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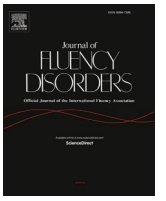

A discussion of topics related to teaching a graduate stuttering course

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ABSTRACT

Purpose: To discuss instruction of graduate stuttering courses with a particular focus on contemporary issues such as the pseudostuttering, counting stuttering, and engaging with materials within the classroom and in clinical practice.
Methods: At a panel discussion at the World Stuttering and Cluttering Organization Congress in May 2024, attendees submitted their questions to a panel of experts in stuttering pedagogy. To document and continue the discussion, each expert responded in turn to the most frequently asked questions.
Results: While the included experts frame key learning activities differently within their respective courses, each takes care to center lived experiences of people who stutter and contextualize learning activities within their clinical purposes.
Conclusions: The pedagogical insights shared in this discussion offer guidance to instructors of stuttering courses to equip students with tools to assess, treat, and counsel their clients who stutter from a humanistic approach.

Graduate level Stuttering/Fluency Disorders courses are the foundation of emerging clinicians' knowledge about this topic. Their instructors must be equipped to provide learning experiences that encapsulate the nuances of stuttering/cluttering. Clinical services for clients who stutter/clutter need to be multidimensional and sensitive to their cognitive, emotional, social, and behavioral needs and desires (e.g., Brundage et al., 2021; Connery et al., 2022; Rodgers et al., 2022). There has also been a palpable shift in the values of the stuttering community, with social models of disability and stutter-affirming practices now in the spotlight (Constantino et al., 2022; Constantino, 2023; Gerlach-Houck & Constantino, 2022; Reeves et al., 2023; Sisskin, 2023). Unfortunately, there is very limited published guidance for effective instruction of Stuttering/Fluency Disorders courses that reflect these updated views. There have been two reports on the effectiveness of simulation-based learning activities for stuttering (Byrd et al., 2022; Penman et al., 2021), and some recent published discussions about the ethics and utility of pseudostuttering activities (Bortz, 2024; Gore & Tichenor, 2024; Tichenor et al., 2024). A recent paper by Connery and Shé (2024) outlined a helpful approach for designing a course that prioritizes the multidimensional nature of stuttering/cluttering. However, their guidance would be strengthened by including discussion about how certain disability models inform how stuttering is understood and taught, as well as consultation with other expert instructors in the

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field. Coupled with limited exposure to stuttering in graduate programs (Santus et al., 2019; Yaruss et al., 2017), the dearth of pedagogical guidelines can have detrimental effects not just on the educational experiences of student clinicians, but on how those student clinicians subsequently provide services to clients who stutter/clutter.

The limited published guidance available for instructors of Stuttering/Fluency Disorders courses motivated our two-part panel discussion at the World Stuttering and Cluttering Organization Congress in May 2024. In part one, Drs. Shelley Brundage, Christopher Constantino, Derek Daniels, and Naomi Rodgers presented information about their objectives for their courses and approaches to teaching. In part two, they fielded questions from the audience about issues surrounding implementation. These questions were submitted through a virtual platform called *Slido*, where attendees could also "upvote" questions they wanted discussed. These four tenure-track faculty are known for their person-centered research and clinical specialization in stuttering, and are dedicated to excellence in graduate education. Together, they have a cumulative 63 years of teaching experience. Chris, Derek, and Naomi bring their lived experiences as people who stutter, and Shelley has been awarded numerous honors for her collegiate teaching. For both seminars, Julia Kerrigan, a clinical master's student in speech-language pathology and prospective PhD student with special interest in stuttering, moderated and provided a students' perspective on teaching practices. In personal conversations with attendees following these seminars, it became apparent that those new to teaching and seasoned instructors alike benefitted from experts addressing these key questions. As such, we decided it would be helpful to document our responses to the primary questions that we discussed in the second seminar, which we present in the following written discussion. As the original panel discussion was not recorded, the text of this paper was newly generated after the conference as the authors recalled and summarized what they shared in person. The order of responding was pre-assigned to ensure equitable representation among experts.

The four experts in this paper—Shelley, Chris, Derek, and Naomi[1]—all teach dedicated stuttering courses at their respective universities. Chris teaches a 3 semester hour course (once a week for 2.75 h each, totaling 41.25 h of instruction), Shelley and Derek teach a 3 semester hour course (once a week for 2.50 h each, totaling 37.50 h of instruction), and Naomi teaches a 2 semester hour course (once a week for 1.67 h each, totaling 25.05 h of instruction). All four experts roughly structure their courses by the following content areas: foundations, assessments, and therapy, although they spend different amounts of time on each area. Each instructor covers other fluency conditions (e.g., acquired stuttering, cluttering, atypical disfluencies) at different points of their course—some as part of differential diagnosis in the assessment unit, others as a standalone topic at the end of the semester.

KERRIGAN: A hot button issue in our field is pseudostuttering assignments, with some students raising concerns about potential ableism with the assignment. In fact, there are several papers just recently published that explore the ethics of these assignments (Bortz, 2024; Gore & Tichenor, 2024; Tichenor et al., 2024). Chris, how do you frame and structure this classic assignment in your course, and what is your rationale for doing it that way?

CHRIS: Perhaps most importantly, I do not have them do a lone experiential assignment involving pseudostuttering. Rather, I design the whole course around experiential learning. Research on simulation experiences suggest they should be frequent and guided by someone with the lived experience you are simulating. My assignments are weekly and guided by a stutterer (me).

The experiences of stuttering are multifaceted, and I do the best I can to give the students a taste of these varied experiences. This starts right away. Their homework for the first week of class is to record themselves trying to match the stuttering of an actual person who stutters. The next week they simulate the loss of control of stuttering by letting a partner control their types of stutters, how long they last, and when they occur. The week after, they do this same loss of control activity on a phone call. They also practice passing as fluent. I have them carry around a fruit of their choice (this could vary from a blueberry to a watermelon), and they have to try to pass as fruitless by hiding and not mentioning the fruit. Next, they cannot use words that start with the first letter of their names to simulate word switching and avoidance. To practice disclosure, I have them share a vulnerable fact about themselves with others in their lives, bonus points for sharing with strangers. They do three assignments where they go out and talk to strangers in novel ways. The first is the classic pseudostuttering assignment. The second involves using Van Riperian stuttering modification strategies with strangers. The third involves using fluency shaping with strangers; this is always their least favorite. To get a feel for avoidance reduction they try to change ingrained habits for a week.

As you can see, some of these assignments involve simulation but many do not. Even in the assignments that do involve simulation, much of what the students report and reflect on are real, not simulated, experiences. The students have real emotions; they experience real anticipation, real fear, real anxiety, real frustration. Stutterers' emotions are not different from those of fluent speakers. Fluent speakers cannot know what it is like to stutter but they can know what it is like to anticipate disfluency and judgment for how they talk. The anxiety stutterers feel is the same as the anxiety fluent speakers feel. This is what I want my students to appreciate. Furthermore, to understand our clients' conditioned responses to the feeling of stuttering, it is important for students to learn how they respond to the simulated threat of stuttering. They often show similar behaviors: censoring their speech, averting their eyes, avoiding, changing their cadence, escaping from disfluencies. This will help them design therapy. Lastly, in therapy we will be walking with our clients. We will be going out and stuttering with them. If students do not practice this, they will not be able to be in solidarity with their clients when they need to be.

DEREK: I agree with Chris. The assignment needs to be carefully framed and guided by someone with lived experience, or also someone who is engaged with the community of people who stutter. I have my students do a pseudostuttering assignment. I have to admit that it has been the traditional one-time assignment in three different situations—two in-person experiences and one on the phone. However, I don't think this is enough, so in future assignments, I will have them do more. I always make sure I let students know

[1] We have chosen to use our first names to reflect the conversational tone of our panel discussion.

that this is not an assignment for understanding the experience of stuttering. It is an assignment where they are learning a strategy that they will teach and model in therapy. I incorporate videos where people who stutter give first-person accounts of their experiences, as a way for students to gain empathy and understanding. Chris, I also like the different types of assignments you offer to students (they are now on my list, if you approve!). I believe students need as much experiential learning as possible.

NAOMI: Like Derek, I've been doing the traditional one-time assignment where students do three pseudostuttering interactions with unfamiliar listeners, introduced in a similar way that Derek does. I expressly state that it is *not* intended to be a disability simulation. The students then do these three interactions alongside an accountability partner from class. More often than not, the assignment backfires; students' written reflections show that the experience did little more than increase their sympathy (not empathy) for people who stutter. This corroborates what Brown (2019) found in his preliminary study in which students completed portions of the Self-Stigma of Stuttering Scale (Boyle, 2013) before and after pseudostuttering with three novel listeners. His results suggest that this assignment, when completed in this traditional way, actually *increases* students' stigma toward stuttering. I'm inspired by Chris and other proponents in this space like Katie Gore, Dr. Seth Tichenor, and Dr. Scott Yaruss who are advocating for *more* experiential pseudostuttering for students, not less. I plan on integrating a lot of Chris' ideas that he outlined above into my course this upcoming semester (with his blessing!) to create a more well-rounded and meaningful experience for my students and, in turn, their future clients.

SHELLEY: In reflecting on Chris, Derek, and Naomi's responses, a few thoughts occurred to me. First, the description of these experiential assignments is critical; students need to know the *purpose* of the assignment, the *tasks expected* of them, and what might constitute *successful completion* of the assignment. The experiential nature of this type of assignment is also critical to student learning; you can't get this experience sitting in an armchair listening to someone talk about it. There is real potential to make things worse, as Naomi noted, so instructors need to be aware and expect to deal with questions about ableism and disability simulation. Second, as Chris noted, these experiences lead to real emotions. Here again, instructors need to be ready to manage and discuss these emotions during in-class discussions. Third, I wondered if a fluency-privileged professor such as myself could or should require such an assignment. I think the answer is "yes" as long as I am open to asking my stuttering colleagues and friends for advice, feedback, and suggestions for improving the assignment. In a very real sense, this assignment pushes me out of my comfort zone almost as much as it does to my students. But, learning to listen to others, especially those who stutter, and engage in shared decision-making for how to learn to work with them in clinical sessions, especially when we are uncomfortable in how our fluency advantages us in society, is a skill that I and every fluent SLP student I teach must embrace. As Derek mentioned, pseudostuttering will be a part of their job and will be a necessary skill to develop to support their clients. Stutterers' perceptions of ableism regarding stuttering matter more than my own perceptions or those of my fluent students. Nevertheless, there are things I can do to clarify the assignment. Like Naomi, I make it clear that the assignment is not a disability simulation, that one of the main purposes is to practice common treatment techniques, and to desensitize themselves to using these techniques. Folks who stutter who talk to my class tell students that the assignment is crucial to students' understanding of stuttering. Even with this clarity and confirmation, student reflection papers still often mention their unease with "mimicking stuttering" and being embarrassed about doing so. At that point, although I cannot rely on my own lived experiences to validate what they are feeling and doing, I can rely on my knowledge about stuttering to respond to their concerns.

KERRIGAN: All of you teach students how to do the Stuttering Severity Index (SSI; Riley, 2009) in your courses. Naomi, why do you use the SSI in your course?

NAOMI: Using videos from FluencyBank (Bernstein Ratner & MacWhinney, 2018), I use an "I do, we do, you do" approach to teaching the SSI. First, I show students a video and share how I quantified and qualified the disfluencies within it. Then, we watch a video in class while students mark-up disfluencies on an associated transcript. Finally, I assign each student a video to assess for homework (graded for completion, not "accuracy" which is arguably impossible to assess). Primarily, I teach students how to do the SSI because it provides a structured way for students to develop skills to observe stuttering patterns. This is important not because overt severity as a metric is in and of itself important, but rather because stuttering patterns can include struggle and avoidance behaviors that contribute to negative life impact, which can be unlearned in therapy if the client wants to. Thus, when I guide students in doing the SSI, we seek to understand and describe the idiosyncratic and nuanced communication pattern that a given stutterer demonstrates. Second, it provides students with firsthand experience with reliability issues of the SSI. When multiple students assess the same video and end up with different values, and when students re-watch their assigned video and notice different things with repeated viewings, we are able to have more in-depth discussions about the unreliability of stuttering severity metrics. Third, the SSI is still a commonly used assessment in our field, so there will be times when clinicians see previous SSI results in a client's records and/or they are asked to provide SSI results to determine a client's service eligibility. In that case, I hope my students feel equipped to contest the need for the SSI, or at the very least, know how to provide additional meaningful data that provide a more holistic view of the client and their communication needs.

SHELLEY: I agree with you, Naomi. It seems to me that this type of assignment is kind of a means to many ends. Sure, practice counting stuttering so you can see how challenging (and ultimately futile) it is. But there are additional things to be learned from this type of assignment, as you note. I have a similar assignment. The students listen to a video, count stuttering and typical disfluencies, and then write the "assessment" section of a SOAP note based on the video. This leads to discussions about listening to what the person is saying and not just how they say it, as well as what is missed if all we do is count blocks, prolongations, and part-word repetitions. As part of my assignment, I have students reflect on the pros and cons of identifying and counting specific types of stuttering moments. I ask them to develop two arguments for and two arguments against doing so and to provide rationales for each. This part of the assignment forms the groundwork for an in-class discussion about counting.

CHRIS: I agree with Naomi and Shelley. I would just add that in addition to using the SSI, I ask my students to describe the client's stuttering in such detail that a layperson (e.g., their grandparent) could produce their client's stuttering simply from reading the

description. The students quickly realize how much the SSI does not capture. They also realize what information usefully contributes to treatment design.

DEREK: I agree with everything that's been said here. I teach the SSI for all the reasons stated above, though I recognize all of its limitations. I also have my students identify and count disfluencies from in-class videos and from FluencyBank. What I will add here is that when I assign a transcript from FluencyBank, I also assign a corresponding OASES for the students to score. This allows them to compare the client's stuttering severity score to their OASES score and understand that a high SSI score doesn't always mean negative life impact, nor does a low SSI score always mean little life impact. Also, when I show videos from past clients, I make sure I show videos of clients who would potentially score low on the SSI but are talking about negative life impact, and vice versa. This way, students understand that if you administer the SSI, and it's your primary measure—and I emphasize that it should not be your primary measure, or a measure at all—you are still missing critical information.

KERRIGAN: For our next question, Derek, how do you support students in applying course concepts to clinical experiences?

DEREK: This is such an important experience, as many times students have difficulty translating course concepts to clinical practice. I also supervise students with clients who stutter in our university clinic, and this helps me understand where gaps exist in applying course concepts to therapy. I use a lot of case studies in my course. These come from my supervision experiences, but also from information platforms, such as the current and archived "Ask the Professional/Expert" sections of International Stuttering Awareness Day online conferences (www.isad.live) and social media platforms where clinicians are asking questions about clients. For instructors who do not supervise, these platforms can be rich sources of information for case studies. I take the content of the question (being careful to preserve anonymity if necessary) and create a case study around it. I inform students that these are real questions from parents, clinicians, or people who stutter. We talk through some case studies as a whole class, and some case studies in smaller groups. For each case study, I ask three questions: 1) does anything about this case concern you; 2) what information do you need to find out; and 3) how would you respond to a message like this. For the first question (does anything about this case concern you), I am looking to see if students identify something of concern, or something that needs to be further investigated. We talk about not only what is being asked, but what may be beneath that. So, for example, if a person asks, "do you think my speech will get better," there's a lot to unpack here. For example, what does the client mean by "better?" Are there underlying feelings of self-doubt? If a parent says they saw no improvement in previous therapy, what is meant by "improvement?" For the second question (what information do you need to find out), I want to encourage students to be critical thinkers. I want them to learn to ask good questions to get to the core of the concern. If this is a preschool or school-age child, for example, do we need a language evaluation or do we need to learn more about family or classroom dynamics to appropriately address the concern? And for the last question (how would you respond), the idea is what can you say in the moment. This can also open the door for potential counseling.

Lastly, based on my supervision experiences, I've learned that it's important to discuss topics such as goal writing, report writing, SOAP notes, and effective and less effective therapy sessions. I make sure to reserve time to talk about these clinical aspects. I could say more, but this is the gist of how I do it.

CHRIS: Like Derek, I supervise in our university clinic. I am able to give hands-on, in-depth guidance to students working with clients who stutter. That said, not all instructors supervise and not all students receive supervision with a stuttering client. It is, therefore, important for the stuttering class, in isolation, to help students apply course concepts to their clinical experiences. I do this in two primary ways: content and assignments. Regarding content, ten of the fifteen weeks I have with my students address therapy topics directly, eight on treatment and two on assessment. We spend a lot of time talking about therapy. We also watch the classic "Adult Stuttering Therapy" videos (Stuttering Foundation of America, 2005), a collection of seven weekly sessions and two follow-ups within the year in which Van Riper guides Jeff, an adult who stutters, through the phases of stuttering modification therapy. These videos expose my students to the therapy process from diagnosis through to follow up. Regarding assignments, I have my students do two projects over the course. For the first project, they take a real person who stutters from FluencyBank and assess their stuttering. For the second assignment, they design an individualized treatment plan for the person they assessed. Therefore, I am confident my students know how to assess stuttering and have a general plan to guide stuttering treatment.

NAOMI: I don't supervise much in our university clinic, so I'm a bit removed from directly supporting students to apply course concepts to their work with clients who stutter. Like Chris, I have them do a case study project over the course of the semester with an assigned "client" from FluencyBank—including background case history, assessment results, and therapy plan. Additionally, students do weekly application activities designed to help them think clinically about the topics we cover in class. Here are a few examples: (1) When we cover theories and etiology, students write a verbatim response to hypothetical questions from clients (e.g., a parent asks you "Experts don't really know what causes stuttering, do they?", an adult who stutters says, "I'm worried I'm going to pass stuttering onto my kids"). (2) When we cover preschool assessment, students read through several case histories of young children who have started stuttering and highlight the indicators of likely stuttering persistence and unassisted recovery. (3) When we cover school-age stuttering therapy, students create a 1-hour lesson plan for a group of children who stutter. For the last assignment of the semester, students compile a "stuttering resource guide" for themselves including video demonstrations of themselves producing stuttering-like disfluencies and stuttering modification techniques, a variety of assessments for each age group (preschool, school-age, teen, adult), a letter to a hypothetical client describing their philosophy to stuttering therapy, therapist resources to facilitate the therapeutic process (e.g., workbooks, peer-reviewed articles, reputable websites and social media accounts), client resources for education and support (e.g., autobiographies, podcasts, stuttering support communities), and where they can go for continuing education in the area of stuttering/cluttering. For each resource, they need to describe the resource, rationale for why it's reputable and valuable, and how to access it. Students consistently report that they are so glad to have this go-to resource guide for when they start working with clients who stutter.

KERRIGAN: Getting students to read assigned readings can be challenging. Shelley, what are some ways that you motivate students

to read?

SHELLEY: At midterm a few years ago, students were grumbling about having to read for class, as it took "so much time;" they were spending approximately 5 h reading a 10-page article. I learned that they were taking notes on literally every page, highlighting most of the article because everything seemed important, and reading linearly, from the beginning to the end of the article. No wonder it was taking so long!

I was lamenting this issue with my colleague Cynthia Core and she mentioned that she highlighted the important parts of research articles so that students could go right to the "wheat" without having to grind through the "chaff." I started doing this in my class, adding my own twist. I annotate each of the articles that students read. These annotations serve four purposes (maybe five). First, I use them to highlight important arguments or findings in the current paper (just like Cynthia). Second, I annotate information that relates back to topics already discussed in class, to help students see linkages between topics and ideas. Third, I annotate to foreshadow upcoming topics that relate to the current article. Fourth, annotations may be used to pose thought questions (e.g., Socratic-type questions, or specific questions such as asking how the information might be used when talking to parents of stuttering children). Finally, sometimes I annotate because something in the article catches my attention and I want to highlight the information for students.

The idea is that students come to class having read the article (or at least the annotations and highlighted parts) and are ready for the small group discussions that occur after a brief reading quiz. These low-stakes quizzes are meant to ensure that students read the articles, but I believe Naomi may have a better way of addressing this.

NAOMI: I assign one reading per week, and curate my reading list to represent varied voices in the stuttering field. To ensure students read and to maximize their engagement with reading, I use a social reading platform called *Perusall* (www.perusall.com). I upload readings as PDFs and within small groups, students highlight and annotate the readings with questions and comments. They can reply to and "like" their peers' posts that resonate with them. Perusall autogrades students' engagement, and instructors can dictate how scores are weighted (e.g., how long they spent reading, if they made it to the end of the reading, the quality and quantity of their comments). Once all students have finished engaging with a reading, I export a report from Perusall that synthesizes students' questions and comments that I then use to facilitate our in-class discussion. Overall, I have found that Perusall increases students' reading engagement, reduces my workload, and enriches our classroom discussions. Perusall is free to use; instructors can check with their institutions to see if they have an institutional license that integrates Perusall with their learning management system (LMS) so that grades get automatically transferred from Perusall to the LMS gradebook.

DEREK: Good ideas, Shelley and Naomi! Every week, I have required readings (usually one required article; two at most) and recommended readings. Like Naomi, I make sure the readings are diverse with respect to content and voice. I know time is stretched thin, given other courses and clinics students are taking. There are many good articles out there, so I try to choose readings that reinforce the gist of my lectures, but also ones that have good clinical application if possible. In addition to the textbook, I want students to have readings they can go back to that support their clinical approaches. My hope is that students read the articles before class, but I know this doesn't always happen. How do I get students to read? I include information from the articles on my exams. I give my students a review sheet prior to each exam. It lists specific questions that I expect them to glean from the lectures, textbook chapters, and articles.

CHRIS: I assign a relatively large number of readings. I want my students to read primary sources, especially canonical texts and innovative research. I also take a relatively hands off approach to making sure they read. They are adults and are primarily responsible for their own learning. Life is always about juggling priorities; we cannot optimize every area of our lives. If students do not have time to read, then they should not read. Sometimes more important priorities require our attention. But they should recognize that not reading means less learning.

I have a few classroom mechanisms that incentivize reading. At the start of class, my students break out into small groups to discuss the readings. Having not read makes it difficult to participate in the discussion. Additionally, I have the students peer review each other's contribution to the discussion using a simple rubric. In order to earn a good participation grade, they must meaningfully contribute to the discussion, which is easier if they have read. After the small group discussions, we have a large group discussion. I give them a participation grade in the large group discussion. Again, it is easier to earn points if the student has read.

KERRIGAN: To close us out, let's look to the future of stuttering pedagogy. Our knowledge of stuttering and how it is taught in the classroom has changed over the past few decades. What are your best hopes for how stuttering courses are taught moving forward?

SHELLEY: Stuttering is unique, in that many people have never met someone who stutters and yet they are confident that they know what stuttering is. Stuttering is also unique in that clinicians often report negative reactions toward persons who stutter. I think this is one of the saddest findings in the literature on stuttering. Teaching is an opportunity to provide accurate information, debunk myths, and explore and reduce biases, with the goal of developing future clinicians who are engaged and excited about working with people who stutter.

I hope that the lived experience of stuttering remains a central focus in the classroom and beyond it. Stutterers are the experts on their stuttering, and therefore the outcomes desired by them should steer our treatment (and therefore what we teach in class). Students need to learn how to "do therapy" when the client is in the driver's seat; thus, learning how to establish and maintain a strong therapeutic alliance is critical. Students need to understand the stigma, discrimination, and negative reactions that their clients encounter due to their stuttering—and then think critically and creatively about what they as clinicians can do to advocate and help. Students need to understand that anticipation, avoidance, concealment, and negative attitudes toward communication are natural reactions to the stigma and biases encountered by persons who stutter. We need to move away from seeing stuttering as something that needs "fixing" and toward teaching methods for increasing acceptance, resilience, affirmation, and wellbeing.

CHRIS: Stuttering pedagogy is trending in the right direction. People who stutter teach many stuttering courses themselves. Fluent

instructors frequently ally with the stuttering community. Consequently, instructors are taking seriously the lived experience of stuttering, with all of its nuances, joys, and pains, rather than reducing it to simply the presence or absence of disfluency.

Stuttering courses must demystify stuttering for new clinicians, turning an abstract, difficult to understand experience into a concrete, intelligible one. To do this, stuttering courses must focus on treatment. We only have so much time with our students. Theoretical discussions of etiology, neuroanatomy and neurophysiology, and genetics should be touched on but not lingered over. Speech-language pathologists are in the business of therapy and that is what stutterers expect from us. It is our responsibility to the stuttering community to know how to help them make stuttering easier and more enjoyable. Classes must stay focused on therapy.

As stutterers from around the world find it easier to connect with each other, a burgeoning stuttering culture is blooming. This culture includes visual art, music, literature, and critical analysis. Stuttering is moving beyond the clinical realm to include the social and cultural realms of life. It is my hope that stuttering courses will include these meaningful and enriching features of the stuttered experience, engaging not just with stuttering as fluency lost but also with stuttering as culture gained. This will require an intersectional approach, as people with myriad lived experiences contribute to this vibrant stuttering culture.

DEREK: One of my best hopes is that every graduate student has a stand-alone course in stuttering – two courses if necessary. When you think about the foundational aspects of childhood-onset stuttering, evaluation and therapy practices, diverse lived experiences, and multicultural, bi/multilingual, and lifespan dimensions, you already have much content to cover. When you factor in cluttering, acquired stuttering, and stuttering as it co-exists with other conditions, you can see how one stand-alone course might not be enough to cover everything. If we want students to be prepared to address the diverse needs of people who stutter, it's important to make sure that we allot the necessary time. I know that graduate curricula are already full and adding another course might not be feasible. I get it. But the hope is that, in whatever way possible, we can prepare students to feel confident working with people who stutter.

Another hope is that we provide students with as much experiential learning as possible. My experience has taught me that students learn best when they can make discoveries. Case-based scenarios are very beneficial for student learning. I also hope that instructors (particularly those who are not specialists in stuttering) have access to resources for making their courses practical. And finally, my best hope is that our courses continue to evolve. I have taught graduate courses in stuttering since 2008. My course is never the same every year. My lectures and readings change to reflect the current evidence, and my assignments change when necessary. As research and clinical practice evolves, and as we continue to listen to the stories of people who stutter, our courses also need to evolve. I appreciate the opportunity to be a part of this discussion!

NAOMI: My best hopes are that instructors (a) align their teaching priorities, practices, and dialogue with contemporary research and values of the stuttering community, and (b) integrate innovative methods for enhancing students' enthusiasm and ability to comprehensively support people who stutter.

Empirical and anecdotal evidence is mounting that traditional fluency-focused interventions for people who stutter are not just unreliable and unsustainable, but may do more harm than good. It's critical that instructors who teach Stuttering/Fluency Disorders understand the lived experiences of stuttering and stutter-affirming practices. This allows them to guide student clinicians to develop a client-centered clinical ethos. To help in this effort, I hope that instructors explore innovative teaching practices to genuinely engage students in thinking critically about stuttering experiences and what holistically supports this population. For example, instructors can facilitate interprofessional training sessions with students from counseling, psychology, and/or education programs to co-explore holistic practices that support stutterers' social-emotional well-being.

Thanks to technological advances, there are lots of other opportunities to engage Gen Z students. For instance, students can spend time with recorded firsthand accounts (e.g., podcasts, documentaries, vlogs) that expose them to different types of stuttering patterns while listening to stutterers' stories. They can also vet information they find online about stuttering (e.g., social media, AI-generated information), and develop advocacy skills by countering ableist representations of stuttering. Virtual reality (VR) and simulated patients can offer students a low-stakes communication environment for them to practice pseudostuttering, counseling-based discussions, assessments, and therapy practices with people who stutter. These are just some examples that instructors can be creative in how they engage students in understanding stuttering. Together, I hope that we can train a generation of inclusive, forward-thinking clinicians who enjoy working with people who stutter.

Conclusion

The shifting clinical landscape and cultural stigma around stuttering can make it a complex and sometimes daunting topic for student clinicians to engage with. Complicated questions arise across many content areas and learning activities (e.g., "Why should I pseudostutter, is it disrespectful?" "What do I say to a client to explain why I'm giving the SSI?"). Discussion with the experts here indicates that learning activities, both traditional and innovative, need to be thoughtfully selected and contextualized for students. Effective instructors are prepared to address common pressing questions and invite their students to share and unpack "in-process" ideas about stuttering. With appropriate guidance, emerging clinicians can extend the lessons of valuing lived experiences and a humanistic approach to therapy from their stuttering course into other clinical areas. While the input from these experts provides a starting point when structuring a stuttering course, more research is needed to establish pedagogical consensus within the field. Didactic stuttering courses present one of the earliest opportunities to situate the next generation of clinicians to approach stuttering as firm allies—in the therapy room and beyond.

CRediT authorship contribution statement

Shelley B Brundage: Writing – original draft. **Julia S Kerrigan**: Writing – original draft, Conceptualization. **Derek E Daniels**:

Writing – original draft. **Christopher D Constantino**: Writing – original draft. **Naomi H Rodgers**: Writing – original draft, Project administration, Conceptualization.

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We have no conflicts of interest to disclose.

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No data was used for the research described in the article.

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