

Letter – Expert Discussion

Contemporary clinical conversations about stuttering: Do speech-language pathologists need specialised training to manage stuttering?

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Short Title: Conversations about stuttering: Specific training need?

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Keywords: Stuttering, training, professional development, discussion.

22 **Prologue**

23 Professional preparation for the discipline of clinical medicine typically requires completion of a medical
24 degree, followed by a supervised postgraduate internship and the opportunity to undertake subsequent
25 specialist training. In contrast, speech-language pathologists (SLPs) enter practice after completion of an
26 accredited degree, with optional continued professional development through workplace learning,
27 supervision, mentoring, and continuing professional education. In the United States, some training
28 programs permit students to complete their qualifications without direct clinical experience with stuttering
29 [1]. Perhaps because of this, many newly graduated clinicians in that country report feeling underprepared
30 to assess and manage stuttering [2], especially with children [3]. That apprehension is not surprising,
31 considering that knowledge about stuttering incorporates many scientific and clinical disciplines. These
32 include psychology, linguistics, phonology, genetics, neuroanatomy, neuroscience, articulatory kinematics,
33 epidemiology, and biostatistics.

34 According to the American Speech-Language-Hearing Association [4], the speech-language pathology
35 profession encompasses nine major practice domains: fluency, speech production, language, cognition,
36 voice, resonance, feeding and swallowing, audition, habilitation and rehabilitation. Specifically, the
37 profession deals with approximately 40 different communication and swallowing disorders.

38 Postgraduate internship and formal specialist training are optional, not mandatory, for the discipline of
39 speech-language pathology. For example, The American Speech-Hearing Association provides a board-
40 certified specialisation in stuttering, cluttering, and fluency disorders, and the European Stuttering
41 Specialization is available in that continent. Hence newly graduated SLPs have latitude to determine the
42 nature and structure of their subsequent career paths, and whether those career paths involve specialist
43 training. To guide junior clinicians in considering this matter, this conversation involves four participants
44 who discuss this matter and give their perspectives. The participants were selected to give a balance of
45 clinical and research perspectives. María Pía Coscueta has a private practice in Córdoba, Argentina, and
46 is affiliated with the Universidad Católica de Santa Fe in that country. Suzana Jelčić Jakšić is in the Faculty of
47 Speech-Language-Pathology at the University of Rijeka in Croatia and also has a private practice in that

country. Ainsley Poulos has a private practice in Sydney, Australia. Sabine Van Eerdenbrugh is in the Speech-Language Pathology Programme at Thomas More University at Antwerp, Belgium. The discussion was moderated by Mark Onslow from the Australian Stuttering Research Centre, the University of Technology Sydney, Australia. The conversation is reproduced below as it occurred spontaneously online. Participants were limited to 100 words per response.

Dialogue

Mark: So, do SLPs need specific training and clinical skills to manage stuttering effectively? Or are they adequately trained for this when they attain entry-level professional education for the profession?

Ainsley: While in theory they are adequately trained, in practice, my experience is that when they undertake further training, it completely “levels up” their skills, competence, and confidence. After I send our team to do specific training, they report back that it was a “game changer.” I think it’s partly a change in learning focus as a result of the effect of being in the workforce and really needing the skills to do the job with the client in front of them in comparison to the student experience. And partly it is due to the time elapsed between the initial learning and the application.

Sabine: I agree. Stuttering is complex and can manifest in various ways. It is necessary to understand the practicalities really well, not only in theory. People experience stuttering in different ways. Therefore, management of stuttering should be personalised. These days, SLPs cannot just deliver one program because that is the one they are trained in. Diverse training is necessary to offer personalised support.

Pia: The depth of training and practical exposure to stuttering can vary among educational programs. In Argentina, and in some other countries, undergraduate training includes audiology and speech-language pathology. Therefore, continuing professional development, mentorship, and specialised coursework can help SLPs enhance their skills, confidence, and effectiveness in supporting those who stutter and their families. It is essential, though, that such specialised coursework is provided by authoritative sources.

Suzana: I agree with what has been said. It is true that stuttering is complex and unpredictable. It can be scary and can make clinicians feel helpless. Treating stuttering demands much knowledge, skill, self-confidence, and training in various therapy programs, so clinicians have freedom to choose. After learning a

74 lot about theory, young SLPs may feel confused and fear they will harm those who stutter. However,
75 training in evidence-based programs is a basic preparation. It gives young clinicians structure and
76 confidence until they gain experience and freedom.

77 *Mark:* So there seems to be agreement among you that entry-level SLPs do need specific training and
78 clinical skills to manage stuttering effectively. That raises several issues for us to discuss. But first, what
79 would you suggest is an appropriate scope of practice for new graduates working with clients who stutter?

80 *Sabine:* It's a difficult issue because new graduates differ in how confident they feel and their clinical
81 experience. Also, it depends on what is offered in their basic speech-language pathology course. If there is
82 no opportunity for further training, new graduates entering the field could focus on one age group, like pre-
83 school or school-age children. That focus would be knowing what types of approaches exist for those age
84 groups, what the evidence is, and what their needs are. Joining groups of colleagues to discuss cases is
85 essential at that career stage, and later.

86 *Ainsley:* I agree with Sabine, and might go even further to narrow down which scope of practice might be
87 good to start in. I feel pre-school and/or adult clients may be much easier areas to start, as they can lend
88 themselves to more structured and prescriptive clinical therapy approaches. In my experience, school-age
89 and adolescent stuttering often is less “clear cut” in terms of which therapy or combination of therapy
90 approaches may be most effective. Those ages require experience to account for the many clinical variables
91 involved.

92 *Pia:* I also find this issue quite challenging. However, I believe that recent graduates should possess
93 foundational knowledge about stuttering and understand the importance of receiving training in evidence-
94 based approaches to assessment and intervention. This is important to help prevent the continuation of
95 outdated practices and the persistence of misconceptions that, unfortunately, still exist. If recent graduates
96 wish to provide intervention services, they should receive appropriate training, have access to mentorship,
97 and work under regular clinical supervision.

98 *Suzana:* New graduates may be well informed about stuttering assessment and therapy. To be able to
99 actually apply that information, they need skills training. Even after training in evidence-based programs,

100 they should (like all of us) have a mentor and join collegial discussion groups. At first, when I saw my
101 colleague's responses, I agreed with the suggestion that new graduates should focus on pre-school age
102 children. But then I remembered that working with children means also working with their parents, and
103 that may be rather demanding for young and inexperienced SLPs.

104 *Mark:* Pía and Suzana raised the issue of postgraduate skills training. So, for the benefit of students of
105 speech-language pathology and junior clinicians who read this for guidance, exactly what training would
106 you all recommend, and in what order would you recommend that training to occur?

107 *Pía:* The following recommendations reflect the approaches I currently use in my clinical practice and have
108 found valuable across different age groups. For preschool-aged children, I frequently draw on RESTART-
109 DCM [5], Mini-KIDS [6], the Lidcombe Program [7], and Palin Parent–Child Interaction Therapy [8]. For
110 school-aged children, I often use the CARE Mode [9]. With adolescents and adults, I commonly choose
111 between Van Riper Stuttering Modification [10] and the Camperdown Program [11]. In addition, I consider
112 it important to integrate cognitive and counselling approaches according to each individual needs and
113 goals: Acceptance and Commitment Therapy [12], Solution-Focused Brief Therapy [13], and Cognitive
114 Behavioral Therapy [14].

115 *Sabine:* New graduates in Belgium typically follow one of two pathways. First, they may enrol in a one-year
116 European Stuttering Specialization Course [15], where they are introduced to a range of approaches for
117 clients of all ages who stutter and receive ongoing mentorship throughout the programme. Alternatively,
118 they may attend a series of courses on stuttering interventions such as those Pía just mentioned, including
119 the KIDS program for school-aged children [16]. Both pathways lead to specialised, professional care.

120 *Mark:* That seems extensive training for a new graduate. Pía and Sabine collectively mentioned training in
121 11 clinical procedures. Sabine used the term "specialised." Are you suggesting that new graduates are faced
122 with a choice of whether they need to specialise in stuttering?

123 *Ainsley:* As Pía said earlier, training pathways and graduate employment settings vary considerably
124 worldwide. In Australia, the specific workplace environment typically dictates a new graduate's clinical
125 exposure. For instance, working exclusively in paediatric or adult settings restricts the variety of fluency

126 treatment options they encounter. Pragmatically, prioritising training tailored to that specific caseload—
127 where receiving direct mentorship is possible—is an ideal starting point. Further, specialising solely in
128 fluency disorders is uncommon in Australia without first gaining a few years of broader, more general
129 clinical experience. Ultimately, training approaches differ by country, making adaptable, localised training
130 essential for growth in expertise in fluency treatment.

131 *Suzana:* I agree with Ainsley. Gaining a few years of general clinical experience is essential. In some
132 countries, it is obligatory to go through a kind of clinical internship after graduation. This gives young
133 clinicians insight into a variety of areas and experience even if they already knew that stuttering was their
134 choice. Joining/volunteering in self-help/support groups for people who stutter may also be useful. There
135 they can learn how to listen and observe, which are basic skills for assessment and therapy. Then they can
136 decide which age group or therapy approach would be their first choice.

137 *Mark:* So, the view is that if specialisation in stuttering management occurs, it would do so after some years
138 of mentored clinical practice, supplemented by experience with community groups of those who stutter.
139 And during that period junior clinicians with a clinical interest in stuttering presumably would receive
140 specialised training in selected intervention procedures. Which raises the fundamental question of which
141 interventions should be chosen for that specialised training. Many of the 11 interventions mentioned
142 previously are not supported by evidence from randomised clinical trials. Given this, are you comfortable
143 suggesting them to students and junior clinicians?

144 *Ainsley:* Although the level of available evidence differs across interventions, in our practice the only
145 stuttering interventions we will suggest and fund our clinicians to be trained in and use, are those
146 supported by a strong body of evidence. Once they have done this, they are in a better position to evaluate
147 other approaches. Inevitably, clients or parents may have heard of various other interventions and wish to
148 discuss them.

149 *Mark:* For which interventions would you support training?

150 *Ainsley:* In our context we use the Lidcombe Program, the Camperdown Program, and the Westmead
151 Program [17], and the Oakville Program [18] as a start. There are other evidence-based programs available,

152 however, mentoring in the nuance of their application is not as easily accessible for us as the ones
153 mentioned above.

154 *Mark:* What do others think of Ainsley's recommendations?

155 *Sabine:* The Lidcombe Program, the Camperdown Program, and KIDS are adopted by clinicians in Belgium
156 too. Clinicians may not adopt the most evidence-based treatments. Some treatments are historically part of
157 a clinician's toolset (a legacy passing from mentor to novice), which may contain evidence-based
158 components. Clients also look for evidence, so it is important that clinicians can offer treatments with a
159 strong body of evidence. However, these may not address all needs of the clients. Other treatments with
160 evidence-based components are adopted in Belgian clinical practice as well.

161 *Mark:* What treatments are you referring to that "contain evidence-based components"?

162 *Sabine:* For example, stuttering modification techniques, as in Mini-KIDS, have been investigated in older
163 age groups but not in preschool children. Or, although individual components of CARE Model have been
164 studied, the overall program is yet to be evaluated.

165 *Pia:* I agree with the perspective that Sabine has outlined, as it reflects the reality of clinical practice.
166 Treatment decisions are often influenced not only by research evidence, but also by professional training,
167 mentorship, clinical experience, and the individual needs of the clients. At the same time, this discussion
168 highlights the importance of strengthening undergraduate education in evidence-based practice. Students
169 should be encouraged from the outset to critically evaluate interventions and prioritise approaches
170 supported by evidence, while also learning how to integrate research findings with clinical expertise and
171 client values when making clinical decisions.

172 *Suzana:* I think that young clinicians should get skills in general therapeutic techniques, by which, I mean
173 listening, counselling, basic fluency shaping, and stuttering modification techniques. Training in evidence-
174 based programs gives them insight into a structured approach to therapy. They will learn over time how to
175 individualise all those techniques for each client and family. So, any evidence-based program training they
176 take is useful. The more the better because then one can offer and choose the right one for a specific
177 client. Even combining elements from different programs works if you want to tailor therapy.

178 *Mark:* You have all highlighted that evidence-based practice with stuttering extends beyond research
179 evidence alone. It incorporates client and family needs, alongside the clinical expertise that comes with
180 experience. With that in mind, and given the broad scope of speech-language pathology practice, do you
181 think that recent graduates should decide at some time to become specialists in stuttering? Or are they
182 able to deliver satisfactory clinical services as generalists?

183 *Pía:* I believe that specialisation should not be viewed merely as an option but rather as an important
184 requirement for clinicians who wish to develop competence and provide high-quality care for people who
185 stutter.

186 *Ainsley:* Career progression often naturally steers clinicians toward specific areas of practice where they
187 develop deeper expertise, whether in stuttering or another domain. In my observation, this specialisation is
188 rarely isolated; rather, it occurs when advanced professional training and direct exposure to specific clinical
189 populations operate synergistically. The Australian clinical landscape rarely supports an exclusive focus on
190 stuttering; true specialisation is often slightly broader. Grouping fluency with related domains, such as
191 motor speech disorders, represents a highly effective practical strategy—one that accelerates clinical
192 expertise while maximising service delivery outcomes.

193 *Sabine:* Yes, specialisation is recommended. However, clinicians are generally internally motivated to
194 specialise rather than being required to do so. Specialisation supports their professional growth. Exclusive
195 specialisation in stuttering is also relatively rare in Belgium. While some students decide during their final
196 year of training to specialise in stuttering, for others, this interest develops over time. Many clinicians
197 combine a specialisation in stuttering with other areas such as speech sound disorders, language disorders,
198 learning disorders, or voice disorders.

199 *Suzana:* Yes, specialisation is necessary if you decide that stuttering is your area of choice and you become
200 an expert. Certainly, broader education and continuing education in fluency disorders, like cluttering, and
201 other areas of speech-language pathology is obligatory. I can say for Croatia that those who don't specialise
202 usually don't treat stuttering but refer such cases to specialists.

203 *Mark:* So, to conclude, could each of you recommend four clinical procedures for stuttering—two for
204 children and two for adults—for new graduates to prioritise learning in their first year of clinical practice.
205 And why do you recommend each of them?

206 *Ainsley:* Four stuttering procedures are quite a load for a new graduate to prioritise in their first year, given
207 other practice areas also require further training. However, for children, I recommend the Lidcombe
208 Program and the Westmead Program. This is because of their strong evidence base, clear guidelines,
209 relative simplicity, and overlapping treatment principles. For adults, I recommend the Camperdown
210 Program and Van Riper Stuttering Modification. The latter provides an alternative for clients who balk at
211 the early stages of speech restructuring involved in the Camperdown Program and are unwilling to try it.

212 *Sabine:* For pre-school children, I would recommend the Lidcombe Program and RESTART-DCM, and for
213 adults, I recommend the Camperdown Program and Van Riper Stuttering Modification. These
214 recommendations do not strictly follow the hierarchy of evidence but rather reflect the diverse needs of
215 clients in clinical practice. Clinicians can develop competence in these through training and mentorship.

216 *Pía:* I recommend the Lidcombe Program for children because it has the strongest evidence base and
217 provides an excellent foundation for learning. I also recommend RESTART-DCM. For new graduates, I
218 recommend these two approaches because they offer a clear, structured framework that helps build
219 confidence and develop clinical skills. For adults, I recommend Van Riper Stuttering Modification and the
220 Camperdown program.

221 *Suzana:* For children I recommend Palin Parent–Child Interaction Therapy and the Oakville Program
222 because they are natural, positive, and intuitive to parents. For adults, I recommend the Camperdown
223 Program and Van Riper Stuttering Modification. Having skills in the latter two approaches enables one to
224 offer two different ways of mastering speech.

225 **Epilogue**

226 The group agreed on some take-home messages for junior clinicians and students about the topic.

- 227 • Additional training and mentorship are desirable for clinicians who are intending to develop
228 expertise in stuttering management.
 - 229 • Clinical mentorship is desirable for new graduates.
 - 230 • Specialising in stuttering is recommended to optimise effective management.
 - 231 • Treatments with the strongest evidence base are recommended, but that is not the only
232 consideration for choosing a treatment.
 - 233 • Specialisation is recommended after some years of mentored general clinical experience.
 - 234 • Specialisation in stuttering may be paired with specialisation in other areas.
 - 235 • Collectively, 11 treatments were endorsed by the group.
 - 236 • The following treatments were recommended by three of the group as priorities for new
237 graduate training: the Lidcombe Program, the Camperdown Program, Van Riper Stuttering
238 Modification.
- 239 One point of contention emerged during the discussion, which we suggest students and junior clinicians
240 reflect on: new graduates are advised to focus their attention initially on one age group; however, pre-
241 school children may be too demanding for them because of the complexities of parent involvement.

242 **Statements**

243 **Acknowledgement**

244 The authors would like to thank Damien Liu-Brennan for his scientific copyediting contribution to this
245 publication.

247 **Conflict of Interest Statement**

248 The authors have no conflicts of interest to declare.

250 **Funding Sources**

251 This study was not supported by any sponsor or funder.

253 **Author Contributions**

254 Mark Onslow conceptualised, moderated, and edited this discussion. All other authors contributed to the
255 free-flowing conversations and reviewed the final draft of the manuscript before submission.

257 **Chair**

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