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Spanish-Speaking Mothers' Experiences of School-Based Speech Therapy

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ABSTRACT

Purpose: Spanish-speaking families are a growing population that speech-language pathologists must be prepared to work with. To provide culturally responsive intervention, speech-language pathologists (SLPs) must understand the perspectives of Spanish-speaking caregivers when providing intervention. These values and experiences may differ from those of monolingual, mainstream culture. Understanding the impact of the COVID-19 pandemic on these experiences is also important. In this qualitative study, we explore the experiences of Spanish-speaking mothers whose children have received school-based speech-language intervention and the impact of the COVID-19 pandemic.
Method: We interviewed five Spanish-speaking mothers who were identified as having bilingual children who had or were currently receiving speech therapy, all through the public school system. The mothers participated in a semistructured interview to share their experiences with their children receiving intervention. We analyzed the transcripts through interpretative phenomenological analysis to identify salient themes among participants. All research team members reviewed and agreed upon themes to ensure credibility.
Results: The findings revealed six group experiential themes: (a) lack of services and frustration with and barriers to accessing services, (b) greater improvements in English compared with Spanish, (c) bilingual speech therapy has positive effects on children and Spanish-speaking mothers, (d) family involvement in speech therapy is highly important, (e) family stress related to speech difficulties, and (f) pandemic negatively impacted children's socialization and learning.
Discussion: The results are discussed in the context of equity. Through understanding the experiences of Spanish-speaking mothers, SLPs can work to ensure service levels comparable with those of monolingual children and support bilingual acquisition.

Among the increasing bilingual population in the United States, Spanish is the most widely spoken non-English language (U.S. Census Bureau, 2021). Given this large and increasing number of Spanish speakers and that a portion of those children will present with a speech-language disorder, speech-language pathologists (SLPs) must be prepared to work with bilingual populations. Understanding the client perspectives of Spanish-speaking caregivers is crucial in developing intervention protocols to meet these needs as part of an evidence-based practice (EBP) approach to providing clinical services, which few studies have explored.

Moreover, the COVID-19 pandemic prompted a shift in the delivery of services for children with communication delays, including bilingual children. The impact of this shift in services and COVID-19 in the United States is still not widely understood. Previous work (Fumero et al., 2021) documents challenges in providing services to children from culturally and linguistically diverse (CLD) backgrounds but not their caregivers' experiences. Thus, there is a significant gap in the understanding of the experiences of Spanish-speaking caregivers with children

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receiving speech-language intervention and their experiences of those services in relation to the COVID-19 pandemic. The International Expert Panel on Multilingual Children's Speech (IEPMCS) defines multilingualism as a term encompassing both bilingualism and multilingualism (IEPMCS, 2012). The present study considers Spanish–English bilingual children with speech-language disorders and their Spanish-speaking mothers' perspectives. This study also explores the impact of the COVID-19 pandemic. Understanding these perspectives can improve the quality of services we deliver as SLPs.

Speech and Language Delays in Bilingual Children

Bilingual children should be assessed in culturally and linguistically appropriate manners. Specifically, both of the child's languages should be taken into consideration. Linguistic skills may present differently across languages (Ebert et al., 2014), skills may overlap, and languages can interact (Paradis & Genesee, 1996), with transferring of skills across each language (Goldstein & Gildersleeve-Neumann, 2015; Irizarry-Pérez, Peña, et al., 2023). A thorough assessment in both languages is needed to accurately identify speech and language delays and to determine appropriate goals and targets.

For bilingual children, speech and language difficulties will also be present across languages (Goldstein & Gildersleeve-Neumann, 2015). For example, a bilingual child who presents with phonological errors, and speaks Spanish and English, will present with phonological errors in Spanish and phonological errors in English. Similarly, evidence of language difficulties will also be present in both languages. Therefore, it is very likely that services must be provided in both languages to fully address any delays or achieve communication goals across communication settings. Because communication skills are embedded within a cultural community that includes parents and caregivers, their perspectives are needed to help inform EBP for speech and language interventions where little information is available and where the impact of the COVID-19 pandemic is not yet fully understood.

Accessing Intervention Services

Despite the need for addressing communication goals in both languages of bilingual children, there exists a notable discrepancy in the demographics of the populations served and the service providers available in our profession. With only 8% of SLPs identifying as bilingual (American Speech-Language-Hearing Association [ASHA], 2023), there is a significant shortage of SLPs to serve bilingual populations. Thus, bilingual children, such as those who speak Spanish and English, do not have the same access to clinical professionals in their linguistic and cultural communities as their monolingual, English-speaking peers.

Although most SLPs in our field are monolingual, SLPs are still responsible for bilingual populations. The ASHA Principles of Ethics I, Rule C, from ASHA's Code of Ethics (Principle 1, Part C; ASHA, 2016) states that "individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, or dialect." This means that SLPs who are not sufficiently bilingual to provide services in Spanish and English still have a professional responsibility to ensure that their clients receive appropriate services. This may sometimes mean an appropriate referral to a bilingual provider. In other cases, the SLP may address the child's communication needs through an interpreter and cultural broker. In all cases, SLPs can lean on the principles of EBP to guide their services.

Evidence-Based Speech and Language Services

An EBP framework (ASHA, n.d.; Sackett et al., 1996; Sehon & Stanley, 2003) can guide clinicians in providing culturally responsive services to bilingual children with speech and language delays. The EBP framework integrates evidence, clinical expertise, and client perspectives. Importantly, no one pillar is less important than the others. We introduce the EBP framework to support the importance of understanding client perspectives during the assessment and intervention process when working with bilingual children.

Evidence

ASHA (n.d.) describes evidence as "the best available information gathered from the scientific literature (external evidence) and from data and observations collected on your individual client (internal evidence)." For bilingual children, research investigating the effects of speech and language intervention with bilingual children continues to be needed, as clinicians have limited published research to draw upon. For example, Irizarry-Pérez, Fabiano-Smith, and Martinez-Fisher (2023) identify 11 bilingual participants across 13 studies that have ever been included in the intervention for bilingual children with speech sound disorders. In a systematic review of 14 articles across six linguistic domains, Nair et al. (2023) note a significant gap in the language intervention literature for bilingual children, with much of the work on vocabulary focusing on cross-language transfer of cognates.

Nevertheless, it is possible to address both languages of a bilingual child to some degree, even when only working in English. For speech, monolingual SLPs may target the shared sounds across phonological systems in English and monitor for a generalization in the other language. This is an example of cross-linguistic generalization that has been noted to occur when working in the second language (English) into the first language (Holm & Dodd, 1999, 2001; Holm et al., 1997; Ray, 2002; Schleif et al., 2021). For language, monolingual SLPs may also target constructs shared across languages or cognitive abilities that one would expect to be shared across languages (e.g., language organization; Kohnert & Derr, 2012; Simon-Cereijido & Méndez, 2022).

In addition, when not possible to directly address both languages, clinicians can utilize approaches that integrate linguistic and cultural assets that the child already holds. Two examples of these approaches are translanguaging approaches (García, 2009; Otheguy et al., 2015) and a "funds of knowledge" approach (Vélez-Ibáñez & Greenberg, 1992). Translanguaging does not focus on any one particular language but rather linguistic skills as a whole, drawing from the complete repertoire of language abilities the child holds. In a similar manner, bilingual households hold sets of linguistic and cultural knowledge (i.e., funds) that provide learning opportunities (e.g., language literacy) for the bilingual child and can be brought into the intervention space. Both approaches shift to an additive language environment where all languages of the bilingual child are utilized and acknowledged.

Clinical Expertise

ASHA (n.d.) describes clinical expertise as "the knowledge, judgment, and critical reasoning acquired through your training and professional experiences." The knowledge and skills of an SLP may be low when working with bilingual children. Not all graduate programs offer bilingual certificates or specialized coursework for students, and practices taught may reflect only those values consistent with white mainstream culture (Cycyk & Iglesias, 2015). Thus, SLPs may struggle when working with clients from cultural and linguistic backgrounds other than their own. Specifically, SLPs have reported low confidence, comfort, and competency with multilingual clients (Santhanam & Parveen, 2018) and feeling underprepared (Hayes et al., 2022).

SLPs can increase their clinical expertise through continuing education. Goldstein (2022) and Kohnert et al. (2020) provide foundational knowledge for bilingual speech sound development and general assessment and intervention principles. Simon-Cereijido and Méndez (2022) offer guidance for bilingual children with language delays. ASHA offers continuing education courses on topics such as bilingual development, cultural competence and responsiveness, and family-centered practices. These courses enhance the knowledge and skills of SLPs, enabling them to provide more effective services to bilingual children and families.

Client Perspectives

ASHA (n.d.) describes client perspectives as "the unique set of personal and cultural circumstances, values, priorities, and expectations identified by your client and their caregivers." EBP requires that client perspectives be part of the decision-making process. Including caregivers in the intervention process is also consistent with the family-centered approach to providing services (Crais et al., 2006), which includes caregivers as active collaborators. In fact, because caregivers directly interact with their children in the home, their involvement may lead to better intervention outcomes for school-age children (Henderson, 1988).

The child–SLP relationship is also an important part of this intervention experience. Washington et al. (2012) interviewed the caregivers of 67 preschoolers receiving speech-language intervention. The rapport between the child and the SLP along with the competence of the SLP were themes that emerged as important aspects of this relationship. Specifically, caregivers commented that the clinical skills of the SLP and their ability to make progress with their child were important factors to families.

However, few studies have explored the experiences of Spanish-speaking caregivers whose children have received speech or language therapy, and no studies have yet to explore their perspectives on school-age children with speech or language delays, especially in relation to the COVID-19 pandemic. Early work suggests Spanish-speaking Latino/a mothers prefer how their children receive intervention services. For example, Núñez and Tejero Hughes (2018) interviewed five mothers of children receiving early intervention (EI) services. These mothers identified as Latina and had children who were also receiving speech-language therapy. The mothers expressed the importance of the wishes of the family being respected, a general lack of understanding of the EI paperwork, the importance of bilingual language support, and mixed involvement in the decision-making process and intervention activities. Some of the parents were actively involved, and others only watched. Only one mother expressed insight as to how strategies could support their child.

The findings of Núñez and Tejero Hughes (2018) suggest that the practices of these mothers were not in line with EBP. These mothers were not adequately involved in the activities of their children as collaborators in the outcomes. The parents expressed little involvement in the decision-making process, which is inconsistent with a

family-centered practice (Crais et al., 2006). In addition, one parent expressed being told that a bilingual environment may confuse her child with Down syndrome, which is not supported by current research (Bird, 2009).

The experiences described above capture the importance of caregivers' perspectives and why they should be included in decisions regarding their child's care and the delivery of those services. Incorporating client perspectives is important for establishing rapport, may impact intervention outcomes, and can support additive language environments, in line with our most current evidence to support the communication skills in both languages of bilingual, school-age children.

The Impact of the COVID-19 Pandemic

The COVID-19 pandemic prompted a shift in the delivery of services for children with communication delays. Many services previously provided in person were discontinued or transitioned to telehealth. For those who transitioned to telehealth, the shift to a new modality brought with it new, unique challenges.

The impact of this shift in the services and COVID-19 in the United States is still not widely understood. Fumero et al. (2021) documented general challenges in providing services to children from CLD backgrounds but not their caregivers' experiences. Hall-Mills et al. (2022) document the challenges and experiences of SLPs providing telepractice during the COVID-19 pandemic. Although understanding the experiences of SLPs with children during the pandemic is important, we cannot fully understand this unique context without understanding the experiences of the families we work with. This may be particularly important for Spanish-speaking mothers for whom language barriers may already exist.

Summary and Purpose of the Study

The cultural and linguistic incongruities between monolingual SLPs and their bilingual clients may result in discrepancies between what is provided and what is expected for intervention services. Culturally responsive intervention is important to ensure positive intervention outcomes. To achieve this, we can utilize the principles of EBP, which incorporate client perspectives. Specifically, if we want to achieve additive language environments, we must involve families by including caregivers' perspectives and values when working with bilingual families. We can acquire this knowledge through interviews that seek to understand what these values and experiences are. Washington et al. (2012) describe the general importance of the SLP–client relationship when providing intervention services. Núñez and Tejero Hughes (2018) describe the specific experiences of Latina mothers receiving EI services. To date, we are unaware of any study exploring mothers' experiences with bilingual children receiving school-based intervention services, or during the COVID-19 pandemic.

Additionally, school-based intervention differs from EI, as it is not typically provided at the family's home. This increases the chance of disconnection between the school team and the family. The COVID-19 pandemic is likely to have compounded this experience even more. Understanding these experiences is essential to advancing our knowledge of how to work with bilingual communities and support bilingual language acquisition.

The purpose of this study was to examine the experiences of Spanish-speaking caregivers of bilingual children receiving school-based speech-language therapy. The state of New Mexico is well suited for this type of investigation, as the Spanish-speaking population is estimated to be almost 25% of total speakers (U.S. Census Bureau, 2021). In addition, this study sought to understand these experiences in relation to the COVID-19 pandemic, as the study was conducted during the height of the pandemic. Findings from analysis of Spanish interviews with Spanish-speaking mothers of bilingual children who were enrolled or previously enrolled in school-based intervention services are presented. The principal research question guiding this study was: What were the experiences of Spanish-speaking mothers of bilingual children with speech-language delays who had received speech therapy? In addition, we wanted to understand how the COVID-19 pandemic impacted the services provided to families receiving intervention during the pandemic. It was crucial to understand the impact of the pandemic as it caused a unique shift in service delivery that is still being understood.

Method

We present our methodology and results in line with published guidelines for qualitative interviews using the Consolidated Criteria for Reporting Qualitative Research checklist (Tong et al., 2007). Specifically, we provide a description of our study design, research team and reflexivity, and our analysis and findings below.

Participants and Recruitment

This study was approved by the institutional review board of The University of New Mexico. All participants provided informed consent. Data collection was conducted during the winter of 2020, during the COVID-19 pandemic. All safety protocols established by the university were followed. Participants were recruited through a larger study investigating target selection for bilingual children with speech sound disorders. Our goal was to

better understand the needs of Spanish-speaking parents in the community to better support culturally responsive intervention practices for their bilingual children with speech and language delays. Participants were recruited via flyers, e-mail, phone, and word of mouth throughout the greater Albuquerque area. Inclusion criteria included (a) caregivers over the age of 18 years, (b) caregivers who spoke Spanish, (c) caregivers who had Spanish–English bilingual children who were currently or previously had received therapy for a speech sound disorder, and (d) caregivers who resided in New Mexico. Respondents for this study who did not meet these criteria were excluded. Five participants were recruited, four through the larger intervention study and one independently. This sample size is in alignment with best practices for interpretative phenomenological analysis (IPA; described below) as proposed by Pietkiewicz and Smith (2014). They advocate for modest sample sizes of relatively homogeneous individuals, five to 10 people on average. All participants were over the age of 18 years, Spanish speaking, and mothers of simultaneous bilingual children whom the mothers reported to be enrolled or previously have been enrolled in school-based intervention services for a speech delay, a term described by all as articulation difficulties. Four mothers also reported that their children had received or currently were receiving school-based intervention services for a language delay. In addition, one mother (recruited independently) reported her child had previously been seen specifically for a speech delay. Demographics for the mothers are presented in Table 1.

Research Team and Reflexivity

Interviews were conducted by the fourth author in Spanish and supervised by the first author. The first author (he/him) was an assistant professor in the Department of Speech and Hearing Sciences and a bilingual SLP with an ASHA certificate of clinical competence. The second author was a first-year doctoral student in a Counselor Education program. The third author was an assistant professor of counselor education and a licensed professional clinical mental health counselor. The fourth author (she/her) was a first-year, bilingual graduate student in a speech and hearing sciences program.

The second and third authors had prior experience conducting qualitative research, whereas the fourth was new to interviewing. The first author had experience in conducting semistructured interviews in both classroom and clinical settings. The first and fourth authors were fluent in Spanish, whereas the second author spoke only English. The third author reported having a conversational understanding of Spanish. None of the authors had any prior relationship with the participants before this study. The first and fourth authors had a particular interest in bilingual speech intervention, which they communicated to the participants.

Data Collection

We created an interview guide, presented in the Appendix. An interview guide helps researchers set a flexible agenda for the interview, anticipate sensitive issues that may arise, and ensure questions are framed in an open-ended manner. IPA interviews tend to be semistructured in nature to allow for the emergence of participant-led priorities and disclosures, with the potential for follow-up questions by the interviewer that may not be included in the guide (Ruslin et al., 2022; Smith et al., 2021). The interview guide for this study was developed per IPA guidelines, such as creating open-ended, in-depth interview questions; attempting to avoid assumptions or questions that lead participants toward desired answers; and focusing questions on topic areas that provide the researchers the opportunity to answer the original research question(s) (Smith et al., 2021). These semistructured interview questions were created to capture participants' experiences with school-based speech therapy and developed after a literature review and multiple research meetings between the first and fourth authors. We also relied on general ethnographic procedures to develop the structure of the questions (Jenkins & Rojas, 2020). The interview guide was sent to an assistant professor with experience in qualitative research for feedback. The final version was then piloted among the authors for acceptability and flow.

Interviews were conducted during the first 2 months at the beginning of the larger intervention study. All

Table 1. Participant demographics.

Identifier	Age of child (years;months)	Services	Country of origin of caregiver	Preferred language
Caregiver 1	4;0	Speech and language	Mexico	Spanish
Caregiver 2	5;7	Speech and language	Mexico	Spanish
Caregiver 3	5;0	Speech and language	Mexico	Spanish
Caregiver 4	5;0	Speech and language	Mexico	Spanish
Caregiver 5	5;4	Speech and language	Mexico	Spanish

interviews were conducted in Spanish. They were done by Zoom to observe COVID-19 safety precautions on social distancing. Each lasted 45–60 min. All interviews were conducted by the fourth author, who was a graduate student at the time. However, the first author supervised all interviews and was present online to provide assistance and guidance as needed. A semistructured interview approach was used, so interviews followed the flow of the conversation and the interviewer used questions as prompts when needed. Each participant was alone in a private space during the interview. Participants received a $25 merchandise card as compensation for their time.

Analysis

The researchers utilized theories of constructivism and applied them to understanding and interpreting lived experiences. When applying the principles of constructivism alongside the qualitative analysis framework of IPA, one can acquire a detailed and intricate comprehension of how individuals experience life. This approach considers the impact of personal perspectives and social constructs on shaping these experiences.

To examine Spanish-speaking mothers' experiences with children receiving school-based speech therapy, we utilized IPA to analyze each participant's interview (Smith et al., 2021). IPA seeks to understand the lived experiences of the participants and is informed by phenomenology (i.e., the study of lived experience), ideography (i.e., focus on the particular), and hermeneutics (i.e., theory of interpretation). This method of data analysis was chosen to understand how specific experiential phenomena are understood from the viewpoint of specific individuals in a specific context (Moustakas, 1994); in this case, the goal was to understand the experiences of Spanish-speaking mothers with children who had speech delays and had received school-based speech therapy. To identify themes within each participant's interview through IPA, there is no formal or prescribed analysis method. However, it is essential to have an appropriately iterative and inductive approach to analysis (Smith et al., 2021). The analysis process involved multiple steps before generating the final set of themes, as outlined in Table 2.

Because the interviews were conducted in Spanish, the initial task was translating them into English. We translated interviews to English to allow all authors to be involved in the data analysis. A graduate student who was fluent in both languages transcribed the audio recordings verbatim and then translated the transcripts into English for analysis. The first author reviewed each transcription for accuracy of transcription and translation. The first author possessed a master's degree in Spanish and 10 years of experience teaching college-level Spanish. Errors noted were primarily in orthography (i.e., placements of accents and spelling) and word phrasing.

Data analysis began with an in-depth review of interview transcripts to be immersed in the participants' world and engage with the data (Braun & Clarke, 2012; Smith et al., 2021) by all authors. Following a line-by-line reading of the transcripts, the second author documented exploratory notes reflecting the semantic content and participants' experiences. Experiential statements were then constructed from the exploratory notes in alignment with quotes from the transcripts. Next, a personal experiential themes (PETs) table was developed by clustering experiential statements based on the similarity of experience, emerging patterns, and higher-order categories (Saldaña, 2021; Smith et al., 2021). This process was repeated individually for each of the five interview transcripts. Once the above process was completed for all five transcripts, all co-authors reviewed the five tables of PETs together to identify similarities, differences, and patterns across all participants. The first and second authors identified group experiential themes (GETs) through the process of clustering and reordering PETs (Smith et al., 2021) and in the data connecting presumedly differing experiences through analyzing interrelationships (Saldaña & Omasta, 2021). All co-authors reviewed themes generated by the first and second authors for reliability. We reached a consensus through discussion to finalize GETs. A step-by-step outline of the analysis is reported in Table 2.

Table 2. Steps of analysis.

1.	All researchers read the interview transcripts multiple times to understand and be engaged with the data.
2.	Exploratory notes examining participants' semantic content and experiences were documented by the second author.
3.	Experiential statements were constructed from explanatory notes by the second author.
4.	Experiential statements were grouped based on similarity of experience to create a table of personal experiential themes (PETs) by the second author.
5.	Steps 1–4 were repeated for each of the five participant transcripts by the second author.
6.	All members of the research team reviewed the PETs for refinement, and through discussion, an agreement on identified themes was reached.
7.	Five tables of PETs were reviewed together to identify similarities, differences, and patterns across all participants by the first and second authors.
8.	Group experiential themes (GETs) were identified through the process of clustering and reordering PETs by the first and second authors.
9.	All members of the research team reviewed the GETs for refinement and agreement on identified themes.

Credibility

The researchers followed guidelines created by Creswell and Poth (2018) to ensure the credibility of this study. Before reviewing each transcript, all co-authors bracketed (Smith et al., 2021); that is, they wrote down any predictions or potential biases that could influence the interpretation of the data to ensure objectivity. All co-authors reviewed the transcripts and PETs generated by the second author, and the GETs generated by the first and second authors, to achieve investigator triangulation (Carter et al., 2014). Consensus on themes was achieved through discussion until a final set of GETs and subthemes was agreed upon.

Member checking is often conducted to establish trustworthiness in qualitative research; however, it may not always be the most effective method (Morse et al., 2002), and it can create an extra burden on participants, particularly during stressful times. However, alternate processes can be employed to ensure trustworthiness. These steps include using a systematic analysis procedure, having multiple analysts review the data to identify any misinterpretations or personal biases, providing enough context information and direct quotes for readers to evaluate interpretations, and highlighting both similarities and differences between cases, even if they contradict the main findings (Goldblatt et al., 2011). Therefore, we did not utilize member checking and instead implemented the above procedures during our data collection, analysis, and presentation of findings. In addition, in line with semistructured and ethnographic interviewing practices, we restated our participants' responses back to them during the interviews to ensure the messages we were hearing were also the ones they intended to communicate.

Results

IPA was used to analyze the transcripts and answer the research question: "What were the experiences of Spanish-speaking mothers of bilingual children with speech-language delays who had received speech therapy?" Six GETs emerged from the five transcripts: (a) lack of services and frustration with and barriers to accessing services, (b) greater improvements in English compared with Spanish, (c) bilingual speech therapy has positive effects on children and Spanish-speaking mothers, (d) family involvement in speech therapy is highly important, (e) family stress related to speech difficulties, and (f) pandemic negatively impacted children's socialization and learning. Table 3 shows the GETs and the subthemes that emerged within each GET. A thorough description and analysis of themes supported by participants' quotes are presented next.

Lack of Services and Frustration With and Barriers to Accessing Services

All participants reported experiencing frustration and/or barriers related to their child's speech therapy. This

Table 3. Group experiential themes (GETs).

GETs	Subthemes
1. Lack of services and frustration with and barriers to accessing services	Encountered difficulties with the school system
	Lack of Spanish support impacts families
	Encountered difficulties with the medical system
	Experienced transportation barriers
2. Greater improvements in English compared with Spanish	Noticing more challenges with children's Spanish compared with their English
	Insufficient support for Spanish in school
	Mothers are concerned about their children's discomfort with Spanish
3. Bilingual speech therapy has positive effects on children and Spanish-speaking mothers	Mothers are more involved when the speech therapist also speaks Spanish
	Children appear to benefit from bilingual speech therapy
	Mothers feel satisfied with children's progress and support provided
	Mothers expressed benefits from bilingual speech therapy
	Mothers expressed gratitude for bilingual help received
4. Family involvement in speech therapy is highly important	Mothers are engaged and desire to be involved
	Family members help and encourage children
5. Family stress related to speech difficulties	Children experience frustration communicating with family members
	Mothers feel discomfort asking for familial support
6. Pandemic negatively impacted children's socialization and learning	Negative impact on children's socialization with peers
	Children experiencing more difficulty with attention
	Increased distractions at home
	Children's learning and interactions with speech therapist negatively impacted

was articulated in a variety of ways. Participant 1, Participant 4, and Participant 5 reported instances of cultural bias within the school system. For example, Participant 1 described barriers to bilingual support in the school system after indicating she wished there had been bilingual speech therapy for her son: "There is a great need [for bilingual therapy] because [my son] had to drop his bilingual program. He was unable to have both [bilingual program & therapy]."

When asked to clarify, she indicated how this lack of bilingual assistance led to her child being in an English program:

> Well, he needed help, and the school didn't have a [bilingual speech] teacher who could help him, so it was very difficult to have him in bilingual classes if he wasn't—if he couldn't pronounce and could not speak well—so he had to go [to school] just in English.

Participant 1 then explained that if her child was in the bilingual program without a speech therapist, she believed he would fall farther behind:

> He did very well in bilingual class, but in first grade they didn't have a [bilingual speech] teacher or teachers that could help him. And they told me that if I left him in, he was going to be further behind because he wasn't going to have the help he needed.

Participant 1 learned that the school had no bilingual therapist to support dual-language education. The speech therapist in first grade did not speak Spanish, so she believed that she had to choose between bilingual classes and the therapy her child needed. There is a sense of helplessness in her words, as she was being asked to sacrifice bilingual support for her child to ensure he did not "fall behind." Furthermore, Participant 5 described instances of school speech therapists struggling to understand and help her child: " . . . The therapist from [school district] who only speaks English does not know how to tell if she is saying a word in English or if she is just making sounds." She went on to describe the interactions between the school speech therapist and her child and indicated the school therapist did not know if her child was saying words in Spanish or "just making sounds." This statement is characterized by a feeling of frustration at the therapist's apparent nonchalant stance regarding the child's Spanish speech. The therapist cannot accurately assess the child's language abilities because she does not speak Spanish. From the participant's account, no efforts are being made to remedy this disparity. Participant 4 echoed the frustration with the school system's lack of support for Spanish speakers expressed by Participants 1 and 5. She described the communication barriers she faced as a Spanish-speaking parent: "I was never really present. Since they spoke English, I spoke Spanish, I didn't know how to ask them . . . [to observe speech therapy]." Participant 4 was unable to observe her child's speech therapy due to communication barriers with the teacher because the teacher did not speak Spanish and a translator was not provided. Participant 1 shared a similar anecdote when asked if she would have preferred to observe her child's therapy: "Well maybe, but I wouldn't have been able to help him much because it was only in English." In addition to experiencing cultural bias and a lack of Spanish support in schools, Participant 4 reported a parallel experience when seeking medical services for her child:

> . . . There are times when it's difficult because they don't speak Spanish so when I can't communicate with someone, for me, it frustrates me because they may be able to help me but there's no way to understand each other and it's a bit frustrating.

Participant 4 expressed willingness and desire to seek support from medical professionals; however, she felt frustrated by the inaccessibility of services due to language barriers. Similarly, Participant 3 highlighted the inequities she faces as a bilingual woman and how this impacts her experience with speech therapy:

> I think it all affects us because here we are in a country that speaks more in English than Spanish so that's where there is—where we have problems. We have to learn the language from here too.

Participant 3 articulated a recurring theme for virtually all participants in this study—experiencing cultural bias and inequities related to the U.S. dominant culture's preference for English over other languages. In addition to cultural bias, Participant 2 also reported transportation barriers that impact accessibility of speech therapy services:

> Well, first of all, I struggled because, for example, when I had appointments with him to have the evaluations to see how he was progressing—I don't know if that's what you mean—we didn't have access to transportation because I don't know how to drive. I struggled with, like, who could take me and who could take care of the other three children.

The barriers reported by the participants impede their ability to participate in speech and language services across multiple domains.

Greater Improvements in English Compared With Spanish

Participants emphasized that their children receive insufficient support with Spanish language skills outside the home environment. Similar to the above theme, Participants 3 and 5 commented on the lack of Spanish language support in their children's educational environments:

> There are children who speak Spanish and that's when he also speaks it, but there is only English there. Right now, he is at a head start but when he enters school, I am going to put him in a bilingual school. (Participant 3)

> ... It wasn't until she began at [school district] at the age of three years that she began receiving pure English, both her classes and therapy. And we kind of had that problem. That the therapist didn't understand if [my daughter] was saying words in Spanish or just making sounds. (Participant 5)

In their current educational environments, the participants' children are not being supported in improving their Spanish communication skills. The participants appear unsatisfied and discouraged by the limited options for Spanish speech therapy in the education system. Due to insufficient support from educational institutions, it appears most of the assistance the participants' children receive with improving their Spanish speech is happening in the home by their Spanish-speaking mothers. For instance, Participant 3 describes helping her child with his Spanish pronunciation:

> ... in my case, I help him a lot after [class] is over when he cannot pronounce something I—in Spanish—I try to help him to say the words better and that he repeats it to me so that he can be able to pronounce it better for the next time since he can say the word correctly.

She went on to explain family efforts to help her child as he struggles with Spanish language acquisition:

> ... Also, at the same time, my husband and I are trying to help him say more words. More in Spanish because he kind of speaks English a little more and is understood more but Spanish is where he is struggling a lot.

Here, Participant 3 pointed to the significance of her child's ability to speak in Spanish and efforts to help him improve his language skills. Participant 1 expressed similar concerns:

> ... I would get frustrated a bit because I knew he could, well, he could learn both languages very well, but since he only received help in English ... we tried to [help] him here in the house, but it is not the same, like, he remained with only English therapy.

Although families play an important role in encouraging their children and correcting speech issues, the participants seem to suggest it is difficult to sustain improvements if their children are not receiving the same support outside the home. For example, Participants 1 and 3 noted greater improvements in their child's English over their Spanish:

> ... He is doing really well in English. He's doing really well. It helped his pronunciation very much. He did not pronounce the letters /r/ and the /s/ and then they helped him really well in that, but only in English. (Participant 1)

> ... well as he sees that they don't understand him in Spanish, he prefers to speak English. He feels that he is more understood in English. (Participant 3)

Participant 3 continued to emphasize her child's discomfort with Spanish and preference for English:

> I don't know if it's because he can't pronounce it well or he can't say the word and he throws in English, but yes, he doesn't want to because I see that he also gets frustrated that he can't say it well. So instead, he speaks in Spanish. In English, sorry.

Overall, insufficient support for the children's Spanish speech has resulted in many participants noting greater improvements in their child's English than in Spanish. This contributes to a shift in language dominance of English over Spanish.

Bilingual Speech Therapy Has Positive Effects on Children and Spanish-Speaking Mothers

The positive effects were evident for the participants whose children received bilingual speech therapy. For instance, Participant 3 reported that bilingual speech therapy has positively impacted her child:

> ... The therapists my son had previously were more in English and this one that he got recently speaks a

> little more Spanish, so she is already helping him a lot because she speaks in English and in Spanish. . . .

Similarly, Participant 4 reported observing a positive attitude change and an increase in her child's motivation as a result of bilingual speech therapy:

> She has even begun to notice herself when she pronounces a word wrong. . . . I mean, I would tell her, "Say agua, not a'a," and she preferred to stay thirsty . . . and that attitude she has dropped . . . in fact when she wants to pronounce a word and she tries to pronounce it again and if it doesn't come out [right] she says "mamá. how do you say that?" . . . in other words, it is a total change of attitude from her.

Additionally, Participant 3 appeared more satisfied and enthusiastic now that her child received bilingual speech therapy. The participant's increased satisfaction may be related to the potential of bilingual speech therapy improving communication between Participant 3 and her child:

> . . . When he started going to the Head Start, he learned more English because it is more English than Spanish so that's where it affected me because he began to speak more English and less Spanish. He understands me but doesn't talk to me [in Spanish]. So, there is the problem.

Participant 4 made similar comments about the benefits of her child receiving bilingual services and stated, "I think that has strengthened her a lot." Similarly, when asked about the most important parts of speech therapy, Participant 5 noted the importance of receiving bilingual services and indicated that she likes that the speech therapist can understand her child "both in English and Spanish." In a recurring theme among participants, it appears incredibly meaningful for Participant 5 to know the speech therapist understands her child in both languages.

Another important feature that emerged from the data was the participants' sense of the positive impact bilingual speech therapy had on them as parents and their ability to be involved in their child's therapy. Participant 3 suggested it is easier to communicate with the speech therapist in Spanish: " . . . And what I like is that everyone speaks Spanish, and we can understand each other better. It's the language, Spanish." In addition to ease of communication when bilingual speech therapy is offered, Participant 3 also reflected on her own growth as it relates to bilingual speech therapy:

> Well, it has helped me a lot too . . . In the way I hear and also with words, I think it has also helped me. I have also practiced the words and Spanish a lot. There were some words I couldn't pronounce and after hearing the sounds and pronunciation even I practice.

There is a sense of appreciation from Participant 3 as she described how bilingual speech therapy has helped her learn and grow alongside her child. Participant 5 also commented on how bilingual speech therapy has helped her support her children. For example, she stated:

> To have more patience I think and . . . Yes, like, now that they are receiving therapy I have more—more knowledge to know how I can help her. Even if you all don't see me, I'm watching [laughs] even if you may not see me, I'm there. I watch how [therapist's name] speaks to [my daughter] and [what he] tells her and I try to apply everything I see in my daily routine.

Participant 5 appeared to view the speech therapist in high regard and, because the therapy is also being offered in Spanish, has gained tools to help her daughter at home through observing online speech therapy sessions. All in all, Participants 3, 4, and 5 expressed their satisfaction and appreciation for bilingual interventions in various ways. Participant 3 stated, " . . . I also owe you many thanks because without you my son would not learn [how to do these activities]." Participant 4 shared: " . . . I feel very happy. I feel that I am complete knowing that she will be able to achieve a lot and—that's all I can tell you. Thank you very much. Thank you very, very much." Finally, Participant 5 shared similar reflections of gratitude:

> I like it. I like it a lot. The fact that they can help my [daughter] to be able to communicate with her words and also the fact that she is receiving help early on because I would not like that when she starts school starts . . . that she would be delayed in school because of speech. . . . Thank you. Thank you very much for helping my little girl and for this service.

Overall, it is clear that bilingual speech therapy is highly valuable and meaningful to participants compared with English-only therapies.

Family Involvement in Speech Therapy Is Highly Important

A significant theme of the participants' descriptions included a desire to be involved in their child's speech therapy. When asked about the parent's responsibility in helping their children, three participants expressed their aspiration to support them. For instance, Participant 5

described her beliefs surrounding her role in speech therapy as a mother:

> Well, I suppose in supporting them and being aware of what they need. Provide them with what they need for their therapies, like a place—now that they're online, a place where there isn't so much noise and she can concentrate. And the things she needs like paper, colors, all the things she needs.

Participant 5 repeatedly mentioned wanting to provide for her child's therapy needs, which suggests a strong inclination to be present and a part of her child's speech therapy. Similarly, Participant 1 expressed feeling responsible for understanding her child's needs when asked about the role of parents in therapy:

> Well, [our role is] to help him in everything we can. To help them and to be on the lookout for what they are doing to know that he … what they are doing, or like understand what they need.

Participant 4 echoed the sentiments of Participants 1 and 5 when asked about her child's well-being in speech therapy: " … I just hope to give her the support she requires to be able to do [things] to the fullest. To the highest ability that she can do [them]." All three participants conveyed a strong need to support and be present for their child's speech therapy. Additionally, three participants communicated the significance of other immediate family members' engagement in helping their children with their speech. Participant 1 discussed the shared responsibility among their family of origin:

> It was what I told the others (family members), that we had to correct him when he didn't pronounce the words [right] or when he didn't want to speak. He would just point to objects or things he wanted, and I would tell them to make him say the words.

Comparably, Participant 3 gave a similar account of the family's responsibility regarding the child's speech:

> In his case, they talk—sometimes they do understand him. But sometimes they kind of like miss something and say "No, I didn't understand him," and I say, "Try to get him to repeat the word to you again," or to say it again—to repeat them again until they understand him. He practices.

In both instances, Participants 1 and 3 reported instructing other family members to assist with correcting the child's speech issues. This conveys that both participants (mothers) lead or direct the family efforts to support the child's speech development. Moreover, supportiveness is emphasized yet again in Participant 5's words when discussing the role of the family:

> Um well. They don't treat her differently. They just kind of concentrate more on something like, "Oh she's talking more," but yes. They try to understand her as much as possible. And support her.

Participant 5 continued describing the family's intentional support and encouragement of her child's strengths:

> I don't think it's so much about the responsibility but rather to treat her the same. Not to make her feel less. Not to draw attention to her disability so much. Rather support her more in what she is.… She really likes to sing, to draw; that's what we focus on.…

According to the participants, the role of the family in speech therapy is substantial; therefore, family involvement may be an area of consideration for speech therapists working with Spanish-speaking mothers. The role could also be one of support versus direct intervention.

Family Stress Related to Speech Difficulties

Several participants indicated that their children's speech difficulties impacted their family communication. For instance, Participant 2 reported that other members of the family had difficulty understanding her child: "Well, it was—it was difficult for them because he would speak to them, and they would have to guess [at what he was saying] because they didn't understand him." Participant 1 also explained that her husband and extended family members struggle to comprehend her child's speech:

> Usually in Spanish they struggle to understand him. Like, they talk to him but many times I have to be explaining what he says, and he gets frustrated. He feels frustrated when they don't understand him.

Participant 1 further elaborated that other family members also have difficulty understanding her child's Spanish because "he does not speak [in Spanish] correctly." In both instances, it appears the participants' children are experiencing stress and frustration around communication barriers with family. Participant 1 expanded on this as she described the differences between her child with speech difficulties and her other children: " … My other children are completely bilingual, as in they

understand very well English and Spanish, and he can't speak Spanish well." This suggests Participant 1's child may feel isolated from other family members due to his difficulties speaking Spanish. Participants 1 and 2 seem to be aware of language difficulties creating a barrier between their children and other family members, which appears to create stress and frustration for the participants and their children.

In addition to experiencing family stress related to communication/speech difficulties, two participants also reported feeling stress due to lacking support from other family members. Participant 2, for example, indicated she feels isolated from extended family:

> Since I live here in the United States, I have no family, I have no siblings, cousins, nothing, nothing, I am alone, so I have no help from anyone. Well from my husband's family, yes a little, but no, it's not much, either.

This statement suggests that Participant 2 feels a great deal of stress and isolation related to helping her child with their speech difficulties. It seems Participant 2 feels she has close relationships with her family of origin and wishes they were near; she indicated she would feel comfortable relying on her family of origin if they were in the United States:

> Well, I don't feel confident in asking for help from my sisters-in-law or my brothers-in-law—my mother-in-law a little bit, but if I had my blood family then I would feel more confident in receiving help. It is because it's my family.

There is a sense that Participant 2 feels uncomfortable asking for help from her in-laws and makes a clear distinction between her husband's family and her family of origin. It seems she feels isolated and solely responsible for her child's speech therapy at times because her family of origin is not nearby to assist her. Furthermore, she also conveyed that although they would help if they lived closer, it is less the job of the in-laws than of the immediate family:

> Well, I imagine more for the siblings, no, it is more the responsibility for the parents and the siblings. [But] as for the rest of the [extended] family members, they aren't going to say, "Well it's not my responsibility [either]," I imagine, right?

Participant 4 shared her reflections related to her extended family:

> We only have uncles—well my husband is the one who has uncles here so no, they're not uncles through relation of our brothers … I think that is why it is a bit difficult—I mean, I can't tell them, "It's your responsibility," you know? I would like to be supported in that way … That type of family support that is closer and that is what is most sad for me because I think that if there were more of us, the balance would be greater, but since it is just me and my husband and from time to time, we go to visit his family, well, it is not much. . . .

Both participants reported wishing they lived closer to their families and had greater support. They also suggested it is inappropriate to ask their in-laws for direct support with their child's speech even if they could provide it. Moreover, Participant 4 indicated additional cultural barriers that were present in receiving familial support:

> Like I don't know, the culture also has that thing of wanting to ignore it because they don't want it to be real even though it's happening so nobody told me anything. In fact, even my husband would get upset. I mean, my husband also had that attitude of "No, she's going to talk on her own time," or "Don't worry," or "She doesn't need any of that."

Several notable concepts emerged from this theme including children experiencing stress related to family communication, mothers experiencing discomfort with asking for help from family members, and mothers feeling the burden of sole responsibility for correcting their child's speech issues.

Pandemic Negatively Impacted Children's Socialization and Learning

This theme was relevant for Participants 2–5, as the child of Participant 1 had exited services before the COVID-19 pandemic. These participants communicated added stressors and a negative impact on their children's learning and socialization due to the pandemic. Many reported that their children felt isolated from their peers, and increased distractions at home created challenges with their children's telehealth speech therapy. Participant 5 commented on the difficulties their family faced while isolated during the pandemic:

> … Yes, yes it affected us quite a bit because we are here all the time, here locked in. It's not that we went out much, right, but the fact that the kids already don't go to school, and they have to be here all day and I don't take them to the store out of fear because they are little—they want to touch everything, you know? Yeah, it has affected us ….

There is an air of sadness to her words as she describes the changes and losses her children experienced. Participant 5 continued to explore the impact of isolation on her daughter's emotional well-being and education. She appeared to face challenging dilemmas related to whether or not to let her daughter return to school:

> . . . But with [my daughter] I couldn't because she—the first day they went back to school, she was on the tablet, and she got very sad on me, crying that she wanted to be with her friends, so then I decided to take her [to school]. . . .

It is evident that Participant 5 was forced to make difficult decisions concerning her child's education throughout the pandemic. On the one hand, she was hesitant to send her daughter back to school out of fear of catching the virus; however, her daughter's social and emotional health was suffering. When asked about the impact of the pandemic on her family, Participant 2 also shared that her children missed socializing with their peers:

> . . . My children want to go to school to—in person. They want to go to places that—for example, to parks at the beginning when it started, to places like that, that closed.

In addition to the impact of the pandemic on the children's emotional and social health, three participants also expressed concerns about the quality of online speech therapy and the children's ability to focus with online services. For example, Participant 2 expressed disappointment in the quality and content of her child's online speech education: " . . . It is not the same because they only talk to ask how he is doing, what he is learning every day, but nothing more." Furthermore, Participant 4 indicated that audio issues via telepractice affected her child's learning and confidence. She indicated her daughter would feel sad because the teacher could not hear over telehealth and this issue often went unaddressed:

> But the teacher asked her twice and didn't understand her and [the teacher] preferred to leave it at that, you know? Also sometimes, I think that well, I don't know if they do it maybe because they think that she is going to feel bad when asking her "What? What? What?" So perhaps they leave it [be] . . . but they didn't understand her on the other end. . . .

Participant 4 seemed to imply that online speech therapy was less effective than in-person speech therapy and may have even discouraged her child from communicating. Other participants noted that the distractions present at home created a challenging environment for online speech therapy. Participant 2 said, "No, it is not the same," when asked if her children are able to pay attention as they did in in-person therapy. Participant 3 expanded on this sentiment when commenting on the hindrances to learning in the home:

> I saw that he was better when he was being given [therapy] in person and concentrated more. And right now, online, like no. I see that they are not the same. He does focus, but it's like I don't even know how to tell you—less—like it's something new for him too and that also affected him. . . .

She also commented on the contrast between her child's behavior and focus in school versus at home:

> . . . They tell me also how he is [in class] and they tell me "He is very calm, he behaves very well and the assignments we give him to do, he does them," and I say no [it can't be] because I mean at home it is different. But not at school. Then they tell me "No, here he behaves very well. What you tell him, he does." So, I'm like well, at home well, what's going on? [laughs]

Participant 3 seemed to indicate that her child became restless and distracted at home and had an easier time engaging with speech therapy when it was in person at school. On a related note, Participant 2 mentioned newfound responsibilities of monitoring her child's learning and helping him maintain his focus:

> . . . Now since it is online well, they give you homework for—it is not much responsibility, but—how to play with them so that they learn more. For example, when they would give him something—for example, if I give him water, tell him the word "water" or tell him the words so that he learns . . . Yes, as you say, be on watch that he is sitting there paying attention to what he is told to do and not get distracted by going to watch TV or doing other things that he does not have to be doing.

Participants overwhelmingly expressed dissatisfaction with telehealth speech therapy and preferred in-person, at-school services.

Discussion

We interviewed five Spanish-speaking mothers to understand their experiences of having bilingual children

who had received speech therapy in public schools. We focused on understanding our participants' perspectives as part of an EBP framework. We used semistructured interviews to record their experiences and IPA to analyze the collected responses. Six themes emerged. These themes highlight important aspects SLPs may want to consider when delivering an intervention to bilingual children with any speech or language delay.

First, SLPs should know their work is valued and needed. Our Spanish-speaking mothers expressed finding the intervention they received from SLPs helpful, regardless of the language of the intervention. Mothers also indicated that a speech or language delay impacted the functioning of the family by creating significant family stress. The COVID-19 pandemic exacerbated this stress. As such, our mothers document the very real need and value of intervention services. They also expressed appreciation and gratitude for the individuals who had worked with their children across settings.

The mothers in this study also expressed that their children's English skills developed quicker than their Spanish when they received intervention only in English. Not surprisingly, they expressed a desire to receive bilingual intervention. They had also expressed positive effects of bilingual intervention when received and an interest in being involved in the intervention their children were receiving. We did find that our Spanish-speaking mothers simultaneously expressed disappointment with some aspects of the services they received. Specifically, although these mothers expressed a very high value for bilingual services, often their children received English-only intervention, and the mothers communicated with monolingual teams. This created barriers for Spanish-speaking mothers to communicate with their children and access their children's curriculum. This was further exacerbated by poor resources reported for Spanish skill development at home. Ultimately, although the children's English development progressed, the mothers reported a lack of similar progress in Spanish. These experiences show how failing to incorporate the client's perspective can negatively affect intervention outcomes. Unfortunately, this decreased ability to communicate in the home language also had the potential to exacerbate communication difficulties versus support an additive language environment.

Finally, Spanish-speaking caregivers may also be immigrants with few social supports, which emerged as an additional source of stress. This isolation can be exacerbated when isolated from their children linguistically. While supporting the home language can be helpful, connecting Spanish-speaking mothers with other Spanish-speaking mothers could also help reduce that isolation.

EBP

The experiences of our Spanish-speaking mothers are consistent with the findings of Núñez and Tejero Hughes (2018) that SLPs sometimes did not provide services that matched the expectations and values of bilingual families. Our mothers expressed the importance of bilingual services similar to those of Latina mothers and wished to be more involved in the services of their children. This article extends those findings to Latina mothers of school-age bilingual children. Additionally, one mother reported that their SLP struggled to differentiate between articulation errors and language differences. The importance of this SLP's competence to this mother is consistent with the findings from Washington et al. (2012) for preschool children, in which competence is needed to establish positive rapport. In this article, we find that the importance of clinical skills includes bilingualism and also extends to school-age children.

When working with bilingual children, monolingual intervention does not align with best practices for addressing both languages. Current best practices indicate that bilingual children should receive intervention services to address both of their languages to satisfactorily address any underlying impairments (Gildersleeve-Neumann & Goldstein, 2015; Simon-Cereijido & Méndez, 2022). Bilingual services do not limit school language growth, and English-only intervention is not superior to bilingual intervention (Harvey et al., 2018).

Of course, we acknowledge that providing intervention services in Spanish may not always be possible in a school setting. As previously discussed, there are ways that SLPs can promote cross-language generalization and support both languages. Choosing shared constructs and utilizing a bilingual modality as goals are ways that SLPs can help promote the acquisition of skills in the home language. SLPs can also help promote the value of bilingual language use and acquisition through translanguaging (García, 2009; Otheguy et al., 2015). Although bilingual intervention ultimately may be needed, these are ways that monolingual SLPs can begin to foster additive language environments.

SLPs can also promote equal access to communication in team settings and support communication rights. The use of interpreters is ideal. However, using free online translation services to send home materials and activities and maintain open and frequent communication with caregivers who do not speak English may be ways that SLPs can quickly include bilingual caregivers in the intervention process and support speech acquisition outside school settings.

Additionally, SLPs also have the opportunity to correct misconceptions about bilingualism and inform

caregivers of educational rights. One mother reported believing she needed to choose between intervention services and bilingual programming for her child. This mother chose intervention over continuing his bilingual education. This came at the cost of her child's ability to communicate with other family members in Spanish. Other participants reported the inability to communicate with their SLP and school team, which makes understanding choices and expressing their wishes incredibly difficult. However, decisions between bilingual programming and speech intervention are false choices. Children in bilingual school programs can also receive special education services even if those services cannot be bilingual as well; a bilingual program, by definition, requires both languages and does not remove the need, conversely, for English.

Client Perspectives

In this article, we advocate for including client perspectives when delivering intervention services as part of an EBP framework. However, including client perspectives may only be the first step in providing culturally responsive services. Those values may include caregiver participation as well when working with bilingual children. One theme that emerged was the importance of family involvement. Our Spanish-speaking mothers expressed a desire to be included in the therapy process. In this sense, when mothers are treated as collaborators, mothers may feel more positively toward the intervention.

SLPs can use the framework and models provided in the study with their clients to ensure culturally responsive intervention by ensuring client perspectives remain part of their EBP practice for bilingual populations. University programs can also support our field by continuing to introduce and expand upon bilingual curricula and bilingual clinical opportunities that reinforce this practice. These components should not be restricted to or aimed only at bilingual students, as all students may confront situations where they need to work with bilingual families, as demonstrated in this study. However, our families expressed positive sentiments toward the value of bilingual speech-language therapy. Bilingual intervention services address a significant portion of these problems. The benefits increase when those services are provided by providers who have been supported to feel confident in their practice.

Summary

From a broader perspective, our findings highlight how reducing bilingual children to monolingual children in bilingual contexts can significantly impact the child's functioning within their familial and educational systems. This is a sociolinguistic situation that monolingual children who speak Mainstream American English do not encounter. Supporting only one language of a child in a bilingual environment can exacerbate communication delays, and a lack of understanding of paperwork also creates a barrier to accessing the child's services. As such, lack of access to bilingual providers, appropriate bilingual instruction, and appropriate bilingual intervention creates inequities between monolingual and bilingual children and the quality of services each receives.

It was also evident that the COVID-19 pandemic affected our participants' experiences. Increased isolation and difficulty maintaining similar levels of rigor for the intervention they received were challenges reported. Having a communication delay, receiving support in only one of their languages, and maintaining the safety of their family were difficulties our families needed to grapple with. SLPs may want to be sensitive to these additional factors when interacting with bilingual families still grappling with the effects of this global pandemic.

Limitations and Future Research

The study represents only a small sample of the experiences of Spanish-speaking mothers within the Albuquerque community. Language support may differ within and across communities in the United States depending on resources and demographics. The results cannot be generalized to all bilingual mothers or caregivers. We also recruited caregivers partially through a separate but related study, which presents a bias in selecting participants who chose to be interviewed. Because some of the children of our participants were also receiving speech therapy intervention from other members of the research lab, there is a potential for bias in their responses as well. Finally, while we began this study recruiting caregivers with children who had received intervention for a speech sound disorder, most children had also received intervention for a language delay. Thus, separating the two types of intervention experiences was not completely possible.

However, we report experiences that have long been neglected in research. Our interviews were an example of including our participants as collaborators in intervention research. Future studies may expand upon this work by interviewing additional Spanish-speaking mothers and mothers of different language backgrounds. Additional data may further help to document experiences reported in our study and expand upon these with new information.

Data Availability Statement

All relevant data are within the article, tables, and appendix.

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Appendix (p. 1 of 2)

Qualitative Interview Agenda

*Key: ST = speech therapy

Bilingual Family Impact Prompts
Overview Questions

1. ¿Cuándo empezó a recibir terapia del habla (su hijo/a) por primera vez? When did your child first begin receiving speech therapy?
2. ¿Cuáles son las partes de la terapia del habla que han ayudado más? Which parts of speech therapy have been most helpful?
3. ¿Cuáles son las partes de la terapia del habla que han ayudado menos? Which parts of speech therapy have been least helpful?

¿Me podría describir el proceso de llegar a tener terapia para su hijo/a? Could you describe for me the process of obtaining speech therapy for your child?

1. ¿En su hogar, se habla inglés y español? ¿Cómo le ha afectado a usted y su hijo(s) ser una familia que habla español durante el proceso de recibir terapia del habla? In your home, are both English and Spanish spoken? How has it affected you or your child to be a Spanish-speaking family while receiving speech therapy?
2. ¿Cree que ser Latina ha tenido un efecto en su experiencia con la terapia del habla? Explíquenos cómo. Do you believe that being Latina has had an effect on your experience with speech therapy? In what way?
3. De su punto de vista, ¿cómo se siente acerca de la terapia del habla en general? From your point of view, how do you feel about speech therapy in general?
   a. ¿Cómo es para usted tener un niño(s) con dificultades del habla? How is it for you to have a child with speech difficulties?
   b. ¿Cuál cree que es la causa de las dificultades del habla de su hijo? What do you believe to be the cause of your child's speech difficulties?
   c. ¿Cómo han reaccionado los miembros de la familia a las dificultades del habla de su(s) hijo(s)? How have the other members of your family reacted to the speech difficulties of your child?
4. ¿Cómo se ve una sesión de terapia para su hijo/a? (Pre-COVID) How does a speech therapy session look like for your child? (Pre-COVID)

Ideal ST Prompts
En una situación ideal ¿Cómo sería la terapia del habla de su hijo/a? ¿Cambiaría algo de la terapia de su hijo/a? (se puede hablar tanto del pasado como el presente) In an ideal situation, how would speech therapy be for your child? Would you change anything about your child's speech therapy?

1. En su opinión ¿Cuál debe ser la responsabilidad del terapista del habla para ayudar a su hijo/a? In your opinion, what should the responsibility of the speech therapist be to help your child?
2. En su opinión ¿Cuál debe ser la responsabilidad de los padres/cuidadores para ayudar a su hijo/a? In your opinion, what should the responsibility of the parents be to help your child?
3. En su opinión ¿Cuál debe ser la responsabilidad del (los) niño(s) para ayudar a su hijo/a. In your opinion, what should the responsibility of their siblings be to help your child?
4. En su opinión ¿Cuál debe ser la responsabilidad de los otros miembros de la familia para ayudar a su hijo/a? (extended family) In your opinion, what should the responsibility of the other members of your family be to help your child?
5. ¿Si no pudiera acceder a los servicios de terapia del habla para su hijo/a, pero sabía que necesitaba ayuda, qué haría usted? If you could not access speech therapy services for your child but you knew that they needed help, what would you do?
6. ¿Qué tan cómoda se siente al buscar otros servicios de salud médica para su hijo/a? How comfortable do you feel looking for other medical services for your child?
7. Si tuviera que buscar ayuda para la salud mental de su hijo/a ¿cómo le buscaría ayuda o que haría usted? If you had to search for mental health services for your child, how would you do that or what would you do?

Appendix (p. 2 of 2)

Qualitative Interview Agenda

Introduce: Sabemos que la vida ha cambiado desde que COVID y nos gustaría saber cuál ha sido su experiencia. We know that life has changed since COVID, and we would like to know what your experience has been.
COVID Prompts:

1. ¿Cómo le ha afectado COVID-19 y la pandemia a usted y su familia? How has the COVID-19 pandemic affected you and your family?
2. ¿En qué manera ha afectado la pandemia a la terapia del habla de su hijo(s)? How has the COVID-19 pandemic affected your child's speech therapy?

Caregiver Reflection Prompts:

1. ¿Qué ha aprendido sobre Ud. misma a lo largo de esta experiencia (terapia)? What have you learned about yourself throughout this experience (related to speech therapy)?
2. ¿Qué ha aprendido de los terapistas de su hijo? What have you learned from your child's speech therapist?
3. ¿Qué necesidades, preguntas, temores o dudas tiene usted todavía sobre el bienestar de su hijo? What needs, questions, fears, or doubts do you still have about the well-being of your child?
4. ¿Piensa que hay algo que debería ser parte de la terapia del habla que no es? Do you believe that there is something that should be part of your child speech therapy that is not?
5. ¿Cuáles son las partes más importantes para usted de la terapia del habla? What are the most important parts for you about speech therapy?
6. ¿Qué le gustaría decir ahora que no ha dicho antes? What would you like to say now that you may not have already said?