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Examiners' Report/ Principal Examiner Feedback

Summer 2013

GCE English Language (6EN04/01) English Language Investigation and Presentation

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Introduction

This year, 74 centres submitted work for this unit. Students carried out research into a wide range of topics, including child language, language disorders and language change over time. The standard of work was high, with students showing real engagement with their own research, and centres clearly providing a good level of support, guidance and preparation.

The administration was generally carried out well, though there were a few errors. Centres should ensure that cover sheets are fully completed with student's and teacher's signatures where appropriate, and a breakdown of marks by AO for each task.

Most centres provided evaluative comments either on the cover sheets or on the coursework itself. This gave the moderators valuable insight into the marking process and was very helpful.

Word counts should be given for each task and a cumulative word count should be given at the bottom of each page. Word counts should not include raw data or material contained in appendices or bibliographies.

Task 1

The submissions covered the range of formats. Articles, presentations and talks were all submitted. The best submissions stated clearly which format the student had chosen and also indicated the target audience.

Talks and presentations were most successful when written for and delivered to fellow sixth formers. They were often erudite, entertaining and sometimes very witty.

Articles need to have a clear focus and direction. Students must decide what, in their investigation topic, would interest their audience, and slant the article in this direction. An investigation into the final speeches given by US prisoners before they were executed was accompanied by a Task 1 article for a broadsheet newspaper that broadened the topic into a discussion of our euphemistic approach to death, opening with 'Death. It's not something we care to face head-on, literally or linguistically,' which engages the interest of the audience and encapsulates the article neatly. This article ended on a witty and upbeat note:

> But it's not all doom and gloom. A performer can variously 'slay' 'slaughter' or just plain old kill an audience and get a standing ovation for mass homicide (....) You can't spell slaughter without laughter.

This student was clearly aware she was writing an article for a specific type of publication, and kept this in focus.

In some cases, Task 1 submissions were weakened by a lack of awareness of format and audience. Articles, presentations or talks that were thinly disguised introductions to the Task 2 investigation were far less successful. Students need

to be reminded of the skills they developed in Unit 2, and apply these again to their Unit 4 Task 1.

Task 1 Exemplar 1 - Presentation to speech therapy trainees

(See Appendix for complete exemplar)

English Language Coursework: Task one

Talk to speech therapist trainees

[*slide* 1] Thank you all for attending. The topic of this talk, today, is to provide a wide range of people with more knowledge about a career in speech therapy and how you can become an effective therapist. The focus of this particular talk, however, is the use of child directed speech and the relevance of it within your practice.

[*slide* 2] Firstly, I would like to begin with a scenario. [*play clip of Sam with impaired* speech] Imagine yourself with a child named Sam, who has speech difficulties. Sam has problems with pronouncing velar consonants, such as 'g' and 'c'. He appears to be able to produce labial and dental sounds efficiently at the front of the mouth, as he is able to place his tongue in the correct position. As a therapist you would ask yourself, how am I supposed to tackle this situation?

[*slide* 3] These problems occur daily in your speech therapy case load and this is a common dilemma that you would come across. How each individual therapist deals with the situation, however, is always unique. Where one therapist would try to form a relationship with the child by the use of jocular language and phatic utterances, another therapist may create a teaching environment through the passing of information and complex, formal language to assert a higher position in the interaction. However, there is common ground between therapists, where certain techniques underpin all of our work. One of which is child directed speech, which allows you to 'converge', or match your style of language with children and help them to open up to you.

[*slide* 4] Child directed speech is a highly useful technique when working with children. It is seen by psychologists, including Bruner, to retain children's attention by the use of high rising tones when asking questions and diminutive forms. For example, the word 'doggie', this makes language more accessible to the child. Even though Bruner believes that children are pre-adapted to learning, he still thinks that child directed speech stimulates the child to speed up cognitive development, along with the involvement of adults and knowledgeable peers.

[*slide* 5] Bruner also believes that children learn by repetition, as it helps to reinforce the maturing of their cognitive development. We, as speech therapists would typically use recasting- involving repeating a phrase or word a child has said and placing it in your own sentence- and expansions- involving re-using the sentence or word a child has used and expanding the vocabulary and sentence structure of it, [*play recording 1 of the therapist reusing the children's sentences in her phrases*] as well as emphasis of key words as a type of repetition. Repetition, re-casting and expansions are all features of child directed speech.

[*slide* 6] So, what is Child Directed Speech?

It is a speech pattern used by any adult when speaking to a young child. Features of child directed speech range from changes in lexis such as concrete language "good," "hard" to phonology, such as high rising intonation on questions, "really?" and grammar, such as one word utterances "right." The main aim of this type of speech is to capture the attention of the learning child and to reinvent language as a game, making language acquisition fun.

You don't have to be worried about finding that balance between implying a patronising tone and effective child directed speech. Psychologists consider child directed speech to be a natural teaching mechanism, aimed at children, naturally occurring for an adult. Whether you are a parent, grandparent or a speech therapist, child directed speech will come naturally to you.

[*slide* 7] But does it really work? Well, these child directed speech techniques were used on Sam and look at his progress. [*play clip3 of Sam with improved pronunciation*]

Sam has been receiving therapy sessions for a few months now; he has been practising pushing his tongue up to the roof of his mouth when pronouncing difficult sounds. He receives much encouragement from his therapist by the use of positive reinforcement, recasting and repetition. [*play clip 4*] During his sessions the therapist repeats the same exercises. However, she makes them interesting by the use of high rising intonation, and jocular language [*play clip 5*].

[*slide 8*] After seeing Sam's improvements within his speech, child directed speech seems a very useful technique. However, there are many more techniques within the speech therapy role involving practical work, exercises and psychological techniques. Which technique or techniques you use is dependent on your experiences and what works for you as a therapist. Remember though that a child-centred approach is often the most effective one.

Moderator's comment:
This presentation looks at a challenging area of linguistics, speech therapy, and presents it to an audience of peers in a way that makes it accessible, but recognises their own awareness of language issues, and of child language. The presentation was accompanied by recordings, and PowerPoint slides that added clarity, and exemplified the issues that were being discussed.

AO1: The writing is fluent and confident, and the material is selected and presented in a way that is accurate and accessible to the chosen audience.
6 marks

AO4: The student has adapted the format to her requirements. The text is clearly adapted for its format and is coherent and controlled with careful signposting. The material is fully relevant to the requirements of topic, audience and format. 17 marks

Task 1 Exemplar 2

Written in the Stars?

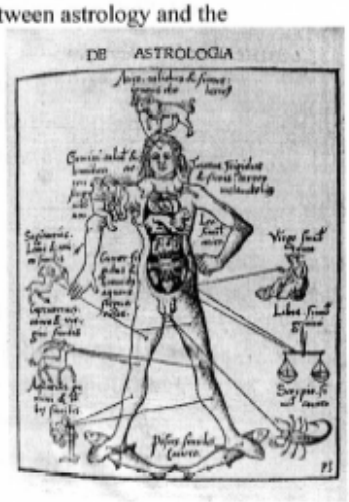
Medicine has always been an important feature throughout the history of mankind and over the centuries there have been some very drastic studies of it. Samantha Storry investigates whether the use of astrology with medicine was a successful turning point in the world of Medicine or a harmful hindering.

For thousands of years man has looked to the stars for answers. They questioned life and death and about everything in between, around the 5th century the Egyptians started making links between the body and the solar system, as different parts of the anatomy corresponded with the 12 constellations such as the Sun, Moon and remaining planets, these in turn corresponded with the 12 signs of the Zodiac. This formed the basis for the new discipline of medicine that was Astrological studies of the Physick.
The link between astrology and medicine began to loosen when physicians and scientists learned more about the body and the factors that caused disease.

At the turn of the 17th century science was beginning to make huge leaps and bounds in terms of discovery of medicine, and people were starting to change their views rapidly to keep up with the new discoveries. Another reason this happened so quickly was that due to printing and books theories could be spread across the world and be written down and people could learn and expand on others ideas. Communication through books and journals meant that people could compare their works to the works of others all over the world, there were some language barriers but around this time many popular books were now printed in numerous languages. To keep costs down the unnecessary letters and alternate word spellings were made redundant and with the use of things like The Oxford Dictionary for spelling guidelines a language was set up in printing that everyone could understand.

In my investigation I have looked at the prominent names of medical astrologers in the 1700's and how they used astrology in both diagnosing and treating people. I also looked at the history and etymology of the Zodiac star signs and how they changed and arrived at the names they have today in one of my data sheets, I also noticed that the texts I chose were rather spread out and very different from each other considering they were all about the same thing. A main factor throughout history has been religion and its input in the world, especially early history and war time. Prominent religions like the Christian church often censored some texts and disapproved of the messages they portrayed. The majority of the texts include strong reference to God and the religion and hoe heaven and space is all divine creation. Surprisingly the 'Christian Guide to Astrology' written by William Lilly id the earliest text I have chosen but even though the opening letter refers heavily to god and religion the actual first chapter itself has no reference to god or any higher power – purely reference to astrology and medicine. I found that the language used was fairly modern as these texts were fairly recent in terms of history but the graphology of the books was what was most interesting, the fact that they still used old letters that are no longer in circulation and that the texts had detailed illuminated letters made the books look both more important but also more archaic.

I have found that people were very reliant on what they knew and that they truly believed that there was a tangible link between astrology and the 'decumbiture' of peoples illnesses and that although what they knew was never really proven some people still use it today as well as other methods when science has not yet discovered the true answer.



Moderator's comment:
This article addresses an interesting topic, but it isn't fully adapted for its format, and the audience has not been clearly identified. The student makes the common mistake of referring to 'my investigation' in an article presumably written for people who are not aware A-Level Language investigations exist. The content is a bit essay-like, though the material she is working with has the potential to be fascinating.

AO1: the writing is clear and accurate, but the material selected is not fully appropriate for audience and format.

3 marks

AO4: the student is clearly aware of the requirements of format and the style is consistent and generally appropriate. She is not fully aware of the needs of her audience.

10 marks

Task 2

Investigations covered a wide range of topics. Students addressed theory areas that included child language, language change, language diversity, the influence of context on different varieties. There was evidence of real engagement and enthusiasm. The work at the higher end of the achievement range was impressive. One moderator said, 'As usual, I have learned something from moderating this unit, and found out things I did not know,' Research skills were well developed, and even at the lower end of the achievement range, students were carrying out genuine research and coming up with relevant findings.

Topic choice

Interesting and successful topics covered this year included an investigation into the language features associated with primary progressive aphasia, the language of final speeches of US prisoners before they were executed, the language of twin children, Islamophobia in newspapers. Developmental studies of child language were popular, and where the students worked with their data, these were successful. They were less so where students tried to force the data to fit their expectations. Students need to be aware that individual children will vary from the theoretical norms, and they should always work with their data and discuss aspects that seem anomalous, rather than ignore them.

Language and gender was also very popular. This is a topic students like to engage with, but they will not gain much insight if they base their work on outdated theorists. Robin Lakoff does not offer a useful model, even one to refute. They also need to move away from vague and inaccurate concepts such as 'empty adjectives.' Students would be better exploring gendered language and speculating how much of the difference they find relates to external contextual factors, and how much to the gender of the participants. One student carried out a very interesting investigation into the ways in which male and female friendship groups offered each other support or competition. Her findings, that women were competitive while apparently offering support whereas men were more overtly competitive was interesting and would warrant further study.

The language of popular culture was also widely covered: song lyrics, sit-coms, TV soaps and dramas were all investigated with varying degrees of success. Where students had a clear investigative focus and a good research question, these investigations were very successful. A comparison of the representation of the father figure as anti-hero in The Simpsons and Family Guy was a fascinating piece of research. An analysis of three rap artists was less so as the artists in question seem to have been chosen because the student liked them, rather than because he had a specific research question in mind. Similarly, students who want to analyse their favourite TV programmes need to identify a focus. These topics can work very well as long as the students know what they are investigating. An investigation into the perennially popular Friends that looked at the changing ways two key characters were represented over time made a successful investigation. A more general analysis of The Big Bang Theory was not able to provide an investigative focus so the final submission was weak, despite the student's obvious enthusiasm.

Analysis

Students need to be selective in the aspects of language they choose to analyse. A blanket coverage of all key constituents may lead to analysis that is not relevant to the focus of their investigation. Where a specific key constituent is selected, the student needs to be clear why this was selected and be rigorous in the analysis. Where students analyse phonology, they must use the correct IPA symbols, not impressionistic spelling.

For example, the comparison between father figures in Family Guy and The Simpsons looked at terms of address within the family, the use of taboo language, the use of question and command and the formation of alliances within the family group. The analysis of The Big Bang Theory looked at phonology, lexis, syntax, discourse and pragmatic aspects, but was not able to pin down the aspects that gave the show its specific appeal.

In an investigation into the language of US prisoners prior to execution, the student analyses clearly relevant aspects of language, backed up by prior research:

> Tucker employs several of Burke's Guilt Redemption techniques, primarily 'universal scapegoating': "I am a product of **your** creation (2.0) I responded as programmed". Here his use of a second person plural pronoun, combined with language from the lexical field of technology — "programmed" with its connotations of automaton-like obedience to command — shifts the blame entirely from his shoulders and disseminates it amongst all, members of society. This includes the speaker, and creates a further point of identification with the audience. However, this can be counterproductive, as he appears to have explicitly disassociated from his own portion of blame. The audience may have felt personally attacked rather than compelled to associate themselves with him and to feel pity. In addition to this, he specifically targets the State system and those carrying out the execution "although you may not feel the burden of murder as I do (.) you are as much as guilty as I am (1.0) and will be held accountable one day". This is what Burke calls 'fractional

scapegoating', as the executioners are vilified as violators of the ideals of social order, lacking in human decency. The rest of the audience may then unite in animosity towards them. 'They' are depicted as unfeeling killers who do not "feel the burden of murder", in contrast to the weight of Tucker's own conscience; his "burden of guilt". In this way he manages to take the moral high ground in a room full of murderers. The other murderers are not likely to respond positively to this; however, this is of little consequence. Tucker's real target audience are those on the other side of the glass; he hopes to inspire revolution in their hearts and "change the existing laws."

Quantitative data analysis was less popular that qualitative. Pie charts and graphs, where used, were illuminating as long as sufficient data had been collected to warrant these. A welcome development was the use of corpus linguistics by some centres. It was encouraging to see this approach being used, and the investigations produced were interesting and illuminating.

Many students had read widely and were able to apply this knowledge, and knowledge from their English Language studies in general to their data. Much of what they read is a summary of the work of various researchers, and students need to be aware of the difference between people who carry out primary research and writers who report this in text books. For example George Keith and John Shuttleworth are not researchers and should not be quoted as such. Their books provide summaries and compilations of the linguistic research of others.

Conclusions

Conclusions should relate directly to the analysis and should refer back to the original focus of the research. The evaluation can then be drawn from this: what worked, what went against expectations, any weaknesses in the investigation that became apparent as conclusions were drawn, possible further developments in this line of research. Some or all of these issues should be briefly addressed.

Bibliography and Appendices

Bibliographies should cover what the student has actually read, not be long, aspirational lists. Raw data can be included in an appendix.

Task 2 Exemplar 1 – An investigation of how a speech therapist uses targeted child directed speech techniques within a therapeutic setting

(See Appendix for complete exemplar)

Introduction

Speech therapists encounter a range of speech difficulties faced by children throughout their careers. Speech therapists usually work in a friendly environment, ideal for fun and learning. Therapists mostly try to form a bond with their patients in order to stimulate learning and help them to open up and be confident when using language around the therapist. Children are mostly given reinforcement and encouragement in order to develop their speech.

For me to be able to study speech therapy at university I had to undergo some work experience in the field. I was fortunate enough to get a placement with a speech and language therapist in a health centre. I found my first placement very interesting and wanted to understand what makes a good therapist, therefore, I decided to use the work experience as a coursework project.

I have learnt that, for effective treatment therapists have to be able to connect with the children to improve their confidence when speaking to someone, and forming a bond so that the children are able to open up to their therapist. They also have to earn respect from the student, and so many speech therapists adopt a 'teaching style' technique. I have noticed from my observations that this mainly includes the use of child directed speech. This brings me to investigate:

An investigation of how a speech therapist uses targeted child directed speech techniques within a therapeutic setting.

Methodology

I picked a group of three, because the group was not too large and would gain a successful recording as there were not too many voices at once. They had all been having sessions for a long period of time and were quite well known to the therapist. The children were aged 7 and 8, which eliminated age bias in the results. However, I was also able to investigate whether the eldest child was spoken to differently. I was already known by the children, as I had visited their session a couple of times previously. Therefore they did not feel as if they were being observed, or that the environment was unnatural and the therapist had a relationship with the children meaning that she had conversed with them before and learnt how to talk to them individually as well as a group.

I obtained consent from the children's parents who I was going to record in the sessions. (See the appendix.)

I chose to carry out my coursework with a particular speech therapist I was familiar with and I had done previous work experience with. This was a benefit in that the speech therapist was used to having me in her sessions and so would act more naturally than speech therapists who were unknown to me. However, there were issues as I was involved in the sessions, a lot more than I wanted to be. To overcome the observer's paradox, I familiarised myself with the children before the session, making sure I had previously taken part in sessions they were in and having the speech therapist introduce me as her 'friend' that was helping her within the sessions. Also, so that the children did not think they were being observed they were not told they were being recorded and the dictaphone was placed out of their sight, so that the experiment was as natural as possible. I wanted to feature in the transcript as little as possible so that I would have the least amount of impact on the therapist's speech.

I observed a few sessions, with separate groups of children, with a speech therapist to begin with so that the therapist felt in a natural environment, and on the third session I recorded a group session with two boys and one girl. The session was held in the therapy room, making the environment very naturalistic and the dictaphone was out of sight so that the children did not feel they were being analysed. The session lasted 35 minutes and consisted of a range of pronunciation exercises which were made into game-like activities, such as following written instructions and drawing food.

For my transcripts, I developed a key: interruptions were indicated using '/' and overlaps were indicated using ' | ' the person who was speaking was indicated with the initial of their first name 'H', 'ST' for speech therapist and 'M' for myself. The words which were used in my analysis as examples were shown in bold font. These transcriptions were analysed and my findings were based on this research alone. Indications of overlapping and interruptions allowed me to investigate patterns in footing, power, Bruner's theories and child directed speech.

Analysis

Footing

The therapist asserts her higher authority discretely, she does this by applying the **consultative level** of **formality**, with a mixed casual and formal tone, when talking to the children, by the use of **footing** techniques, such as **discourse markers** and **framing moves** ("*right*", "*ok so first of all*") which shows the children that she is the person of higher footing and they must co-operate with her when she creates a topic shift in order to be polite. The children also co-operate to her topic shifts because she does, mostly, with theirs' ("*do they (.) why*"). The therapist however does not directly prove her higher authority to the child as she creates a friendly and relaxed **tenor** with the children by the use of **jocular language** in order to converge with the children, ("*shall we stick it to you... no I'm just teasing*").

She also uses many **imperatives** with a relaxed tenor within her speech, ("*go on turn it over*", "*put your hands up if you have a pet*") as well as **mitigated imperatives**, (*"would you like to pick from here which your sound is", "H's turn"*) which also asserts her higher status within the interaction, enabling her to hold the floor within the conversation. However, the therapist not only asserts her authority, but she also shows concern for their feelings. For example, A was talking about his father who had recently died, ("[redacted] *is my dad's name*"), and whilst correcting his virtuous error with regards to the tense, ("*y-your dad was called* [redacted] *wasn't he,*") she also raises the tone in her voice, to create a more sympathetic and interested tone.

Child Directed Speech

The therapist talks to the children with the use of **positive reinforcement** ("*excellent", "good girl"*) to stimulate their learning and make them see learning language as a fun experience. In a usual speech therapy session the therapist will use a high degree of **positive reinforcement** as theorised by the **behaviourist** approach, however, the heightened frequency of its usage suggests a **child directed speech** at play, also. [See table 1]

She also uses **simple, monosyllabic lexis**, ("*stuff*", "*leaf*") so that the children are able to understand her language and learn from the communication easily as she is getting them to **phonetics** and how to pronounce **lexis** they would use every day rather than trying to expand their vocabulary. More complex words could be used in replacement, such as '*documents'* instead of "*stuff*". Also the therapist suggests the **noun**, "*leaf*" to match L's name where she possibly might have used more complex lexis with an older group of children, such as '*lightening*'. Her **concrete language** ("*have a look in the mirror*", "*yours has got a smiley face*") allows her to **converge** with the children by commenting on the sources available in the context, for example, when she is talking about 'smiley faces' she is looking at the pictures the children have drawn for their homework. This enables her to form a bond with them more easily, in turn, improving their confidence when speaking.

The therapist also uses many **politeness features** when using **imperatives** by the use of **mitigated imperatives** (*"would you like to pick from here which is your sound", "let's look at A's then"*) and **hedges** (*"then we'll just pop them", "let's just pop them"*). This allows the therapist to form a familiar relationship with the children as she is friendly and respectful towards them within her speech patterns, sometimes applying the **casual level** of **formality**, allowing her to gain more respect from the children which stimulates their learning.

The therapist also uses **back channelling behaviour** (*"ok (5) right", "ah hum"*) in order to create **positive reinforcement** for the child whilst they are pronouncing difficult areas of their speech (". "). It also shows the children that the therapist is listening to them and will, as a result, expand further on what they are saying and correcting the words they say incorrectly; for example, when H says the word sister as (*"siher."*) The therapist repeats her lexis once, correctly, (*"hop if you have a sister,"*) so that she is not making the child embarrassed that they said it wrong, however, she is still subtle enough whilst correcting them.

The therapist also shows a high degree of **repetition** towards the children (*"that one"*, *"stand up if you have blue eyes"*) in order to emphasise the **declarative**. For example, the therapist repeats what the other child has read out previously (*"hop if you have a siher"*) in order for the other children to understand what was said by the child with the speech impediment. This makes the language more accessible to the other children as well as reinforcing what the other child has previously said. This is a pattern in the session, as it occurs each time a child reads out a card; sometimes, it is non-corrective and is more for the other children's benefit, as they may not have understood the other child's pronunciation.

Frequent interrogatives are also used mostly in the form of **tag questions**, (*"it's a hard one actually is a K for a boy's name isn't it"*, *"y-your dad was called wasn't he"*) in order to get the child to use expansion in their sentences, which in turn develops their vocabulary and improves pronunciation by filling out their sentences structures.

The therapist uses the child's name when interacting with one of the children, (*"H you turn over the first card then"*, *"and L"*) so that she is able to capture their full attention and all the children know exactly who she is talking to and do not **interrupt** the interaction. This teaches the children about the rules of **turn-taking** and how to co-operate with each other within communication, bringing all the children out of the **egocentric** stage in their development, as they tend to overlap, and so they will begin to listen to others.

In the transcript there is considerable evidence for the use of **deixis** in the therapist's language, (*"first girl's name here"*) as the children are able to understand **context dependent lexis** because they are in the same environment as the therapist and the children can associate the reference to the therapist's body language. By using **context dependent lexis** and **deixis** the therapist is able to determine whether the children are able to understand **past** (*"I've played this"*), **present**, (" *is my dad's name"*) and **future participles** and are able to use them in their own language. By finding this out the therapist is able to determine where the

child is in terms of language development, and is able to adapt her language style and techniques to suit the needs of the child.

There is also evidence of many **expansions** ("*cards on our back and we had to guess*", "*hop is you have a sister so everyone with a sister*") and **re-castings** ("*has he got blue eyes*", "*tiger or a lion do you think*") as a type of repetition which creates **positive reinforcement** for the child and a way of showing them how to expand their vocabulary. The therapist uses **recasting** and **expansions** in order to show the children how to elaborate on their sentences by providing a role model for them to copy. She does not make the children copy her in most instances, but she provides an example naturally whilst she is speaking because she is deemed a significant other to the children. For this reason, they will learn from her examples through **social learning theory**. During the transcript, at the point where the therapist says, "*cards on our back and we had to guess,*" the therapist is leaving the sentence open for some of the children to chip in with their **expansions** for the sentence, as well as providing **positive reinforcement** when one child tries to have a go ("*go on*"). By doing this, the therapist is showing the children how to use **conjunctions** ("*and*") and starting the sentence for them, allowing a starting point from which they have to continue the sentence.

Table 1: A table to show the frequency of child-directed speech features used by the therapist:

Tag questions	Deixis	Mitigated imperatives	Positive reinforcement	Re-casting	Expansions	Repetition
19	102	10	18	11	11	32

Differences In Speech Patterns When Communicating With Different Ages

These examples of **child directed speech** are only used when talking to the children in this session. I have come to this conclusion due to identifying that the therapist interacts with the older child in a different way to the other two. Firstly, she uses **higher register lexis** ("*that was a good description* ") **past tense** ("*that was*"), **future tense** ("*do this game again next week*"), **complex sentences** ("*a lot of friends can be can't they even when they're your friends*"), more **direct imperatives**, ("*describe your best friend*", "*have a look in the mirror*"), less direct **interrogatives** ("*and* L"), and more **deixis** ("*you'll get that*") as he is able to respond to the **context** of the situation.

Table 2: A table to show the differences of key language features used by the therapist, between younger and older children:

	Deixis	Past/future tenses	High register lexis	Complex sentences	Direct imperatives	Indirect interrogatives
Older child	49	33	6	12	18	10
Younger children	53	38	7	5	19	4

(Take into account, there are two younger children and one older child.)

Moderator's comments:

This is an ambitious investigation that the student has carried out well. She is interested in speech therapy as her area of research, and has focused on the way in which speech therapists use child directed speech when working with children. The investigation is thorough and meticulous, and the aspects of language the student chooses to analyse have been carefully chosen.

AO1: the research methodology has been carefully chosen and applied rigorously. The research is supported with good exemplification, the use of terminology is accurate and the investigation itself is written fluently and confidently.

9 marks

AO2: the student understands the area of linguistics she is investigating and approaches her topic knowledgeably and with investigative rigour. She is fully aware of the significance of her results. Her approach is open-minded and she demonstrates a clear understanding of of theory relevant o her investigation.

12 marks

AO3: the student is fully aware of the context of her data, and analyses her chosen constituents of language with rigour and accuracy.

14 marks

AO4: the investigation shows evidence of independence and open-mindedness. It is written with the reader in mind. The analysis is presented clearly and the submission is structured and signposted to assist the reader.

12 marks

APPENDIX – Complete folder for Task 1 Exemplar 1 and Task 2 Exemplar 1

English Language Coursework: Task one

Talk to speech therapist trainees

[*slide* 1] Thank you all for attending. The topic of this talk, today, is to provide a wide range of people with more knowledge about a career in speech therapy and how you can become an effective therapist. The focus of this particular talk, however, is the use of child directed speech and the relevance of it within your practice.

Signals topic clearly

[*slide* 2] Firstly, I would like to begin with a scenario. [*play clip of Sam with impaired* speech] Imagine yourself with a child named Sam, who has speech difficulties. Sam has problems with pronouncing velar consonants, such as 'g' and 'c'. He appears to be able to produce labial and dental sounds efficiently at the front of the mouth, as he is able to place his tongue in the correct position. As a therapist you would ask yourself, how am I supposed to tackle this situation?

[*slide* 3] These problems occur daily in your speech therapy case load and this is a common dilemma that you would come across. How each individual therapist deals with the situation, however, is always unique. Where one therapist would try to form a relationship with the child by the use of jocular language and phatic utterances, another therapist may create a teaching environment through the passing of information and complex, formal language to assert a higher position in the interaction. However, there is common ground between therapists, where certain techniques underpin all of our work. One of which is child directed speech, which allows you to 'converge', or match your style of language with children and help them to open up to you.

Glosses specialist term for audience

[*slide* 4] Child directed speech is a highly useful technique when working with children. It is seen by psychologists, including Bruner, to retain children's attention by the use of high rising tones when asking questions and diminutive forms. For example, the word 'doggie', this makes language more accessible to the child. Even though Bruner believes that children are pre-adapted to learning, he still thinks that child directed speech stimulates the child to speed up cognitive development, along with the involvement of adults and knowledgeable peers.

[*slide* 5] Bruner also believes that children learn by repetition, as it helps to reinforce the maturing of their cognitive development. We, as speech therapists would typically use recasting- involving repeating a phrase or word a child has said and placing it in your own sentence- and expansions- involving re-using the sentence or word a child has used and expanding the vocabulary and sentence structure of it, [*play recording 1 of the therapist reusing the children's sentences in her phrases*] as well as emphasis of key words as a type of repetition. Repetition, re-casting and expansions are all features of child directed speech.

Reiterates meaningful context to talk

[*slide* 6] So, what is Child Directed Speech?

Creates cohesive links between topics

It is a speech pattern used by any adult when speaking to a young child. Features of child directed speech range from changes in lexis such as concrete language "good," "hard" to phonology, such as high rising intonation on questions, "really?" and grammar, such as one word utterances "right." The main aim of this type of speech is to capture the attention of the learning child and to reinvent language as a game, making language acquisition fun.

You don't have to be worried about finding that balance between implying a patronising tone and effective child directed speech. Psychologists consider child directed speech to be a natural teaching mechanism, aimed at children, naturally occurring for an adult. Whether you are a parent, grandparent or a speech therapist, child directed speech will come naturally to you.

[*slide* 7] But does it really work? Well, these child directed speech techniques were used on Sam and look at his progress. [*play clip3 of Sam with improved pronunciation*]

Returns to original anecdote to demonstrate point

Sam has been receiving therapy sessions for a few months now; he has been practising pushing his tongue up to the roof of his mouth when pronouncing difficult sounds. He receives much encouragement from his therapist by the use of positive reinforcement, recasting and repetition. [*play clip 4*] During his sessions the therapist repeats the same exercises. However, she makes them interesting by the use of high rising intonation, and jocular language [*play clip 5*].

Recycles terms to exemplify them

[*slide 8*] After seeing Sam's improvements within his speech, child directed speech seems a very useful technique. However, there are many more techniques within the speech therapy role involving practical work, exercises and psychological techniques. Which technique or techniques you use is dependent on your experiences and what works for you as a therapist. Remember though that a child-centred approach is often the most effective one.

Speech Therapy and Child Directed Speech

Welcome!

What will I gain from this talk?

Sam

How am I supposed to tackle this situation?

Different Therapist Styles




Child Directed Speech

'Doggie' or 'dog'?

A child would more likely associate 'doggie' with this picture than 'dog'.

Repetition

Is a technique associated with CDS.

What Is CDS?


Sam's Improvements

What Technique Will You Choose?

Task 2 **Language Investigation** **Scores Summary**

Name: Candidate Number:

AO1: 9	AO2: 12	AO3: 14	AO4: 12

AO1 – Band 4

Clear, fluent writing, with everything clearly set out and formatted correctly. The analysis offers extensive exemplification, with a wide array of linguistic terms covering all the key constituents. The methodology offers a lucid discussion of how validity and reliability was achieved, with a sensible discussion of overcoming the Observer's Paradox. The evaluation discusses clearly what routes for further study would be most fruitful, and how idiolect bias in the data could be accounted for.

AO2 – Band 4

The introduction offers a clear and practical rationale for the investigation and identifies child-directed speech (CDS) as a viable tool in speech therapy. Uses linguistic approaches assiduously to explore features of CDS in the analysis. The conclusion is initially a little facile, which is a shame, although she does compare frequency of CDS use against that of behaviourist principles.

AO3 – Band 4

Context is discussed fully and with confidence, and is always rooted in analysis of theory and grammar simultaneously. There is some insightful discussion of Joos and some reflective comments on the therapist's sensitivity to client needs. Key constituents are used rigorously, with a wide array of terminology.

AO4 – Band 4

Cohesive, confident and exploratory investigation, written in a style entirely appropriate for the task. Linguistic analysis is explored at considerable length; it is a shame, however, that the initial conclusion was a little self-evident.

An investigation of how a speech therapist uses targeted child directed speech techniques within a therapeutic setting.

Word Count- 2,323

Contents

Introduction

Speech therapists encounter a range of speech difficulties faced by children throughout their careers. Speech therapists usually work in a friendly environment, ideal for fun and learning. Therapists mostly try to form a bond with their patients in order to stimulate learning and help them to open up and be confident when using language around the therapist. Children are mostly given reinforcement and encouragement in order to develop their speech.

For me to be able to study speech therapy at university I had to undergo some work experience in the field. I was fortunate enough to get a placement with a speech and language therapist in a health centre. I found my first placement very interesting and wanted to understand what makes a good therapist, therefore, I decided to use the work experience as a coursework project.

I have learnt that, for effective treatment therapists have to be able to connect with the children to improve their confidence when speaking to someone, and forming a bond so that the children are able to open up to their therapist. They also have to earn respect from the student, and so many speech therapists adopt a 'teaching style' technique. I have noticed from my observations that this mainly includes the use of child directed speech. This brings me to investigate:

An investigation of how a speech therapist uses targeted child directed speech techniques within a therapeutic setting.

Methodology

I picked a group of three, because the group was not too large and would gain a successful recording as there were not too many voices at once. They had all been having sessions for a long period of time and were quite well known to the therapist. The children were aged 7 and 8, which eliminated age bias in the results. However, I was also able to investigate whether the eldest child was spoken to differently. I was already known by the children, as I had visited their session a couple of times previously. Therefore they did not feel as if they were being observed, or that the environment was unnatural and the therapist had a relationship with the children meaning that she had conversed with them before and learnt how to talk to them individually as well as a group.

I obtained consent from the children's parents who I was going to record in the sessions. (See the appendix.)

I chose to carry out my coursework with a particular speech therapist I was familiar with and I had done previous work experience with. This was a benefit in that the speech therapist was used to having me in her sessions and so would act more naturally than speech therapists who were unknown to me. However, there were issues as I was involved in the sessions, a lot more than I wanted to be. To overcome the observer's paradox, I familiarised myself with the children before the session, making sure I had previously taken part in sessions they were in and having the speech therapist introduce me as her 'friend' that was helping her within the sessions. Also, so that the children did not think they were being observed they were not told they were being recorded and the dictaphone was placed out of their sight, so that the experiment was as natural as possible. I wanted to feature in the transcript as little as possible so that I would have the least amount of impact on the therapist's speech.

I observed a few sessions, with separate groups of children, with a speech therapist to begin with so that the therapist felt in a natural environment, and on the third session I recorded a group session with two boys and one girl. The session was held in the therapy room, making the environment very naturalistic and the dictaphone was out of sight so that the children did not feel they were being analysed. The session lasted 35 minutes and consisted of a range of pronunciation exercises which were made into game-like activities, such as following written instructions and drawing food.

For my transcripts, I developed a key: interruptions were indicated using '/' and overlaps were indicated using ' | ' the person who was speaking was indicated with the initial of their first name 'H', 'ST' for speech therapist and 'M' for myself. The words which were used in my analysis as examples were shown in bold font. These transcriptions were analysed and my findings were based on this research alone. Indications of overlapping and interruptions allowed me to investigate patterns in footing, power, Bruner's theories and child directed speech.

Analysis

Footing

The therapist asserts her higher authority discretely, she does this by applying the **consultative level** of **formality**, with a mixed casual and formal tone, when talking to the children, by the use of **footing** techniques, such as **discourse markers** and **framing moves** ("*right*", "*ok so first of all*") which shows the children that she is the person of higher footing and they must co-operate with her when she creates a topic shift in order to be polite. The children also co-operate to her topic shifts because she does, mostly, with theirs' ("*do they (.) why*"). The therapist however does not directly prove her higher authority to the child as she creates a friendly and relaxed **tenor** with the children by the use of **jocular language** in order to converge with the children, ("*shall we stick it to you... no I'm just teasing*").

She also uses many **imperatives** with a relaxed tenor within her speech, ("*go on turn it over*", "*put your hands up if you have a pet*") as well as **mitigated imperatives**, (*"would you like to pick from here which your sound is", "H's turn"*) which also asserts her higher status within the interaction, enabling her to hold the floor within the conversation. However, the therapist not only asserts her authority, but she also shows concern for their feelings. For example, A was talking about his father who had recently died, ("[illegible] *is my dad's name*"), and whilst correcting his virtuous error with regards to the tense, ("*y-your dad was called* [illegible] *wasn't he,*") she also raises the tone in her voice, to create a more sympathetic and interested tone.

Child Directed Speech

The therapist talks to the children with the use of **positive reinforcement** ("*excellent", "good girl"*) to stimulate their learning and make them see learning language as a fun experience. In a usual speech therapy session the therapist will use a high degree of **positive reinforcement** as theorised by the **behaviourist** approach, however, the heightened frequency of its usage suggests a **child directed speech** at play, also. [See table 1]

She also uses **simple, monosyllabic lexis**, ("*stuff*", "*leaf*") so that the children are able to understand her language and learn from the communication easily as she is getting them to **phonetics** and how to pronounce **lexis** they would use every day rather than trying to expand their vocabulary. More complex words could be used in replacement, such as '*documents'* instead of "*stuff*". Also the therapist suggests the **noun**, "*leaf*" to match L's name where she possibly might have used more complex lexis with an older group of children, such as '*lightening*'. Her **concrete language** ("*have a look in the mirror*", "*yours has got a smiley face*") allows her to **converge** with the children by commenting on the sources available in the context, for example, when she is talking about 'smiley faces' she is looking at the pictures the children have drawn for their homework. This enables her to form a bond with them more easily, in turn, improving their confidence when speaking.

The therapist also uses many **politeness features** when using **imperatives** by the use of **mitigated imperatives** (*"would you like to pick from here which is your sound", "let's look at A's then"*) and **hedges** (*"then we'll just pop them", "let's just pop them"*). This allows the therapist to form a familiar relationship with the children as she is friendly and respectful towards them within her speech patterns, sometimes applying the **casual level** of **formality**, allowing her to gain more respect from the children which stimulates their learning.

The therapist also uses **back channelling behaviour** (*"ok (5) right", "ah hum"*) in order to create **positive reinforcement** for the child whilst they are pronouncing difficult areas of their speech (". "). It also shows the children that the therapist is listening to them and will, as a result, expand further on what they are saying and correcting the words they say incorrectly; for example, when H says the word sister as (*"siher."*) The therapist repeats her lexis once, correctly, (*"hop if you have a sister,"*) so that she is not making the child embarrassed that they said it wrong, however, she is still subtle enough whilst correcting them.

The therapist also shows a high degree of **repetition** towards the children (*"that one"*, *"stand up if you have blue eyes"*) in order to emphasise the **declarative**. For example, the therapist repeats what the other child has read out previously (*"hop if you have a siher"*) in order for the other children to understand what was said by the child with the speech impediment. This makes the language more accessible to the other children as well as reinforcing what the other child has previously said. This is a pattern in the session, as it occurs each time a child reads out a card; sometimes, it is non-corrective and is more for the other children's benefit, as they may not have understood the other child's pronunciation.

Frequent interrogatives are also used mostly in the form of **tag questions**, (*"it's a hard one actually is a K for a boy's name isn't it"*, *"y-your dad was called wasn't he"*) in order to get the child to use expansion in their sentences, which in turn develops their vocabulary and improves pronunciation by filling out their sentences structures.

The therapist uses the child's name when interacting with one of the children, (*"H you turn over the first card then"*, *"and L"*) so that she is able to capture their full attention and all the children know exactly who she is talking to and do not **interrupt** the interaction. This teaches the children about the rules of **turn-taking** and how to co-operate with each other within communication, bringing all the children out of the **egocentric** stage in their development, as they tend to overlap, and so they will begin to listen to others.

In the transcript there is considerable evidence for the use of **deixis** in the therapist's language, (*"first girl's name here"*) as the children are able to understand **context dependent lexis** because they are in the same environment as the therapist and the children can associate the reference to the therapist's body language. By using **context dependent lexis** and **deixis** the therapist is able to determine whether the children are able to understand **past** (*"I've played this"*), **present**, (" is my dad's name") and **future participles** and are able to use them in their own language. By finding this out the therapist is able to determine where the

child is in terms of language development, and is able to adapt her language style and techniques to suit the needs of the child.

There is also evidence of many **expansions** ("*cards on our back and we had to guess*", "*hop is you have a sister so everyone with a sister*") and **re-castings** ("*has he got blue eyes*", "*tiger or a lion do you think*") as a type of repetition which creates **positive reinforcement** for the child and a way of showing them how to expand their vocabulary. The therapist uses **recasting** and **expansions** in order to show the children how to elaborate on their sentences by providing a role model for them to copy. She does not make the children copy her in most instances, but she provides an example naturally whilst she is speaking because she is deemed a significant other to the children. For this reason, they will learn from her examples through **social learning theory**. During the transcript, at the point where the therapist says, "*cards on our back and we had to guess,*" the therapist is leaving the sentence open for some of the children to chip in with their **expansions** for the sentence, as well as providing **positive reinforcement** when one child tries to have a go ("*go on*"). By doing this, the therapist is showing the children how to use **conjunctions** ("*and*") and starting the sentence for them, allowing a starting point from which they have to continue the sentence.

Table 1: A table to show the frequency of child-directed speech features used by the therapist:

Tag questions	Deixis	Mitigated imperatives	Positive reinforcement	Re-casting	Expansions	Repetition
19	102	10	18	11	11	32

Differences In Speech Patterns When Communicating With Different Ages

These examples of **child directed speech** are only used when talking to the children in this session. I have come to this conclusion due to identifying that the therapist interacts with the older child in a different way to the other two. Firstly, she uses **higher register lexis** ("*that was a good description* ") **past tense** ("*that was*"), **future tense** ("*do this game again next week*"), **complex sentences** ("*a lot of friends can be can't they even when they're your friends*"), more **direct imperatives**, ("*describe your best friend*", "*have a look in the mirror*"), less direct **interrogatives** ("*and* L"), and more **deixis** ("*you'll get that*") as he is able to respond to the **context** of the situation.

Table 2: A table to show the differences of key language features used by the therapist, between younger and older children:

	Deixis	Past/future tenses	High register lexis	Complex sentences	Direct imperatives	Indirect interrogatives
Older child	49	33	6	12	18	10
Younger children	53	38	7	5	19	4

(Take into account, there are two younger children and one older child.)

Conclusion and Evaluation

It seems that the therapist uses a high frequency of **child directed speech** features, mainly, features such as a high level of **correction** and **non-face threatening acts** from the therapist. The therapist created a very friendly and helpful environment for the children and tried to create a bond with them by playing games that would help her to gain more information about them. Certain **child directed speech** features such as **non-face threatening acts**, **convergence**, **indirect correction**, **jocular lexis** and **simple lexis** allowed her to foster sensitivity towards the children and the situation. The entire range of **child directed speech** features may not use every technique in their language, such as **diminutive forms** and **repeated sentence frames**. However, they do use most of the features associated with **child directed speech** such as **expansions**, **re-casting** and **deixis**. Firstly, **deixis** is used in order for the therapist to determine whether the child can understand **past**, **present** and **future participles** in order to understand where about they are situated in the cognitive development process. **Recasting** and **expansions** are used in order for the therapist to show the children how to expand their sentences and how to use words in different **contexts** and experiment with **pragmatic** meanings.

Therefore, I would conclude that the therapist uses **child directed speech** to a high degree in her therapy session, when helping with pronunciation, more than she uses behaviourist features such as positive reinforcement.

I would need to investigate further because one therapy session may differ from others in terms of the methods and activities used, a different therapist may have different methods and there may be idiolect bias. I would observe around ten more sessions with at least five different therapists and a variety of different speech implications within children's speech difficulties, such as pronunciation, age of children, stammers, lisps, late speech and mutism, if I were to make certain that therapy includes the technique in every session and to provide valid data in order to develop an accurate theory. I could also do a cross-comparison of CDS and behaviourist strategies and investigate which method would improve development in the children the most.

Grade Boundaries

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