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DISCUSSION OPEN ACCESS

'Don't say "fis" say "fish"', 'I said "fis"': Ethical Considerations in Therapy to Change Child Speech

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ABSTRACT

Background: Historically, assessment of child speech has focused on transcription and analysis of speech sound production with no exploration of the child's own perception of his or her speech. This article explores the possibility that whilst children with speech 'difficulties' may be aware that 'talking to people' is problematic, they may *not* be aware that the reason for their communication difficulty is that their speech is unclear. Similarly, in a therapy context, the child's own appreciation of the purpose and progress of therapy has not been explored. Given the current concern for child well-being, particularly in educational settings, it is timely to examine the premise that all children with speech difficulties are *consciously aware* that their speech is different, that they want to change the way they talk *and* that they welcome help to improve their speech.

Aims: This overview of a child's own perception of his or her 'disordered' speech aims to bring the child's perspective clearly into focus. Long-held assumptions that children are aware of their speech differences and seek to change them are revisited, and consideration is given to the possibility that young children with speech disorders don't perceive the difference between adult pronunciations and their own. An ethical perspective of engaging young children in activities to change the way they talk before they have developed an appreciation that their pronunciation is different from an adult model is presented and considered. Readers will gain new insights into a child's perspective of not being understood and of being confused by efforts to help them to speak more clearly when their own perception is that their speech already matches the adult pronunciation. Clinicians will come to appreciate that strategies to 'help' children with their speech may feel confusing and even distressing to the child. Given the likelihood that children with SSD/D have little or no awareness of their mispronunciations, a case is made for a less corrective, directive style of therapy and for more facilitative, non-corrective therapy.

Method: Childhood experiences of growing up with speech sound difficulties are considered through child-focused interpretation of clinical video data and relevant literature. Review of a small selection of parent-consented videos originally collected for clinical or audit purposes prompted reflection on the child's perspective of assessment and therapy. In addition, adult reflections on their childhood experiences of speech problems in different contexts and at different ages were considered. Principles of ethical practice provided a framework for conceptualising ways in which well-intentioned therapy might provoke imperceptible emotional harm. Strategies are proposed for ensuring that 'problem-based' therapy is child-focussed, promotes autonomy and positive self-esteem and minimises the risk of imperceptible emotional harm.

Main Contribution: This discussion article highlights a gap in clinicians' recognition that children in early and middle childhood (2-7 years) may be unaware of their specific speech differences and that they are likely to be confused by therapy activities that

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require them to change the way they talk. An ethical perspective introduces the possibility that, without some child-focused explanation about the reason for therapy, intervention might cause distress, which children are likely to suppress, and, in some cases, long-term therapy may cause emotional harm. Strategies based on ethical principles are proposed for communicating with children about speech and for introducing 'new ways' to pronounce sounds. Development of a training route for equipping speech and language therapists (SLTs) to adopt a non-directive, collaborative style is recommended.

Conclusion: From an ethical perspective, this discussion paper introduces the possibility that well-intentioned therapy aimed at changing a child's speech could inadvertently cause emotional harm. It proposes that subtle adjustments to therapy style may elicit new sounds without conscious effort from the child, thereby reducing risks to emotional well-being such as fear of failure and confusion when new productions are deemed to be 'right' but *feel* wrong to the child. Collaboration between SLT, parents, school and, where possible, ELSA (Emotional Literacy Support Assistant) would reduce the risk of unintended harm that might be caused by practice-based therapy.

WHAT THIS PAPER ADDS

What is already known on this subject

- The question as to whether or not children are able to perceive mismatches between their own mispronunciations and their intended production has, to date, been sadly overlooked. This is reflected in the absence of any reference to the child's perspective in routine speech assessments. Existing literature indicates that children have little or no awareness that their speech is distinctive or in what ways it needs to be changed. Hence, it is quite possible that a proportion of children undergoing therapy are confused and could be distressed by therapy which seeks to change the way they talk.

What this study adds to existing knowledge

- By viewing therapy to change and 'improve' a child's speech, from the child's perspective, this article invites clinicians to question their assumptions that children will appreciate 'help' to speak more clearly. Attention is drawn to the risk that therapy might provoke an accumulation of unexpressed negative emotions which could lead to emotional harm. Strategies are suggested for exploring a child's perspective of their speech and for creating opportunities for collaborative therapy planning in the hope that therapy might boost, rather than erode, a child's self-esteem.

What are the potential or actual clinical implications of this work?

- Increased awareness of the risk that children who are compliant with therapy for speech 'differences' may experience emotions such as confusion, anger or general distress during therapy might lead to adjustments in therapy style. It is proposed that shared exploration of a child's speech patterns, with the child, at assessment, followed by collaborative therapy planning and child-focussed progress reviews, might enrich both therapist and child experiences of therapy for speech differences in childhood.

1 | Introduction

In the natural course of speech development, young children who mispronounce words such as 'fish' as 'fis' or 'go' as 'doe' are probably unaware that their output has not matched the adult target and, when encouraged to correct a 'mispronunciation', they will repeat their immature realization, "I *said* 'fis'" as in the title of this article. This type of emphatic rejection of adult correction suggests that children *do* perceive the difference between 'fish' /fɪʃ/ and 'fis' /fis/ in adult speech but, they perceive their own immature production /fis/ as a match to the target /fɪʃ/. This is known as the 'fis' phenomenon (Berko and Brown 1960 p. 531). Berko and Brown (1960) theorise that young children have one linguistic 'store' for decoding their own output and another for decoding incoming stimuli. In this article, it is proposed that, the same idiosyncratic misperceptions in typical childhood immaturities will operate with atypical realizations in speech sound disorders (SSD) that is a child who pronounces fish as [gɪʃ], will, most likely, believe that his production has matched the target [fɪʃ].

1. Before, and during, therapy children may not perceive their own mispronunciations, and they may not be aware that they have a speech 'difficulty/disorder'
2. Output practice and adult correction may cause confusion and unexpressed distress
3. Exploration of each child's perception of their own speech at the outset of therapy, and explanations about the aims of therapy activities may minimise the risk of unintended, imperceptible emotional harm to children.

In typically developing speech whole classes of sounds are affected by simplification processes such as stopping, fronting and context sensitive voicing, and a child's pronunciation of 'sue, shoe, two,' and 'do' sound like 'do' /du/. Since young children are likely to be completely unaware that most of these productions fail to match the target sounds, it seems logical to deduce that young children whose early speech includes atypical simplification processes such as 'backing', or glottal patterns, are

unlikely to be aware that their productions have not matched their target, that they are unusual, or that their speech is difficult for listeners to understand.

Drawing on 25 years of clinical experience with cleft palate-related SSDs, this article considers SLT for child speech disorders through a child-focused lens, recognising potential differences between clinician and child perspectives of clinical sessions. The author's clinical concern about the child perspective of therapy was prompted by observation of signs of unease, self-consciousness or embarrassment in videos of speech assessments and therapy videos (Harding-Bell 2019). These observations of childhood interventions raise two ethical questions for discussion here: a. *could* practice-based speech therapy programmes do unintended harm? b. do children undergoing therapy to change aspects of their speech perceive the distinctiveness of their pronunciations?

Discussion opens with a review of what is known about the child perspective of his or her own speech and the extent to which children perceive that they have a 'speech problem', how they view therapy, and to what extent their perspectives align with adult perceptions of their speech. These reflections reveal the potential risk that therapy which aims to change a child's speech without first exploring his or her awareness of the *need* for these changes, might have a negative impact on child well-being. This risk is discussed in the context of ethical principles introduced by Beauchamp and Childress (1979, 2009) and applied to speech therapy by Body and McAllister (2009). Four ethical principles, beneficence, non-maleficence, respect for autonomy, and justice provide a framework for reflecting on the potentially harmful impact of therapy to change child speech. In conclusion, recommendations are proposed for promoting more exploratory and collaborative therapy relationships with children which might eliminate some potentially harmful aspects of current therapy approaches. In addition to improving the clarity of a child's speech, the therapy process might also promote a child's emotional well-being and enrich child self-esteem.

1.1 | Child perception of his or her speech

In child speech assessments, the primary focus is on elicitation and analysis of a speech sample. Very few studies explore children's own perspectives of their speech. McCormack et al. (2019) reported that 79.7% of 132 children aged 4;0–5;4 years with SSDs indicated they were 'talking right' on the KiddyCAT scale (Vanryckeghem and Brutten 2007), and 78.9% of the same group rated themselves as 'happy with the way they talk' on the SPAA-C (McLeod 2022). It might seem surprising that, despite a diagnosis of SSD, nearly 80% of children were satisfied with their speech but, when considered in the context of emotional development, this is not surprising because typically, young children (aged 2–4 years) have unrealistically positive self-perceptions. They lack the neurological and emotional maturity to perceive differences between their target behaviour and actual performance (Harter 2012). During middle childhood (5–7 years), as neurological capacity increases, they develop the emotional maturity needed to recognise differences between adult performance and their own (Harter 2012).

Recognition of the impact of emotional immaturity on self-awareness provides an explanation for McCormack et al. (2010) finding that all but one of a group of thirteen 4–5-year-old children perceived that their communication difficulties were attributable to listeners failing to hear what they said. None of the children in the study had described their difficulty communicating as a problem with their speech. Similar insights emerge in a videoed conversation between two young adults who had both grown up with severe speech difficulties (Illingworth et al. 2019, Video Clips 1.a Adult reflections on being misunderstood as a child, 1.c Negative experiences in teenage years). One of the adult speakers remembered that despite attending speech therapy sessions from about 18 months of age, it was not until she was about seven years old that she had finally appreciated that the reason why people had failed to understand her talking had been because her speech was not clear.

Even when children are able to acknowledge that their speech is distinctive their descriptions are somewhat general, not 'sound specific' For example 'I have a different voice', 'I talk differently', 'I can't say words much' (Daniel and McLeod 2011). In a study focusing on the child's perspective of therapy, McCormack et al. (2018) reported one child's confusion and frustration: 'I couldn't say anything right... I couldn't hear what I said wrong'. This speaker was *becoming* aware that there was a problem with her speech, but she was unable to perceive the specific differences. This type of perceptual confusion is potentially distressing, even harmful, particularly when emotions such as frustration and misunderstanding have to be suppressed because children are not yet able to explain how they are feeling, or how they had felt in therapy.

So, it seems unlikely that young children referred for therapy under the age of 5 years would attribute their experience of communication breakdown to inaccuracy pronouncing particular sounds. They might recognise that talking is effortful and unrewarding without perceiving specific inaccuracies in their speech production until the later stages of 'middle' childhood (5–8 years). Until then, children will have little or no awareness of their mispronunciations as they speak, and only a superficial 'taught' understanding that they need to practice particular sounds, and that those sounds are relevant to their communicative success. This point is underlined by Weiss (2004), in her paper promoting the child as an "agent for change" in therapy. She noted: "It's always disconcerting to discover that a child has no response or an inaccurate response to the question, why are they receiving therapy." She added that "it would at least be reassuring if children were to respond with 'because sometimes people don't understand me when I talk' or 'to help me talk more clearly', or, in the case of older children, if they could tell you what sounds they are practising" (p. 241).

2 | Child Feelings About Their Speech and About Therapy

2.1 | Feelings about diagnostic terminology

Speech assessment findings would usually be discussed with the parent or teacher, not directly with young children. Gradually, from about age 5 years, children might become aware that they

have a 'speech problem' but many would not be consciously aware in what ways their speech is difficult to understand and would have no innate motivation to change it. At this stage they may feel mild confusion and would most likely disengage from therapy planning discussions. Hence, in this article, child-friendly diagnostic terminology is introduced in order to promote the reader's conscious awareness of the child perspective throughout the assessment and intervention process. The clinical term 'SSD' is hereafter appended with a child-focussed diagnostic descriptor: 'speech sound disorder/differences', (SSD/D).

2.2 | Feelings associated with negative listener reactions

Until a child becomes consciously aware of his or her speech differences, negative listener reactions to his or her unclear speech may provoke anxiety, self-consciousness and/or confusion which may be revealed in gaze aversion or physically moving away from an activity (Speake and Harding-Bell 2019 p.388). Examples of unhelpful listener responses as described by Van Riper and cited by McLeod (2011 p. 31) included: multiple requests for repetition; raised voices as if the child was deaf; guessing at the child's meaning; and responding with a random 'yes' or 'no'. Similar unhelpful reactions were reported by two young adults who reflected on their experiences of being misunderstood as children (Speake and Harding-Bell 2019). They remembered some of their coping strategies which included silent avoidance; agreeing with inaccurate adult misinterpretations of what they had said, and even, when expected to report weekend activities at school, inventing 'news' that would be understood by the teacher, for example saying 'I went to MacDonald's'. Merrick and Roulstone's (2011) study of eleven 7–10-year-old children found that some children reported that they had become aware that their speech was distinctive during therapy, and this awareness had a negative effect on their self-confidence and self-worth. So, there seems to be a need for more in-depth research to explore children's feelings about being misunderstood at different ages and stages of development and for recognition that childhood experiences of unsuccessful communication are likely to provoke emotions such as confusion, frustration, anger, disappointment and discouragement.

2.3 | Feelings about therapy to change speech

Since, at age 3 years, young children have not developed sufficient emotional maturity to recognise their articulatory mismatches (Harter 2012) or to verbalise their emotions about not being understood (Lindsay et al. 2002), it seems likely that corrective therapy sessions could provoke negative emotions such as confusion, distress, failure and low-self-esteem (Lindsay et al. 2002) which might be expressed behaviourally or, might be suppressed.

In cases where children are compliant, and willing to 'practise', they may cooperate with a style of therapy which provokes anxiety and emotional suppression, and which could have a long-term negative effect on developing self-identity and self-esteem (Lewis et al. 2023). This is a particular risk where children are regarded as passive recipients of therapy (Ferguson 2009). For

example, children may be presented with 'trial and error' sound production games which, in the early stages of learning the sound, inevitably involve multiple experiences of failure (Illingworth et al. 2019 p. 438). Until children are able to perceive their own mispronunciations of speech sounds as they talk, when they are congratulated for 'accurate' pronunciations in output practice activities, they are likely to be confused. They may be unable to discern for themselves why particular attempts to match the clinician's model have been 'successful' and others have not. This type of confusion about the goals of individual tasks may be expressed in negative behaviour in the therapy session or later, in the classroom or at home. Alternatively, compliant children might suppress their emotions which is likely to precipitate erosion of developing self-esteem.

A study by Owen and colleagues (Owen et al. 2004) reported findings from interviews with 12 school age children about their experience of speech and language therapy for a wide range of communication difficulties. Some children thought speech therapy was to 'help them', some thought it was to 'help others' but none of the children noted that therapy was intended to help particular sounds in their speech. The children's reports of their experience of therapy was mostly positive, particularly if they could take a friend with them, however, one child demonstrated passive compliance: *'I just think "Well she's here, so I better go"'*; and another expressed worry and confusion about what was required, similar to that reported by Merrick and Roulstone (2011). So here is one of the risks associated with therapy: in the absence of age-appropriate discussion with children about the sounds that are 'different' from other children, and/or about the purpose of therapy, they are likely to be confused, and uneasy about activities requiring them to change the way they talk. As new sounds are acquired in single words and practice sentences, there is a further risk that adults might expect children to spontaneously generalise new sounds into connected speech. This risk can be minimised by ensuring that parents and educational staff understand the complexity of the planning needed for new sounds to be integrated into connected speech.

One of several reports from the Child Talk Programme Grant (Roulstone et al. 2015) included a unique study which specifically focussed on the feelings, attitudes, experiences and perceptions of preschool children, 2–5;11years, in a range of SLT activities. Analysis of video recordings taken during group therapy activities categorised child responses into specific behaviour patterns which were then interpreted as expressions of each child's feelings in relation to the relevant activity. Specific behaviours were thought to reflect the extent to which children felt at ease with each therapy style: for example body language, vocalisations, visual attention and physical orientation towards or away from an activity. Responses thought to reflect caution and uncertainty included minimal vocal engagement and hunched physical posture with legs tucked together. Other signs of discomfort and/or anxiety included fidgeting, continuous handling of objects, repetitive movements and withdrawal from a group during an activity. In contrast, an upright posture with legs stretched out and leaning back on their hands was taken as a sign of ease and relaxation. Body movements towards an object, and open, smiling facial expressions were taken as indicators of confidence and relaxation. A particularly significant general finding from the author's review

of therapy session videos was that children were more vocal, and body language was more confident and energetic during unstructured child-led activities than in adult-led, turn-taking sessions.

Even when children have learned to pronounce target sounds accurately in practice materials, they may still struggle to integrate these productions into conversational speech. If adults try to intervene by segmenting target words, for example modelling sounds with an intrusive vowel /ka/ as [kə.'a] or word final /d/ in 'road' as [rəʊ:də], the resulting distortion of syllable structure can confuse children and disrupt efforts to stabilise new motor programmes. Consequently, well-intentioned adult intervention may not 'feel' helpful to the child and may provoke frustration or anger, emotions they often learn to suppress, (Gross and Cassidy 2019).

More research is needed to explore the hypothesis that children with speech differences might experience some degree of stress and confusion when engaged in therapy to change the way they speak. The methodology for such research would need to consider that children may cooperate with therapy while concealing emotional stress. In these cases, the emotions expressed by their 'public self' may not reflect what they feel in their 'private self' (Denham 2007). Clearly, there is a need for more evidence about which components of therapy might be emotionally harmful and what strategies might protect and enhance emotional well-being.

In recent years two groups of children with speech differences whose self-awareness and emotional needs have been prioritised, are those with disfluency (Boey et al. 2009), and those with a history of cleft palate (Calladine and Vance 2019 pp. 329–360; Speake and Harding-Bell 2019 pp. 361–406). Children born with cleft palate in the UK receive therapy advice from about 18 months and undergo routine speech assessment at 5 years. These assessments include a sentence repetition task which is video recorded and transcribed live and then transcribed again through consensus listening, for audit purposes. Most children are compliant with the speech elicitation task which involves picture description with sentence repetition, but in the authors search through speech videos for transcription practice examples, some videos revealed subtle signs of emotional distress which included fleeting anger, sudden impatience, clownish behaviour and physically turning away from therapy activities. Similarly, Speake and Harding-Bell (2019) reported an example of a child who, after some mildly negative feedback from the clinician looked embarrassed, smiled, and then giggled and grabbed the clinician's spectacles! This negative behaviour was interpreted as an effort to camouflage self-conscious emotions about mildly negative feedback (Harding-Bell 2019, Video Clips 12.2d.ii 'ts' output with reaction to negative feedback; 11.2a.ii Oral plosive target modified to an oral fricative). In many clinical settings this type of avoidant and aversive behaviour is likely to be interpreted as non-compliance and a 'lack of motivation for improving speech' (McCormack et al. 2012), and is held responsible for unproductive therapy. It would seem then that, despite the intention to do 'good', speech-focussed therapy also has potential to cause harm. The risk that therapy might provoke emotional unease and even distress is considered here within an ethical framework.

3 | An Ethical Perspective of Therapy to Change a Child's Speech: Risks and Benefits

All clinicians have their personal ethical philosophy which guides their personal and professional behaviour, but an ethically principled clinical perspective is more theoretically driven, more focused and more explicit. Body and McAllister (2009, p.5) reference Seedhouse's (1998) definition of ethics as 'an ongoing process of deliberation about how to act in other's lives.'

Since ethical practice within healthcare requires that all intervention aims to 'do good, to avoid harm, and to respect an individual's autonomy (Eadie and Charland 2005, Irwin et al. 2007), it is important to focus on the patient's experience of intervention as well as on achieving the treatment goal of 'normal speech'. In the current climate of evidence-based interventions and outcome measurement, clinicians tend to focus on achieving improved consonant production scores without consideration of child's perspective. There is a risk that some children could be imperceptibly distressed and/or conflicted by the process of 'being changed'. This article adopts the framework of ethical principles outlined by Body and McAllister (2009) in their text about ethics in speech and language therapy, as the basis for exploration of the potential risks associated with therapy for child speech difficulties. Ethical issues in a therapy context might be categorised as ethical dilemmas or ethical considerations. Ethical *considerations* in a therapy context can be viewed as less polarised than ethical *dilemmas*, and more difficult to specify. An example of an ethical consideration in the case of a child's speech 'difficulty' would be considering whether, and when, to make a child aware that his /her speech is different from other children's. As with ethical dilemmas, ethical considerations include weighing the relative beneficence, and potential maleficence, of each possible course of action.

Four principles of ethics, described by Body and McAllister (2009), were originally propounded by Beauchamp, and Childress (2009 6th Edition, p. 19–27 1979); Beauchamp 2007, pp. 1–8). These principles serve two functions for clinicians working with speech difficulties: firstly, they can provide a lens through which to examine therapy interactions; secondly, they can provide a framework for child-centred therapy planning. The four principles can be summarised as follows:

3.1 | Beneficence

The obligation to do good and to balance potential risks and benefits in favour of a person's welfare. It seems reasonable to assume that notions of beneficence are central to people's thought processes when they decide to take up a career in speech and language therapy and other health professions' (Body and McAllister 2009, p.17).

3.2 | Non-maleficence

The obligation to do no harm, is often considered to be the overriding ethical principle in health care.

3.3 | Respect for autonomy

Beauchamp and Childress (as cited in Body and McAllister 2009, p.16) describe autonomy as 'self-rule that is free from controlling influence by others and from certain limitations such as an inadequate understanding that prevents meaningful choice'. This definition appears to have been formulated with adults in mind. Informed consent with children involves skilled explanations and opportunities for children to behave autonomously, with careful interpretation of negative behaviours. For instance, when children refuse to imitate a therapist's model of new sounds it is likely that they are behaving autonomously to avoid the risk of failure. In this situation a clinician who respects a child's right to a degree of autonomy and who is concerned to minimise the risk of emotional harm (non-maleficence) will explore ways to modify tasks and activities to engage children.

3.4 | Justice

Of the four principles of ethical practice, the principle of justice is likely to be the least relevant to individual clinicians in their clinical practice. It primarily applies to large-scale considerations concerning society, politics and the economy. One example of a justice issue which might be considered at national level relates to the lack of equity in therapy provision across different regions (Bercow 2018).

All four principles outlined by Beauchamp and Childress (2009) have relevance for SLTs working with child speech difficulties because, despite every intention to be beneficent, therapy which seeks to change an aspect of a child's behaviour, and which requires them to 'unlearn' a behaviour which is not usually under conscious control, might be inadvertently maleficent.

4 | Risk of Inadvertent Harm (Maleficence) in Therapy to Change Speech

Owen et al. 2004 finding that children had been confused about the reason for attending therapy highlights a risk of emotional harm and raises an ethical question: should children be submitted to therapy which, whilst seeking to do them good, might generate negative emotions that are suppressed at the time and remain unresolved? The risk of Adverse Childhood Experiences (ACE) has been noted in a study reflecting on interventions intended to help children with their social, emotional and mental health (SEMH) difficulties in educational settings (Dolton et al. 2020). Analysis of interviews with these children concluded that 'support' in an educational setting could, for some children, become ACE's, which could have a long-term impact on individual children.

The hypothesis that speech and language therapy could also have long-term negative effects has not been formally investigated. However, verbal feedback from adults returning to multidisciplinary cleft palate clinics suggests that they had been passive recipients of interventions throughout childhood. In one consultation an adult who was seeking surgery for a persistent nasal fricative was distraught when she was advised that surgery would not resolve the problem, and, instead, she was offered specialist

speech therapy. She had wept in the clinic and recounted the emotional trauma of prolonged ineffectual childhood therapy. For her, therapy had been a significantly adverse experience, an ACE. At the time she had probably concealed her intense emotions from the clinician, and even from her parents. This case reveals the risk that well-intentioned therapy could do unseen, but long-term emotional harm.

Similarly, in the recorded conversation mentioned earlier (Speake and Harding-Bell 2019) between two young adults about growing up with a speech difficulty, one speaker recalled being extracted from interesting classroom projects to practice saying a vocabulary of 'baby-ish' words. She recalled painful emotions in relation to her output-practice based therapy:

- a. *Anger* about being subjected to demeaning activities in school-based speech therapy and missing interesting project work. Later, in her teenage years at her first multidisciplinary clinic appointment, she had been angered by an SLT who raised the topic of her 'speech'. Until that point, although she had been acutely aware that her speech was distinctive, and often unintelligible, she had managed her self-consciousness by containing the problem and not discussing it with anyone. She had made an autonomous decision to repress her concern about her speech difficulties, yet the clinician had unwittingly, but catastrophically and irreversibly, undermined this autonomy by inviting her to 'talk about' her speech and the possibility of more therapy. Interestingly, when she shared this experience in the previously mentioned reflective conversation, the other adult had reacted strongly, saying that if anyone suggested *she* needed more therapy, it would 'tear her apart!'
- b. *Confusion* as a child, because she hadn't understood why she had been singled out for therapy in school and couldn't see any value in the sound practice activities. An additional point to note here is that her confusion had been exacerbated by a difficulty understanding one SLT's South African accent.

In this case, both assessment and therapy had been unintentionally maleficent. The impact of being repeatedly submitted to therapy activities that seemed demeaning, without any opportunity to express herself or to make choices, had a long-term, negative effect on her developing self-esteem. This is an example of iatrogenic psychological harm, as described and discussed by Rees (2012). Whilst it may be inevitable that some therapy activities may precipitate unease, it is possible that such unease and distress are concealed by a child's ability to suppress their emotions, as described by Gross and Cassidy (2019).

In the previously mentioned Child Talk study (Roulstone et al. 2015), a comparison of children's engagement with different therapy activities identified behaviours reflecting ease and relaxation, as well as behaviours indicating caution and uncertainty. Similar observations were noted in therapy video clips in Harding-Bell's publication (Harding-Bell 2019). In most clips, children were positively engaged with the therapy activities; however, two examples show reactions to mild negative feedback from clinicians. One example, cited above, (*Video Clips 12.2d.ii 'ts' output with reaction to negative feedback*) features a child responding to corrective feedback. In the same clip, a second example involves a 3-year-

old little girl who, when the clinician remarked on a difference between her adult model and the child's output attempt, looked downcast and turned away from the game (Harding-Bell A. 2019 *Video Clip 12.2d.ii 'ts' output with reaction to negative feedback*). A longer extract from this child's therapy session appears in her case study videos (*Video Clip 11.2a.ii Oral plosive target modified to an oral fricative*). She apparently perceived a very subtle, critical element in the clinician's comparison between their productions and she looks down and disengages from the activity. In both cases, the children's embarrassed behaviour was immediately interpreted by their therapists as signs of unease, and activities were quickly adapted so the children re-engaged with therapy activities. Both clinicians took responsibility for restoring child confidence. It can be deduced then that the risk of maleficence in therapy can be minimised by clinician responsiveness to a child's physical engagement with therapy activities. Particularly careful attention may be needed to minimise the risk of inadvertent maleficence in therapy with highly self-conscious children.

Reflection on these examples of unintentional maleficence in therapy indicates that there is a need for clinicians to pay close attention to children's emotional well-being throughout therapy. The NICE guidelines for Social, Emotional and Mental Well-Being in Primary and Secondary Education (2022 NG223 para 1.4.4, 1.4.7) recognise the risk of harm and unintended consequences from interventions with children and young people identified as needing additional support. Whilst there are no formal procedures available to clinicians for assessing the risk of harm in therapy, the NICE guidelines specify that professionals should confer with children about any planned additional support in school.

5 | Application of ethical principles Minimise the Risk of Emotional Harm in Therapy

Awareness of the risk of inadvertent harm in therapy leads to consideration of strategies to prioritise a child's emotional well-being. Hand (2009 p. 101) recommended that 'we should not make assumptions or take shared perspectives for granted. We should treat all clients as having no reason to value or understand what we do before we start. We must see our job as informing, persuading, empowering and negotiating with clients, of engaging with what they think and believe, in order to be effective. We must adapt, not just persevere or withdraw.' This principled approach is more explicitly described by Holliday and colleagues (Holliday et al. 2009) who recommend that the style of therapy might be tailored to 'ensure that children's real needs, rather than their presumed needs, would be met in therapy'. The following paragraphs consider how these principles could be applied to discussions with children about speech assessment findings and about therapy planning and programme monitoring without compromising the goal of reshaping atypical speech patterns.

5.1 | Shared discussion about a child's speech

Whilst there are a few assessments that explore how children feel about talking, currently there are no protocols that elicit a child's own reflections on how they perceive their speech. In the UK

the SPAR-QL, (Underwood and Fromberg 2018) was developed for children with a history of cleft palate, but it has not yet been published. At the time of writing, only two published assessments explore how children feel about talking and their perception of what other people think about their speech; however, these questionnaires do not include questions about how children perceive and feel about their own pronunciation. The Speech Participation and Activity Assessment of Children (SPAA-C; McLeod 2022, 2004,) was developed in Australia with Australian SLPs, and the KiddyCAT (Vanryckeghem and Brutten 2007; Clark et al. 2012) was developed in Germany to explore self-awareness of childhood dysfluency. KiddyCAT has since been translated for use in English with children who have a speech impairment (McCormack et al. 2019). Children are presented with 12 'yes/no' questions that explore a child's level of awareness of their difficulty talking and listener responses, but not the accuracy of their speech. Examples include: 'Do you talk right? Is talking hard for you? 'Is it hard for you to say your name?' 'Do your words come out easily?', 'Do people like how you talk?'

In contrast, the SPAA-C child questionnaire explores how the child feels about talking in different contexts. Children select their answers to each question starting 'how do you feel when...' from a range of emoticons representing a. happy b. in the middle c. sad d. another feeling and e. don't know. In addition to exploring the child's experience of talking, the SPAA-C (McLeod 2004) includes questions for family members and friends about the child's communicative confidence in a range of social contexts. A separate set of questions for the child about social preferences, with one revealing question that specifically asks, 'do you think your talking is different from other children? McLeod (2004) encourages clinicians to prioritise exploration of each child's perception of their unusual speech and recommends that clinicians adapt and supplement the published questions in the SPAA-C to suit clinical and research contexts.

While there are no standardised age-adjusted assessments of a child's perception of their own speech accuracy, it is proposed here that, where possible, some structured informal assessment should be routinely undertaken and documented in case files. This would help ensure that therapeutic intervention is, to some extent, child-focused as well as impairment-focused. Table 1 introduces a proposed extension to all conventional child speech assessments, Self-Perception of Speech Conversation (SPSC). A series of questions, aim to identify whether or not children consider they have a speech difficulty. The questions have been developed to help children to explore and to express feelings that might otherwise remain unidentified'. The first question is very similar to one in the SPAA-C assessment (McLeod 2022): "Do you think your speech is the same as other children or a *little bit* different?" but by specifying that speech might be 'a *little bit* different' children might feel able to acknowledge the possibility that there *might be* differences in their speech even though they don't perceive them. Minimising the degree of difference may be more emotionally 'manageable' for self-conscious children than having to choose whether their speech which is 'the same or different' as in the suggested questions in SPAA-C (McLeod 2004). The child's response to this question would serve as a guide in therapy planning. For children who recognise that their speech is distinctive, direct therapy might be offered; but for those who are either unaware or too self-conscious to acknowledge the

TABLE 1 | Self-perception of speech conversation (SPSC).

1. Do you think your talking is the same as other children or a little bit different? If the answer is a little bit different progress to Qn 2
2. Would you like your talking to be the same as other children?
3. Do grown-ups understand what you say: all the time; some of the time?
4. How good are grown-ups at listening to what you say: very good; not very good?
5. Do grown-ups want you to say things again: never; sometimes; lots?
6. Are there some words that are difficult for you to say?
7. If grown-ups don't understand you, do you feel a bit grumpy?
8. If grown-ups don't understand you, do you sometimes feel worried or sad?
9. Would you like to play games with me to help your talking?
10. Would you like another child to come with you to play some 'sound-practice' games or would you like to come on your own?
11. Do you like to be on your own at playtime or play with other children? Who do you like to play with?
12. Who does the most talking in your class. Do you talk a lot, or not much?

difference, then a less directive, non-corrective therapy approach, such as input modelling, might be adopted.

All the questions in the proposed SPSC invite expression of the child's perspective and their experience without requiring them to disclose much about their feelings. Responses may lead to further discussion, such as whether they would like their talking to be more like other childrens, whether they think that there are any sounds their tongue/mouth can't say clearly, or whether they might like to play games to find 'new' ways to say some of sounds that are a bit 'tricky'. It is hoped that children would feel that this is a conversation rather than an assessment, and that it would promote the development of autonomy and resilience.

5.2 | Promoting shared understanding of assessment findings and exploring possible solutions

NICE Guideline (2022 NG223 para 1.4.4 p13) recommends the use of age-appropriate explanations about assessments and opportunities for children to ask questions about planned interventions and opportunities to express their views and preferences. For children who have SSD/D, discussion about all, or some of, the 12 questions in Table 1 might provide a helpful basis for exploring a child's perspective of talking and of the accuracy of their own 'talk'. Answers to the questions might reveal some insights into a child's perception of their own speech, and about their feelings when listeners fail to understand them. These conversational, open-ended questions lead away from an impairment-based, quantitative perspective, towards more qualitative personalised support, tailored to the individual child as recommended by Hand (2009). While clinicians will also need to use systematic assessments of speech patterns, expression of the findings in child-centred explanations would help clinicians to maintain their focus on each child's experience of communicating verbally. When a child agrees that sometimes people don't understand what they say, the clinician might then offer to play some games

to help the child's 'tongue and lips' find some new ways to says words and sounds.

6 | Child-Centred Intervention

For children who decline an invitation to explore new ways to make sounds, the clinician might introduce 'modelling' activities. For example, children are usually happy to play listening and watching games, such as articulatory awareness activities, for instance: "can you see my tongue when I say.... [f::]?" In this activity, the child is invited to focus attention on the clinician's articulatory gesture without the risk of 'failing' an imitation task. It is proposed here that new motor programming and planning will be stimulated through attention to repetitive input of carefully crafted models of target sounds (Calladine and Vance 2019).

Engaging young children in therapy planning and providing choices during sessions helps develop autonomy and maximises attention and motivation. Similarly, minimising the risk of anxiety and confusion enhances development of social and emotional competence (Bywater and Sharples 2012). The importance of promoting emotional well-being in the clinical context is underlined by the NICE guidelines (updated 2022), which recommends that clinicians should 'Explain targeted support to the child or young person and involve them in decisions about the support offered to them, including when and where it is offered' and 'Where appropriate and possible, obtain their agreement before starting the support'. (Social, emotional and mental wellbeing in primary and secondary education NG223, para 1.4.4 p.13)

The NICE guidelines also recognise the social risks associated with receiving support in school and recommends that 'support should minimise the risk of any unintended adverse consequences and stigma' (NG223, Para 1.4.7 p. 34]. Therapy styles which engage children in shared activities, provide choices, and place minimal emphasis on 'task fulfilment' or notions of 'success' and 'failure' might reduce the risk that therapy could generate feelings of anxiety, stress, or low self-esteem. In addition

to promoting successful and stress-free verbal communication a supportive therapy relationship could foster development of personal qualities that are thought to equip young people to succeed in life such as self-confidence, social awareness, and empathy (Bywater and Sharples 2012). A positive one-to-one relationship with the SLT might also promote development of personal qualities such as an optimistic disposition, self-control, confidence, social connectedness, and flexibility (Phillips et al. 2019).

6.1 | Minimising the risks associated with therapy

Rees (2010) identifies several sources of harm in professional practice with children. These include ‘ill-judged spoken words, inappropriate attitudes and behaviours, failure to listen, and assumptions that fill unrecognised gaps in knowledge’ (Rees 2010). She advised that ‘Good care means listening. It means standing back and noticing the emotional context of presenting problems.’ Hand (2009) provided more explicit recommendations for minimising the risk of harm in clinical relationships with children: by varying the degrees of directness or indirectness; of control or handing over control; and of explanation or demonstration. Similarly, Dolton et al. (2020) advocated the active engagement of children in their own intervention planning, in order to promote resilience and development of positive self-identity.

In a therapy context, many children are motivated by fun therapy activities; however, some are more cautious, less resilient, and perceive a risk of failure that could undermine their emotional well-being. Some children may express their unease through aversive behaviour, but some are able to mask any negative impact of therapy and to conceal any distress from the therapist. If children are repeatedly coaxed into fear-provoking activities, with rewards for co-operation, this may lead to an emotional cost that remains imperceptible to both the therapist and parents.

6.1.1 | Anxiety

For some children, fearful and anxious emotions provoked by task-based activities can be minimised by introducing choices. Activities could invite participation through attention to the clinician’s model, for example “this game is about ‘t’, I call it my ‘tip touching teeth’ sound. Can you watch my tongue while I make some sounds and tell me whether my tongue touches my teeth? You can touch your teeth with your tongue as well if you like!” Giving children a choice about engaging with an activity minimises the risk of harm because the element of choice promotes autonomy. Alternatively, the locus of control can be passed over to the child and the child judges whether the clinician has pronounced words correctly or incorrectly using minimal or maximal contrasts (Calladine and Vance 2019; Harding and Bryan 2000). This strategy releases children from anxiety about their own capacity to produce sounds and words whilst engaging full attention on the clinician’s repetitive model of articulatory patterns. According to mirror neuron theory (D’Ausilio et al. 2014; Rizzolatti and Craighero 2004), attention to models of target behaviour stimulates new motor programming and planning in output processing without the risk of failure at the level of motor execution (Calladine and Vance 2019).

6.1.2 | Confusion

As noted above, children who mispronounce specific sounds may have little awareness of their atypical realizations so when they are corrected or required to practice new sounds, they may feel confused, confused about which sounds need to be changed and in what way. Ethically-aware therapy would provide children with clear explanations about the purpose of therapy and would involve children in goal setting and decision-making as recommended by Dolton et al. (2020). Therapy approaches might avoid activities where children attempt output and might think they *have* matched the target sounds but their production is not affirmed by the clinician, as this can lead to feelings of failure. Instead, activities presented in the style described in the paragraph above, could promote reflection on specific phonetic aspects of a target sound. For example, the clinician might draw attention to articulatory features in quiet softly articulated models for example, when targeting a bilabial or a velar sound children could be invited to observe the articulatory model with a discriminatory task “*do you see my lips come together when I say ‘pop’? Do my lips move when I say ‘cake’?*” Similarly, attention could be focused on airflow and a tactile sensation: “*can you feel a little wind on your hand when I say ‘offffffff’?*” (softly prolonged /f—[f:]) “*Can you feel any wind on your hand when I say ‘mummy’?*” This type of activity highlights specific features of sounds, stimulates motor programming and motor planning, *without* triggering confusion and anxiety about how and what to change for sound production tasks.

When children gain confidence to attempt production, further confusion might occur if their new productions are accepted as accurate, but *feel* and *sound* unusual or ‘wrong’ to them! In such cases, adult enthusiasm and congratulation for ‘successful’ production which didn’t *feel or sound* right to the child, could leave a child feeling isolated and confused. So, it is noteworthy that adult celebrations of ‘new’ sounds, could be maleficent if the child has not perceived their output as a match for the target. Calladine and Vance (2019) recommend that clinicians minimise this risk by moderating their responses to ‘successful’ productions by giving quiet, explicit and explanatory feedback. This could be more open-ended observation of new articulatory patterns for example “*Oooo, (quietly spoken), your tongue just made a ‘t’ in a new way. Now you have two ways to say ‘t’. The new way probably feels a bit odd to you at the moment, but it sounds really good to me.*”

6.1.3 | Failure or feeling a failure

In clinical practice it has been observed that children who resist direct, output-practice based therapy, and who might be classed as ‘unco-operative’ or ‘not ready for therapy,’ will often engage in activities which make no demands on them for output practice, that is, where there is no risk of ‘failure’. Multi-Sensory Input Modelling, (Harding and Bryan 2000; Calladine and Vance 2019) is a non-directive, non-corrective approach to therapy which modifies activities and sound models used in conventional output practice activities and specifically focuses on engaging a child’s conscious attention to visual, auditory and/or tactile aspects of target sounds. Mirror neuron (D’Ausilio et al. 2014; Rizzolatti and Craighero 2004) and imitation theories (Kuhl and Meltzoff 1996; Köster et al. 2020) promote the thesis that repetitive stimulation

of input pathways is a valid strategy to stimulate the development of output processing pathways (Hari et al. 2014). Instead of the child being required to *produce* new sounds, the child *observes* the clinician's repetitive models. According to mirror neuron theory, engaging a child's conscious attention to multiple examples of a new sound, through visual and auditory input processing, actively promotes development of new motor programming (Hari et al. 2014). As children observe repetitive models of carefully crafted, softly articulated, and 'unusual' articulatory gestures, they may naturally mentally rehearse the sound or some aspect of it. When a clinician's model is distinctive, and interesting to the child, it is likely that some level of output planning will be stimulated. There might be posturing of the tongue or lips, or motor programming without any motor planning. Parents may need to be reassured that this type of activity *will be* promoting new output planning and laying the foundations for new output processing without the risks of failure, confusion, anger or distress that can be associated with direct output practice.

6.1.4 | Suppressed anxiety

Of the two examples of adult memories mentioned above, one adult revealed that residual anxieties about childhood therapy had persisted into adulthood. Another adult had re-referred herself to the cleft palate service seeking a surgical solution for her residual active nasal fricative. She reported a history of severe childhood anxiety associated with unsuccessful speech therapy. At the time she had suppressed her distress with self-regulatory strategies, but she was still suffering from the long-term impact of her therapy-related ACE. Sadly, the severity of her suppressed emotions from therapy in childhood prevented her from accepting the specialist SLT treatment option for her nasal fricative.

This example underlines the importance of facilitating adult understanding of, and empathy with, the child perspective of speech problems, and of therapy. Children undergoing therapy to change their speech may need to be helped to understand the purpose of therapy and to feel that they have some control over it. They could be invited to reflect on therapy sessions. "Which activities have you enjoyed today? Shall we do that again next time, or shall we do something different?" Similarly, responses to new successful output could be calm, allowing time for children to process articulatory 'success' internally. For example, the response to a child's new, age appropriate, dentalised [t̪], might be "I like that new 't', I could see your tongue touching your teeth."

6.1.5 | Promoting autonomy

Explanations about the purpose of speech assessments, about the findings, and about the possibility of therapy to 'find some new sounds' would promote self-esteem. Visual charts with circles around accurately pronounced sounds would provide a shared focus which would release the child from eye-to-eye contact with the therapist while they listen to explanations about their speech patterns. The visual symbols on a chart would facilitate understanding and retention of information about which sounds are 'clear' and which sounds need a 'bit of help'. After the clinician's explanation about the speech assessment findings children can be empowered by being given choices about different

aspects of therapy planning for example, making choices about the time of therapy sessions, which of the clinician's games to play, or what rules will apply to the therapy games.

One idiosyncratic example of child autonomy was recalled by one of the two adults who reflected on childhood therapy. As a 4 year child she had adopted a strategy of engaging positively with therapy activities but she had avoided any risk of 'failure' by deciding not to speak at all during therapy sessions. Hence her therapy had proceeded with input modelling sessions which had been videoed to watch at home. She and her mother watched the video frequently and played the therapy games together. Her speech gradually changed without requiring output practice.

For children who are willing to engage with 'low demand' output activities, autonomy might be promoted by inviting them to choose what role to play in a game. For example, "This is our 't' game: "While I make the sound 't', could you put your tongue between your teeth like this [t̪]?" (a relaxed inter-dental 't' with body of tongue rocked forward to rest on lower teeth, and upper teeth resting on margins of the tongue). Alternatively, the clinician could offer to say the target sound for example, [t] while the child adds a vowel or syllable for example, the clinician produces a soft, breathy interdental voiceless plosive [t̪] and the child follows with a prolonged [hu] so together they have produced the sound sequence [t̪.hu]. In this type of activity, the child can remain autonomous because completion of the activity is not dependent on the child's output. If a child is hesitant about adding their part of the sound sequence, or looks 'ill at ease,' the clinician can quietly produce the child's sound.

At the end of each session children might be given opportunities to reflect on which activities they have enjoyed and which ones they might like to include in the next session. A strategy recommended in the NICE (2022) guidelines, is that children can be given some control over the context of therapy by inviting a friend or a parent to go with them to therapy. Similarly, where it's feasible, older children might be given choices about where to see the therapist—at school, or somewhere away from school such as a community clinic, or sometimes, at home. All opportunities to express preferences will promote the development of autonomy and increase a child's self-worth.

Even when there is no perceptible change in speech patterns and a child chooses to discontinue therapy, memories of therapy techniques may be retained and retrieved years later. One 12 year-old boy had requested discharge from therapy for his cleft-palate-related lateral 's' when he was 9 years old because it was not a problem with familiar listeners. Then, when he was reviewed in an MDT clinic at age 12 years his lateral 's' had completely resolved without further therapy. He had explained to the therapist that when he had changed school in year 7 (10 years old), he had been teased about his speech, but he had remembered how he used to practise his 's' in speech therapy, practised on his own at home, and it had 'come right'!

6.1.6 | Promoting beneficence

The two young adults who reflected on their speech therapy treatment as children recommended that the materials for speech

assessment and therapy needed to be tailored to each child's age and maturity, and that material linked with classroom topics would make therapy more interesting and relevant to the individual. Child well-being in relation to school-based therapy might also be promoted by close collaboration between SLTs and support workers. Some education authorities now provide specially trained Emotional Literacy Support Assistants (ELSAs) (Wong et al. 2020), who are regarded by children and young people as 'friends' rather than 'teachers'. This type of relationship with their SLT might maximise the benefits of therapy and minimise any emotional distress related to their speech differences or anxiety about school-based therapy (McEwen 2019). Later, at 16 years, when responsibility for clinical decision making is transferred from parents to the young person, young adults have suggested that a summary of medical and psychological treatments should be made available to every young person. Historically, in some Health Trusts, if a young person requested copies of their medical history it was their responsibility to approach each relevant department and, in some health trusts, to pay a fee which would impose a barrier to becoming fully autonomous. The opportunity to reflect on a comprehensive treatment summary of cleft team care would help young people to review and adjust their self-identity.

6.1.7 | Ensuring service-wide justice in therapy

The principle of justice can be considered in relation to service delivery, service planning, staff training and collaboration between professionals. For example, economic decisions to redeploy SLT staff may be economically beneficial to the organisation but destabilising a child's relationship with a trusted clinician is likely to have a negative impact on a child's emotional well-being. The risk of emotional harm relating to loss of relationships has been noted in the NICE Guidelines but has not yet been identified and addressed within RCSLT child speech guidelines.

In the interest of ensuring justice in therapy provision, there is a case for routinely completing a structured assessment based on the PERIK assessment of social well-being and resilience of children in early childhood settings (Mayr and Ulich 2009). Findings from an assessment of emotional well-being alongside a speech assessment, could provide a national database to explore research questions, inform service planning and optimise speech and language therapy services for children.

Ensuring justice and ethically principled speech and language therapy provision would require some level of training for SLTs. To date, education about children's emotional development and emotional needs has not been integral within undergraduate SLT courses in the UK. An adapted version of the training programme delivered by educational psychologists for ELSA (Leighton 2015), might be a possible post graduate CPD route for SLTs. Whether or not SLTs receive emotional literacy training, collaborative relationships between SLT and ELSA's should be fostered.

From a service perspective there may be a case for modifying outcome measures to include a measure of child 'satisfaction' with their speech, and with therapy. In the field of cleft palate, outcome measures relating to clinician ratings of jaw development, dental alignment and speech accuracy are clearly specified and reported

annually. However, Kitson et al. (2013) have recommended a shift away from concern with physical, visible outcomes towards prioritising emotional well-being (Kitson et al. 2013). Similarly, a more recent analysis of adult reflections on treatment experiences in a 20year care pathway for cleft lip/palate services, concluded that a more collaborative approach to decision making about interventions at the various stages of surgical, audiological, speech and orthodontic treatments would enhance the treatment experience for young people (McWilliams et al. 2024). According to Hand (2009, p.104) a shift of focus away from interventions and toward shared decision-making should also be reflected in the language used for clinical note keeping and report writing. The primary interest should be in the child/young person's well-being, and the clinical issues should be considered with close reference to individual preference and emotional well-being.

7 | Clinician Perspective of Ethically Principled Child-Centred Therapy

Owen et al. (2004) observed that SLTs who had interviewed children about their experiences of therapy had recognised a difference in their own communicative style in the interviews. The conversational nature of the interview had been less directive and therapists felt they had 'developed their own skills in listening to children and collaborating with them'. It is possible that therapy approaches can be adopted which actively explore, and respect, the child perspective of his or her own speech, and of the assumption that they need therapy to change it. A change of emphasis in the clinician's style away from a hierarchical 'teacher/director' role towards a friendly 'facilitator' role, gives flexibility to the clinician/child relationship and eliminates any task-oriented fear of failure, thereby minimising the risks and increasing a child's sense of well-being and enjoyment of therapy.

8 | Conclusion

The primary ethical issue raised here is whether it might be potentially harmful to require children with speech sound disorders/differences (SSD/D) to engage in corrective, output-based practice without first exploring the extent to which each child is aware of, or concerned about, their speech differences. It has been suggested that conventional output-practice based therapy activities which carry a high risk of failed attempts and associated feelings of unease, confusion, anxiety or distress, may be inadvertently and imperceptibly maleficent. Enquiry into the child's own perception of his or her speech, combined with clear, simplified explanations about assessment findings and therapy goals, could empower children to give informed consent to intervention. For children who have no awareness of their speech differences at the time of assessment, the risk that therapy might precipitate anxiety could be minimised with an input-based, non-directive and non-corrective therapy style.

In ethically principled therapy, clinicians would be sensitive to the child's perspective of their speech and parents/carers would be guided in strategies that encourage engagement with therapy activities at home. This approach would minimise the risk that therapy could have an erosive effect on a child's developing resilience, self-identity and emotional well-being (Spratling et al.

2019; Hay 2019). A collaborative, nurturant therapy style would invite choice about levels of engagement, with opportunities to watch and listen to new sounds, and choices about when and what they feel able to 'output'. Ideally children will feel 'safe' and will view their therapist as a friendly, fun person, more like an ELSA than a teacher. Until more is understood about the ages and stages at which children might develop a conscious awareness that their speech is different from other children, and/or, in what ways it is different, responsibility lies with clinicians to explore each child's perception of their own speech, to provide timely, age-appropriate explanations about speech assessment findings, and to encourage children to contribute to goal setting and activity selection. As therapy progresses, opportunities to reflect on their own output with their therapist would provide insights into any changes in the child's perception of their own output. Given that older children and adolescents may choose to conceal their social, emotional worries from their parents and that compliant children may show no evidence of distress while undergoing therapy, it has to be a clinician's responsibility to recognise when some aspect of therapy *might* be having a negative impact on a child's emotional well-being which, if recurrent, *might* remain unrecognised and unmanaged into adult life. Reducing the risks of maleficence, promoting beneficence and fostering autonomy might help to minimise the risk that therapy could provoke unexpressed feelings of unease, uncertainty or worry.

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Consent

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References

- Beauchamp, T. L. 2007. "Four Principles Approach to Biomedical ethics." In *Principles of Health Care Ethics*, edited by R. E. Ashcroft, A. Dawson, H. Draper and J. McMillan, 3–10. John Wiley and Sons.
- Beauchamp, T. L., and J. F. Childress. 1979, 2009. *Principles of Biomedical Ethics*. 6th ed. Oxford University Press.
- Bercow, J. 2018. Ten Years On—An Independent Review of Provision for Children and Young People With Speech, Language and Communication Needs in England Published by ICAN and RCSLT Available Online: <https://www.bercow10yearson.com/wp-content/uploads/2018/03/337644-ICANBercow-Report-WEB.pdf> Downloaded March 2022.
- Berko, J., and R. Brown. 1960. "Psycholinguistic Research Methods." In *Handbook of Research Methods in Child Development*, 517–557. Wiley.

- Body, R., and L. McAllister. 2009. "Practising Ethically." In *Ethics in Speech and Language Therapy*, edited by R. Body and L. McAllister, 15–19. Wiley ISBN 978-0-470-05888-6.
- Boey, R. A., P. H. Van de Heyning, F. L. Wuyts, L. Heylen, R. Stoop, and M. S. De Bodt. 2009. "Awareness and Reactions of Young Stuttering Children Aged 2–7 Years Old Towards Their Speech Disfluency." *Journal of Communication Disorders* 42, no. 5: 334–346.
- Bywater, T., and J. Sharples. 2012. "Effective Evidence-Based Interventions for Emotional Well-Being: Lessons for Policy and Practice." *Research Papers in Education* 27, no. 4: 389–408. <https://doi.org/10.1080/02671522.2012.690242>.
- Calladine, S., and M. Vance. 2019. "A Psycholinguistic Approach to Therapy With Very Young Children Born With Cleft palate." In *Case Studies in Cleft Palate Speech: Data Analysis and Principled Intervention*, edited by A. Harding-Bell, 329–360. J&R Press.
- Clark, C. E., E. G. Conture, C. B. Frankel, and T. A. Walden. 2012. "Communicative and Psychological Dimensions of the KiddyCAT." *Journal of Communication Disorders* 45, no. 3: 223–234. Web.
- Daniel, G., and S. McLeod. 2011. "Listening to Children's Experiences of Speech Impairment." In *Listening to Children and Young People With Speech, Language and Communication Needs*, edited by S. Roulstone and S. McLeod. J&R Press.
- D'Ausilio, A., L. Maffongelli, E. Bartoli, et al. 2014. "Listening to Speech Recruits Specific Tongue Motor Synergies as Revealed by Transcranial Magnetic Stimulation and Tissue-Doppler Ultrasound Imaging." *Philosophical Transactions of the Royal Society B: Biological Sciences* 369, no. 1644: 20130418.
- Denham, S. A. 2007. "Dealing With Feelings: How Children Negotiate the Worlds of Emotions and Social Relationships." *Cognition, Brain, Behavior* 11, no. 1: 1–48.
- Dolton, A., S. Adams, and M. O'Reilly. 2020. "In the Child's Voice: The Experiences of Primary School Children With Social, Emotional and Mental Health Difficulties." *Clinical Child Psychology and Psychiatry* 25, no. 2: 419–434.
- Eadie, T. L., and L. C. Charland. 2005. "Ethics in Speech-Language Pathology: Beyond the Codes and Canons." *Journal of Speech-Language Pathology and Audiology* 29, no. 1: 29–36.
- Ferguson, A. 2009. "The Discourse of Speech-Language Pathology." *International Journal of Speech-Language Pathology* 11: 104–112.
- Gross, J. T., and J. Cassidy. 2019. "Expressive Suppression of Negative Emotions in Children and Adolescents: Theory, Data, and a Guide for Future Research." *Developmental psychology* 55, no. 9: 1938–1950.
- Hand, L. 2009. "Paediatric Speech and Language Disorders." In *Ethics in Speech and Language Therapy*, edited by L. McAllister, C. Pickstone and R. Body. Wiley.
- Harding, A., and A. Bryan. 2000. Multi-Sensory Input Modelling Video, available from CleftNetEast Office, Cambridge University Hospitals NHS Trust, Addenbrookes Hospital, Hills Road, Cambridge CB2 0QQ.
- Harding-Bell, A. 2019. "Video Clips in Harding-Bell. A." In *Case Studies in Cleft Palate Speech: Data Analysis and Principled Intervention*, 437–459. J&R Press.
- Hari, R., M. Bourguignon, H. Piitulainen, E. Smeds, X. De Tiège, and V. Jousmäki. 2014. "Human Primary Motor Cortex is Both Activated and Stabilized During Observation of Other Person's Phasic Motor Actions." *Philosophical Transactions of the Royal Society B: Biological Sciences* 369, no. 1644: 20130171.
- Harter, S. 2012. "Developmental Differences in Self-Representations During Childhood." In *The Construction of the Self: Developmental and Sociocultural Foundations*, P27–59. 2nd ed. Guilford Press.
- Hay, D. F. 2019. "Shame and Guilt." In *Emotional Development From Infancy to Adolescence: Pathways to Emotional Competence and Emotional Problems*. Routledge.
- Holliday, E. L., L. J. Harrison, and S. McLeod. 2009. "Listening to Children With Communication Impairment Talking Through Their Drawings."

- Journal of Early Childhood Research: ECR* 7, no. 3: 244–263. <https://doi.org/10.1177/1476718x09336969>.
- Illingworth, C., A. Jeremy, and A. Harding-Bell. 2019. “A Psychological Approach to Cleft-Related Speech Difficulties in Adolescence and Adulthood.” In *Case Studies in Cleft Palate Speech: Data Analysis and Principled Intervention*, edited by A. Harding-Bell, 437–459. J&R Press.
- Irwin, D., M. Pannbacker, T. W. Powell, and G. T. Vekovius. 2007. *Ethics for Speech-Language Pathologists and Audiologists: An Illustrative Casebook*, 4. Thomson Delmar Learning.
- Kitson, A., A. Marshall, K. Bassett, and K. Zeitz. 2013. “What are the Core Elements of Patient-Centred Care? A Narrative Review and Synthesis of the Literature From Health Policy, Medicine and Nursing.” *Journal of Advanced Nursing* 69, no. 1: 4–15.
- Köster, M., M. Langeloh, C. Kliesch, P. Kanngiesser, and S. Hoehl. 2020. “Motor Cortex Activity During Action Observation Predicts Subsequent Action Imitation in Human Infants.” *Neuroimage* 218: 116958. Available at: <https://doi.org/10.1016/j.neuroimage.2020.116958>.
- Kuhl, P. K., and A. N. Meltzoff. 1996. “Infant Vocalizations in Response to Speech: Vocal Imitation and Developmental Change.” *The Journal of the Acoustical Society of America* 100, no. 4: 2425–2438.
- Leighton, M. K. 2015. ELSA: Accounts From Emotional Literacy Support Assistants. DEdPsy Thesis. University of Sheffield. <http://etheses.whiterose.ac.uk/12444/>.
- Lewis, K. M., P. Barrett, G. Freitag, and T. H. Ollendick. 2023. “An Ounce of Prevention: Building Resilience and Targeting Anxiety in Young Children.” *Clinical Child Psychology and Psychiatry* 28, no. 2: 795–809.
- Lindsay, G., J. Dockrell, B. Letchford, and C. Mackie. 2002. “Self Esteem of Children With Specific Speech and Language Difficulties.” *Child Language Teaching and Therapy* 18, no. 2: 125–143.
- Mayr, T., and M. Ulich. 2009. “Social-Emotional Well-Being and Resilience of Children in Early Childhood Settings—PERIK: An Empirically Based Observation Scale for Practitioners.” *Early Years* 29, no. 1: 45–57. <https://doi.org/10.1080/09575140802636290>.
- McCormack, J., E. Baker, and K. Crowe. 2018. “The Human Right to Communicate and Our Need to Listen: Learning From People With a History of Childhood Communication Disorder.” *International Journal of Speech Language Pathology* 20, no. 1: 142–151. <https://doi.org/10.1080/17549507.2018.1397747>.
- McCormack, J., L. McAllister, S. McLeod, and L. Harrison. 2012. “Knowing, Having, Doing: The Battles of Childhood Speech Impairment.” *Child Language Teaching and Therapy* 28, no. 2: 141–157.
- McCormack, J., S. McLeod, and K. Crowe. 2019. “What Do Children With Speech Sound Disorders Think About Their Talking?” *Seminars in Speech and Language* 40, no. 02: 094–104. <https://doi.org/10.1055/s-0039-1677760>.
- McCormack, J., S. McLeod, L. McAllister, and L. Harrison. 2010. “My Speech Problem, Your Listening Problem, and My Frustration: The Experience of Living With Childhood Speech Impairment.” *Language, Speech and Hearing Services in Schools (Online)* 41, no. 4: 379–392A.
- McEwen, S. 2019. “The Emotional Literacy Support Assistant (ELSA) Programme: ELSA’s and Children’s Experiences.” *Educational Psychology in Practice* 35, no. 3: 289–306. <https://doi.org/10.1080/02667363.2019.1585332>.
- McLeod, S. 2004. “Speech Pathologists’ Application of the ICF to Children With Speech Impairment.” *Advances in Speech Language Pathology* 6, no. 1: 75–81. <https://doi.org/10.1080/14417040410001669516>.
- McLeod, S. 2011. “Listening to Children and Young People With Communication Needs: Who, When and Why.” In *Listening to Children and Young People With Speech Language and Communication Needs*, edited by S. Roulstone and S. McLeod. J & R Press.
- McLeod, S. 2022. Speech Participation and Activity Assessment of Children (SPAA-C) Questions SPAA-C Licensed Under a Creative Commons Attribution-NonCommercial-NoDerivs3.0UnportedLicense. Downloaded from <http://www.csu.edu.au/research/multilingual-speech/spaa-c> June 2022.
- McLeod, S. 2025. Speech Participation and Activity Assessment of Children (SPAA-C) Questions SPAA-C. Downloaded from <https://www.csu.edu.au/research/multilingual-speech/speech-assessments/spaa-c>. <http://www.tandfonline.com/doi/abs/10.1080/14417040410001669516>. in 8 languages.
- McWilliams, D., M. Thornton, M. Hotton, M. C. Swan, and N. Marie Stock. 2024. “It’s on Your Shoulders Now” Transitioning From Child-to-Adult UK Cleft Lip/Palate Services: An Exploration of Young Adults’ Narratives.” *The Cleft Palate Craniofacial Journal* 0, no. 0: 0. <https://doi.org/10.1177/10556656241236006>.
- Merrick, R., and S. Roulstone. 2011. “Children’s Views of Communication and Speech-Language Pathology.” *International Journal of Speech-Language Pathology* 13, no. 4: 281–290. <https://doi.org/10.3109/17549507.2011.577809>.
- NICE Guidelines. 2022. <https://www.nice.org.uk/guidance/ph40> Social, Emotional and Mental Wellbeing in Primary and Secondary Education Published: 6 July 2022. www.nice.org.uk/guidance/ng223 Nice guideline [NG223] Published: 06 July 2022: 34.
- Owen, R., L. Hayett, and S. Roulstone. 2004. “Children’s Views of Speech and Language Therapy in School: Consulting Children With Communication Difficulties.” *Child Language Teaching and Therapy* 20, no. 1: 55–73.
- Phillips, S. P., J. L. M. Phillips, and S. Wang. 2019. “Assessing Wellness in the Well-Child Check. What About Social and Emotional Development?” *Canadian Family Physician* 65, no. 6: 388–388.
- Rees, C. 2010. “Promoting Children’s Emotional Wellbeing.” *Paediatrics and Child Health* 20, no. 9: 439–446. <https://doi.org/10.1016/j.paed.2010.07.001>. <https://www.sciencedirect.com/science/article/pii/S1751722210001356>. ISSN 1751–7222.
- Rees, C. 2012. “Iatrogenic Psychological Harm.” *Archives of Disease in Childhood* 97, no. 5: 440–446.
- Rizzolatti, G., and L. Craighero. 2004. “The Mirror-Neuron System.” *Annual Review of Neuroscience* 27: 169–192.
- Roulstone, S. 2015. “Exploring the Relationship Between Client Perspectives, Clinical Expertise and Research Evidence.” *International Journal of Speech Language Pathology* 17, no. 3: 211–221. Available at: <https://doi.org/10.3109/17549507.2015.1016112>.
- Roulstone, S. E., J. E. Marshall, G. G. Powell, et al. 2015. “Evidence-Based Intervention for Preschool Children With Primary Speech and Language Impairments: Child Talk—An Exploratory Mixed-Methods Study.” *Programme Grants for Applied Research* 3, no. 5: 1–408.
- Seedhouse, D. 1998. *Ethics: The heart of healthcare* (2nd Edition), Chichester, Wiley p.47.
- Speake, J., and A. Harding-Bell. 2019. “Principles of Intervention.” In *Case Studies in Cleft Palate Speech: Data Analysis and Principled Intervention*, edited by A. Harding-Bell, 361–406. J&R Press.
- Spratling, R., N. Cavanaugh, A. D. Derouin, M. D. Dirks, and L. Searcy. 2019. “Building Resilience in Childhood and Adolescence.” *Journal of Pediatric Health Care* 33, no. 5: A11–A13.
- Underwood, I., and M. Fromberg. 2018. SPAR-QL (Speech and Resonance Quality of Life Measure, West Midlands Centre for Cleft Lip and Palate Service, Birmingham Children’s Hospital) Steelhouse Lane.
- Vanryckeghem, M., and G. J. Brutten. 2007. *Communication Attitude Test for Preschool and Kindergarten Children Who Stutter*, KiddyCAT Plural Publishing.
- Weiss, A. L. 2004. “The Child as Agent for Change in Therapy for Phonological Disorders.” *Child Language Teaching and Therapy* 20, no. 3: 221–244. <https://doi-org.sheffield.idm.oclc.org/10.1191/0265659004ct273oa>.
- Wong, B., D. Cripps, H. White, et al. 2020. “Primary School Children’s Perspectives and Experiences of Emotional Literacy Support Assistant (ELSA) Support.” *Educational Psychology in Practice* 36, no. 3: 313–327. <https://doi.org/10.1080/02667363.2020.1781064>.