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speechcare
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SPEECHCARE APPROACHES THESE WITH CAUTION

Practice/Diagnosis	Evidence Base	Affirming Potential	Comments
Orofacial Myology Therapy	●●	●	Mixed evidence. Can be appropriate for structural concerns (e.g. tongue thrust), but risks being non-affirming when focused on "normalising" speech patterns or oral postures without functionally relevant goals.
Tongue-tie Intervention	●●	●	Evidence is improving but still contested. Can be helpful for feeding/speech in some cases, but over-diagnosis is common. Should not be used to "fix" speech sounds unless clearly impacting function.
Social Stories	●●	●	Originally designed to help autistic individuals understand social situations. Can be affirming when co-created and used for preparation—not to teach "appropriate" (normative) behaviours. Avoid "I can…" statements that imply compliance.
Social Communication Groups	●●	●●	Can be affirming when focused on connection, shared interests, and self-advocacy—not training neurotypical scripts. Affirming intent increases with individualisation, group compatibility, and informed consent.
Prescriptive Programs Not Adapted to Individual Needs	●	●	Generally low evidence for long-term benefit and not affirming. These approaches often assume deficit, impose external goals, and ignore autonomy.
Central Auditory Processing Disorder (CAPD)	●	●	CAPD is a controversial diagnosis with unclear boundaries. Many children identified with CAPD may have broader language, attention, or sensory processing differences. Best approached with functional, holistic support rather than isolated training.
Multiple Language-Based Diagnoses for One Child	●	●	Labelling a child with multiple overlapping diagnoses (e.g. DLD, phonological delay, receptive-expressive disorder) can be confusing and deficit-based. Instead, a strengths- and needs-based formulation is more affirming.
PDA Diagnoses Without Exploration of Social Communication Supports	●	●	PDA (Pathological Demand Avoidance) is not formally recognised in all diagnostic manuals and is contentious. Assigning this label without understanding why a person resists demands (e.g. sensory, trauma, autonomy) risks pathologising valid responses. Exploring co-regulation, autonomy, and trust-based supports is essential for affirming care.

Evidence Base: ●●● Strong/high-quality evidence | ●● Moderate/inconsistent/mixed evidence | ● Limited or low evidence
Affirming Potential: ●●● Highly affirming | ●● Can be affirming if adapted | ● Risk of being non-affirming unless significantly reframed | ● Not affirming

Most affirming: Thoughtful use of social groups, collaborative social stories, identity-informed diagnostic approaches
Most caution required: Orofacial myology, tongue-tie surgery, CAPD, PDA labels, and prescriptive programs without individualisation
Least affirming: Generic, compliance-focused interventions that prioritise "fixing" over understanding