances when categorizing a child may have harmful effects, professionals and parents are in some sense guided toward the classification route, as if it is the only course of action. These classification practices, which may inadvertently cause burden and harm to families, are normalized and regularized as everyday processes at the clinic-school interface (Blum, 2012; Gibson et al., 2009; Innocenti, Huh, & Boyce, 1992; Rehm, Fisher, Fuentes-Afflick, & Chesla, 2013; Smith, Oliver, & Innocenti, 2001). We have previously reported data in which parents lamented the need to classify or label their children, yet they realized that it was necessary in order to function within current systems (Phelan & Ng, 2014). The classification approach is not the only available approach, but it is the current dominant approach, largely influenced by the International Classification of Functioning (Hollenweger, 2013). An alternative is the social relational approach, which is subtly but importantly different, and requires engagement with critical social sciences as opposed to biopsychosocial perspectives (see Reindal, 2008).

### Applying a Critical Social Sciences Lens: A Brief Introduction

The tendency for members of society to adhere to the status quo, even when the status quo may be harmful, is termed hegemony (Wodak & Meyer, 2009). It is the function of critical social scientists to reveal how dominant, hegemonic discourses function in everyday life. Recall, the use of the term discourse throughout this article refers to a language- and text-based (including visual images) system of meaning that shapes how we ‘see,’ what we think and do, and what is considered ‘normal’ (Hodges, Martimianakis, McNaughton, & Whitehead, 2014; Hodges, Kuper, & Reeves, 2008; Phelan et al., 2014; Wodak & Meyer, 2009). These ways of seeing, thinking, and conceiving of normality are ‘socially constructed’ by those with authority in society. These ideologies (ways of thinking and understanding) may be preserved as a way to maintain prevailing power relations (Wodak & Meyer, 2009). Foucault has referred to “regimes of truth” and “technologies of power” that limit and constrain practice, at the service of particular groups and at the expense of other groups (Kemmis, 2005). While we are not implying that particular groups are striving consciously to maintain power per se, these regimes of truth may influence actions such that existing ideological and work structures are perpetuated, along with their hidden or subtle effects (Smith, 2006; Wodak & Meyer, 2009).

For example, the discourse of ‘compliance’ positions patients

to follow the instructions of a health professional. Otherwise, they are ‘constructed’ as non-compliant (Hodges, Kuper, & Reeves, 2008). Recall that by ‘constructed,’ we refer to how discourses construct possibilities for individuals and groups in society, and create objects as products of the discourses. This discourse of compliance creates a particular power structure between the patient and the health professional and thus constructs typical subject positions or identities for patients and health professionals. But compliance is not a natural phenomenon that has been discovered scientifically. Rather, the discourse of compliance is a social construction, which has powerful effects on how patients are discursively/socially ‘constructed’ as either ‘good, compliant’ patients, or ‘deviant/difficult, noncompliant’ patients. Therefore, in a discourse of compliance, an adolescent choosing not to use his/her hearing assistive technology (e.g. an FM system) is framed as choosing poorly in terms of setting him/herself up for ‘success.’ Efforts to encourage use are then framed, within this discourse, as educating and counseling the teen (toward compliance) to appreciate how the FM system will enable him/her to achieve his/her goals. But these goals are often presented as normative societal expectations and definitions of educational and social success. When seeing through only a discourse of compliance, one may fail to consider how the very efforts to educate, counsel, and convince a teen to use his/her FM system can be disempowering and evoke resistance from the adolescent. A discourse of compliance constructs a lack of autonomy in a teen at a time when s/he may be avidly seeking a sense of autonomy. Through a critical perspective, we would argue that we, as a field, are limited in our understanding and approach when we operate naively within a discourse that constructs teens as making the ‘right’ choice for themselves only when they are following the wishes of older, wiser, health professionals, educators, and parents.

Critical disability studies, as a field, was sparked by resistance to “regimes of truth” that have driven the medicalization of disabilities (Block et al., 2005; Erevelles, 2005; Molloy & Vasil, 2002; Phelan et al., 2014). While professions like medicine, audiology, and occupational therapy espouse intentions of enabling equitable access and opportunity for individuals with disabilities, the language used to discuss disability can be entrenched within a dominant discourse that sets up health and rehabilitation professionals to fix, to rehabilitate, and to treat. This arrangement can have inadvertent negative effects on patients when it contributes to negative portrayals of individuals with disabilities as having something that needs to be ‘overcome’ or to be ‘fixed.’

Indeed, person-first language is problematized (challenged) in critical disability studies. Calling someone “a person with disability,” while supposedly aiming to be sensitive, implicitly suggests that individuals are people first, but carry their disability with them at all times, as if it is something they possess (Titchkosky, 2001). Critical disability studies reclaims the term disability, and uses the term ‘disabled,’ by explaining that societal factors can disable people. For example, if a train station has poor signage and poor acoustics, this societal context has disabled certain individuals. They are not people with disabilities, but, in this instance, are disabled by society. This framing, thereby, positions disablement as something to be overcome in society rather than

in individuals. The disablement is an action that is done to the individual, rather than a ‘natural’ feature that is inherently affixed to the individual (Liasidou, 2013; Phelan, 2011).

We intend, through the example of disability and disablement and the prior example of compliance and technologies of power, to demonstrate a key practice of critical social science: critical reflexivity. Critical reflexivity involves reflection upon taken-for-granted assumptions, values, norms, possibilities, and positions, in relation to power structures embedded in cultural, social, political relations (Phelan & Ng, 2014). We next apply this practice to the process of creating recommendations to redress the two issues presented above (the issue of creating and perpetuating conflict with reports, and the issue of silencing and excluding parents and children).

## The Recommendations

In this section, critical social theory is used to reveal hegemonic practices within clinicians’ written reports. Recall that hegemonic practices refer to recurrent, normalized practices that we may not realize are doing harm because they seem natural. By identifying these hegemonic practices, we seek to illuminate ways that clinicians may be more critically conscious and thereby more sensitive to how their language practices are implicated in a complex social web. With the type of awareness we raise next, report-writers may be empowered to exact more deliberate control over their own language practices toward realizing their espoused goals of supporting children.

## Written construction considerations

We begin with a disclaimer – we presume that no competent audiologist intends harm in their written reports. Instead, we assume the opposite – that audiologists write reports with the hope of supporting children. Therefore, if report-writers can be sensitized to the powerful effects of language, they may be able to avoid some of the pitfalls in creating reports that reproduce hegemony and dominant discourses. Again, we emphasize that the reproduction of dominant discourses is not necessarily conscious; yet, it is important to recognize how and when one might be caught up in doing so. Through actions, all individuals unintentionally (and at times intentionally) reproduce societal norms that may be harmful, as that is the very nature of a dominant discourse and of hegemony. Language is social action (Lingard, 2007). Critical theory raises awareness to the potentially harmful effects of routinized social acts, including language use, showing the interconnectedness of seemingly independent acts, and thus liberating us from their rule (Smith, 2006; Wodak & Meyer, 2009).

Practically speaking, report-writers might consider the following two effects of language. First, directive phrases in reports, from clinician to school, can set up children, families, and professionals for conflict even if they were written with collaborative or advocacy intent. Second, report-writers should pay attention to language that 1) alludes to disability as a feature inherent in the individual, 2) sets those involved on a path of striving for normality, and 3) implies a passive role of the child and family.

Directive phrasing (e.g. “the teacher should...”) in clinicians’ reports can set up a relationship precluding collaboration and dialogue. It is important for clinicians to recognize that school-based professionals may have a different (but not necessarily

incorrect) position relative to supporting a child’s needs and context. Paying attention to language use would alert report-writers to the possibility that phrasing in reports can come across as either directive (as if clinicians can and should dictate and direct what happens at a school), or as collaborative (in which case genuine dialogue between clinicians and school-based professionals is invited). For example, a clinical audiologist may be unaware of the complexities of the classroom setting (e.g. there are 6 children, in one classroom of 24 students, all requiring considerable support). Further, the clinical audiologist may not fully realize the ways in which the work of educators is tied, inextricably, to policies and discourses of categorization and classification. Therefore, the clinician may have unrealistic expectations of the educators. In our dataset, we saw that clinicians and school-based professionals were often ‘pitted against’ one another, as a result of dueling systems and not of their own desire to work against one another.

Here, a critical approach can help in illuminating the influence of discourses and policies on local practices. For instance, critical theorists and sociologists describe how texts like medical reports, policies, and protocols, are a mechanism for social coordination, which carry within them the messages of dominant discourses (Smith, 2006; Smith & Schryer, 2008; Stooke, 2010). Because we use these texts every day, we become unaware of their influence on our actions as we tend not to question their authority. Therefore, we may not question why we use texts in the way that we use them, or see how they shape our choices. It is difficult to see and think outside a dominant discourse, since it is a dominant system of meaning and truth. Critical reflexivity is an attempt to do this: How often have you, as an audiologist or educator, questioned the taken-for-granted language in use, such as ‘accommodation’ and ‘(re)habilitation,’ and what these discourses lead one to do and see as normal?

Applying critical theory would enable audiologists to see that they are socialized to practice in a particular way. That is, audiologists are wording assessment results and recommendations in a way that is deemed ‘professional,’ perhaps in the name of advocacy, which is a key professional duty. Through a critical lens, one may see that similarly, school-based professionals have been socialized through a related but different set of social structures. For instance, when a clinical report arrives at school recommending hearing assistive technology for a child, the recommendations may be contraindicated in socially complex ways (e.g. children in one classroom with competing needs). The contraindications may be apparent to school-based professionals, but not to the clinical audiologist. Without the opportunity for dialogue among parents, children, clinicians, and school-based professionals, parents may be compelled to explain or advocate for the clinician’s recommendations. Due to the advocacy role placed on parents, they may feel that a tangible solution directly recommended by an expert clinician is being resisted, without good reason, by the school. The communication channels may be open between clinicians and parents, or parents and schools, but all three groups are not usually in dialogue together at once.

Opening up dialogue through truly collaborative report-writing is thus an opportunity for clinicians to circumvent such conflict. For example, the school professionals’ concerns about the technology’s appropriateness may be valid; or, the school professionals may

misunderstand the report writer's intent. Together, the family, clinicians, and school-based professionals may be able to find an appropriate solution. While many will argue that the health and education systems are not set up for such collaborative dialogue to occur, we argue that through critical awareness individuals may be better able to act as agents of change. In our larger dataset, we saw instances of clinicians who had indeed employed a critical social awareness to their practices. For example, a pediatrician described long, nurtured relationships with audiologists, speech-language pathologists, school principals, and others. She had developed relationships that enabled her to make phone calls to teachers, and to send notes as a clinician partner to the school rather than as just another faceless clinician. She did not speak of clinicians and school professionals working on different 'sides,' she seemed subtly aware of power relations between organizations and individuals and able to work within them in a nuanced way. We argue that structures and protocols to enable dialogue could be helpful but would be insufficient if implemented without a critical social science orientation.

In addition to the first consideration of directive phrasing, clinician report-writers could also critically examine language use in relation to disability and normality. For example, a sentence suggesting that a child has "best chances for success through technology" risks representing the child as passive and powerless, yet at the same time positions the child to shoulder the burden of achieving 'success' as s/he grows up. A recommendation worded as "John should be reminded to run through his hearing aid and FM system check every morning. He needs to use the FM system to ensure he has the best chance at success in the classroom" indicates a narrowly conceived view of what is 'best' and what is 'success.' In this phrasing, what is 'best' and what is 'success' is vague, and assumes a universal definition of 'best' and 'success' (Phelan et al., 2014). Further, while enabling John's self-advocacy and independence may be the intent of the preceding example, alternative phrasing could place more responsibility on others to be accepting and supportive, while also sending a message that John is an agent of his own journey. This message could perhaps be conveyed in a section labeled "What we can do to support John."

Linguistically passive conceptualizations of children directly contradict attempts to support children to actively work towards their own development and decision-making (Gibson et al., 2009). These representations insinuate that children do not possess the autonomy, ability, or ambition to achieve their goals. While we suggest linguistically positioning children in written reports as active agents in their own lives, we simultaneously raise caution against independence as the singular ideal. In the discourse of independence, which is prevalent in rehabilitation technology marketing materials and thus influences clinicians' written reports, lies a potentially harmful effect (Phelan et al., 2014). Independence may be a goal that seems universally positive and inherently better than dependence (such dualisms are not productive, nor do they consider culture and context), but there are instances in which independence as a discourse may actually transition a child from having support to not having support, since independence was the goal of the initial support (Phelan et al., 2014; Phelan, 2011). This message toward independence could also be detrimental,

particularly as a child transitions from elementary to secondary school, and secondary school to the workforce or post-secondary education. Independence can be construed as an attempt to normalize a child with hearing loss, by conforming him/her to society and enabling him/her to 'fit in' through technology use, rather than building a society to be accepting and supportive. As a field, we could take some onus off of children to conform, through critical awareness of the subtle messages transmitted through language in written reports. Specifically, we need nuanced understandings of how messages of normality, disability, success, and failure actively shape, define, and affect a child's identity and opportunities (Phelan, 2011; Phelan & Kinsella, 2009).

A failure to attend to these discursive influences may underlie failed attempts at supporting children and families (Phelan & Ng, 2014). For example, audiologists may be socialized to reproduce discourses that aim to minimize the perceived differences of children with hearing loss. This discourse is exemplified through the notion that assistive technology can make children appear more 'normal' (Phelan et al., 2014). Although these messages may stem from good intentions, they can potentially damage children's self-image by reinforcing their perceived differences (Phelan et al., 2014; Phelan, 2011). This critical perspective does not aim to position assistive technologies as harmful. Rather, it demonstrates that the language used to describe such technologies can be rooted in hegemonic (entrenched, normalized) practices that may be damaging for children. Children receive mixed messages, on one hand, about "being accepted for who they are," and on the other hand, the importance of using technology to "be more like everyone else." Critical theory enables critical reflection on report-writing, encouraging awareness of linguistic choices and what and whose message and interests are represented.

We emphasize that it is not a matter of finding the single best phraseology. Any attempt to find the singularly best way to talk about disability will be mired in negative consequences of standardizing and categorizing a group of diverse individuals as the same in some fundamental way (Titchkosky, 2001). Assuming that there is one way to represent such varied individuals is misguided. A variety of ways to talk about a variety of individuals is likely more helpful (Titchkosky, 2001). Therefore, instead of suggesting 'the best' practice in terms of language to use, we suggest, instead, continually (re)examining what articulations in one's reports are actually saying and doing.

### **Visual construction considerations**

Next, visual rhetoric is introduced to encourage the inclusion of parents and children through written reports. Visual rhetoric is the effective use of visual elements to communicate information (Rosenquist, 2012). When designing forms and reports, primary information is displayed as a visually prominent feature, whereas supplemental information is more subdued in visual presence (Horton, 1990). Further, page-formatting techniques are effective in communicating the structural hierarchy of a document; elements placed at the beginning of the document automatically convey that they are the most important items, while elements at the end are understood as the least important. Lastly, according to the Gestalt principle of proximity, the strength of the relationship of visual

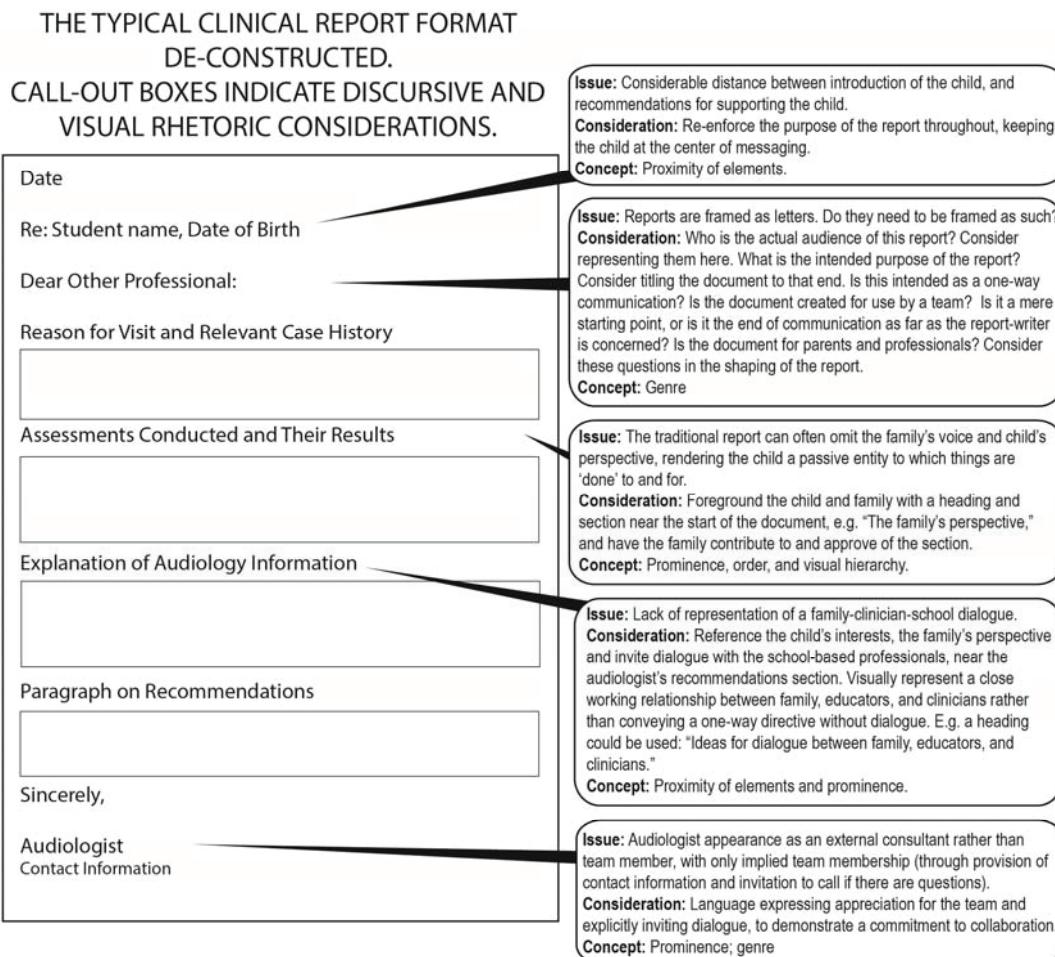
elements is directly proportional to the distance separating the items (Gribbons, 1991). By referring to the Gestalt principle of proximity, one can understand how specific elements within a document may be perceived as related or unrelated due to their proximity or distance from one another on the page.

In visual rhetoric, it is necessary to consider the context of use as well as the technical details of documents (Kwasnik & Crowston, 2005). For example, when considering a clinical report, one can better understand how the structure (e.g. sections) can enable or prevent collaboration between clinicians, school-based professionals, and parents. Discourses create, maintain, and transform relational bonds or structures (Barrett, Thomas, & Hocevar, 1995). Through this understanding of the way texts constitute relational bonds, one can come to understand how the contributions of parents and children to a child's educational planning can be enabled or constrained by the written reports created and circulated to advance that plan.

As the literature attests, there is great emphasis on parent involvement and positive outcomes in supporting children with health needs at school (Elbaum, 2012; Frew, Zhou, Duran, Kwok, & Benz, 2012; Griffin, Taylor, Urbano, & Hodapp, 2013).

However, traditional genres (genres are regularized formats, styles, and content expectations of texts) (Miller, 1984) of forms and reports do not necessarily display the importance of parent or child input. In order to invite and enforce family involvement, report-writers could include a section labeled "*Parent's Name Here Input*" as well as one for "*Student's Name Here Input*." In addition to parents' and children's rights to contribute to the child's educational programming, families and the children can provide crucial information that clinicians and school-based professionals need to know (Cannon, 2011; Gibson et al., 2009). In order to fully incorporate parent and child experiences, perspectives, and concerns and to actualize family-centered care, parent and child input sections should be considered when composing the clinical report. Based on visual rhetoric theory, parent and child sections must be placed prior to an educational plan or clinicians' recommendations because information that is at the top or beginning of a form is unconsciously perceived by readers as the most important element. Refer to Figure 1 for a deconstruction of a typical audiology report format through the lens of critical theory and visual rhetoric principles.

**Figure 1.** Deconstruction of a typical audiology report format through the lens of critical theory and visual rhetoric principles.



## Conclusion

This article presents two main problems: firstly, clinical professionals like audiologists may be advocating for children at school by proxy, thus lacking the opportunity for collaborative dialogue with school-based professionals and parents; secondly, children and families may be disempowered by language choices if clinician report-writers lack a critical social awareness of the constituting power of language.

Three opportunities, informed by critical social science theories, to ameliorate the above problems were also presented. Specific considerations are: 1) to include more dialogic language in reports to facilitate true collaboration rather than unintentionally promote conflict, 2) to be aware of the shaping effects of language on children's identities and opportunities, and 3) to make use of visual rhetorical theory to construct reports that represent and highlight parents', children's, clinicians', and school-based professionals' perspectives as equally important and in mutual ongoing dialogue.

Research and experiential evidence have shown how clinicians, school-based professionals, and parents may experience frustration and difficulty in working well together for and with children when trying to access school-based health supports; written reports are strongly implicated in these problems. Applying a critical social science perspective to the common practice of report-writing presents possibilities for overcoming these persistent and insidious challenges at the clinic-school interface. This article is not meant to be prescriptive, but rather an opportunity to challenge assumptions and engage in ever more sensitive and informed practices. The article also serves, for clinical educators, faculty members, clinicians, and learners of all types, as an introductory lesson in some principles and practices of critical social theory. The references to theories throughout this article may be a starting point for anyone interested in the sociological call to "make the familiar strange." We suggest that the critical social sciences offer us an opportunity, as a field, to engage in empowered social change.

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