Bilingual Assessment of Simple Sentences (BASS)

An expressive language screening assessment of
early sentence production
for children with a Pakistani heritage background
speaking Mirpuri, Punjabi or Urdu as a home language in the UK

Devised by
Dr Sean Pert and Dr Carol Stow

Translations by Zahida Warriach. Illustrations by Angie Brain,
based on original photography by Dave Freeman

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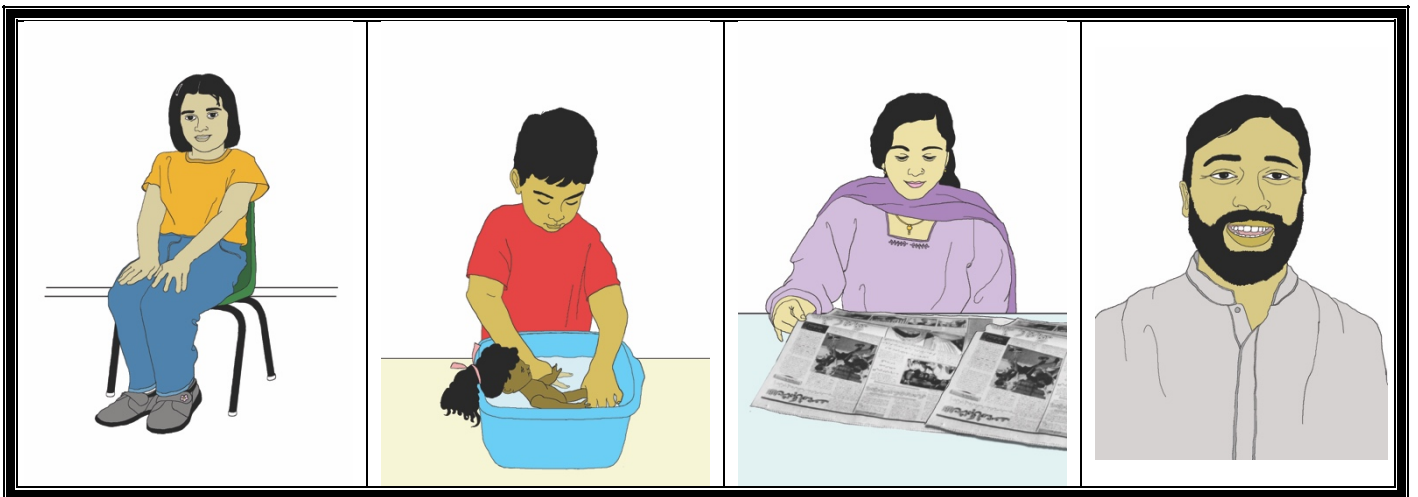© 2019

MANUAL

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Dr Sean Pert and Dr Carol Stow

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The assessment was devised by Dr Sean Pert as part of his PhD studies, with comments, suggestions and improvements made by Dr Carol Stow and Dr Carolyn Letts, Newcastle University.

Dr Carol Stow, retired Consultant Speech and Language Therapist in Bilingualism receives special thanks. Carol had the vision to build a specialist speech and language therapy service for bilingual children and their families in an area of high socioeconomic deprivation. This service was designed around and with the local community, including the development of specific bilingual care pathways, the employment of local bilingual individuals, the selection of culturally appropriate toys and pictures and the design and décor of the clinic building.

This service employed three specialist speech and language therapists, as well as seven bilingual speech and language therapy assistants. The service delivered assessment and therapy in home language (mother tongue). '…possibly the only SLT department in the country that works so passionately with other languages, and adapts both assessments and therapy for other languages' (Warriach, 2006).

The value of this approach was proved by the overwhelmingly positive feedback provided by numerous local families, whose children maintained their home language despite experiencing speech, language and communication difficulties. In doing so, these families were able to preserve their language and culture. The service was visited on numerous occasions by speech and language therapists, researchers and practitioners from the UK and abroad. The service also introduced student speech and language therapists to the fascinating area of bilingualism. It was in this very special service that the assessment was devised, honed and completed. Feedback from the entire clinical team means that BASS is also an effective clinical screening assessment as well as a research tool.

The team, led by Dr Carol Stow contributed to the bilingualism guidelines in the first versions of RCSLT's professional standards, *Communicating Quality* (1996, 2006)*,* as well as RCSLT Position Papers (2015) and numerous research articles and book chapters.

Dr Carol Stow was made a Fellow of the Royal College of Speech and Language Therapists in recognition of this important national and international contribution to the field of bilingualism. Dr Carol Stow and Dr Sean Pert were also awarded the Sternberg Award for Clinical Innovation for their work on bilingual assessment (2005).

The target sentences were translated by Zahida Warriach. Zahida is an award-winning bilingual speech and language therapy assistant (Chartered Institute of Linguists, 2005) with knowledge of Pakistani heritage languages including Mirpuri, Punjabi and Urdu as well

as English. Zahida has extensive experience of working with specialist speech and language therapists to deliver assessment and therapy in home language.

The picture materials are based on original photography by Dave Freeman. The illustrations were made by Angie Brain.

Many thanks to the models who sat for the original photographs, giving their own time to assist children with speech, language and communication difficulties. These photographs have been adapted in the published illustrations to ensure anonymity of these models.

Many thanks to the children and families who contributed freely to the development of this assessment. The development of the normative data and important research findings would not have been possible without their involvement.

Introduction

The Royal College of Speech and Language Therapists (RCSLT) provide clinical guidelines for working with bilingual clients. The guidelines state that 'Assessment and intervention must always be carried out in both/all languages.' (2018).

The *Bilingual Assessment of Simple Sentences* (BASS) is an example of a screening assessment that is designed to be delivered in the client's home language (mother tongue). It was devised as a research tool to elicit an expressive language sample from children who speak a Pakistani heritage language, Mirpuri, Punjabi or Urdu in England.

This research tool was used extensively by a specialist bilingual children's speech and language therapy service in the North West of England and was found to be a useful descriptive assessment of children's early expressive language skills.

The assessment was designed with the following key features:

- Ethnically and culturally appropriate picture stimuli
- Able to describe the child's language skills regardless of whether the child uses home language only, English only or code-switched expressive language
- Capable of being delivered and analysed by a monolingual English-speaking speech and language therapist working alongside a bilingual professional such as a professional interpreter or bilingual speech and language therapy assistant.

The development of this assessment has previously been described in detail by Pert and Stow, (2001), and the data collected described by Pert and Letts (2003). The full research project is described in detail by Pert (2007).

Language disorder and the bilingual child

It is important to recognise that 'Bilingualism does not cause, or contribute to, a speech, language or communication disorder' (RCSLT, 2018).

It is one of the aims of this assessment that the child's full range of abilities across both / all languages is discovered. Comparison to the monolingual English child is both inappropriate and theoretically invalid.

The assessment examines first sentences in Mirpuri, Punjabi, Urdu and separately, English. The syntactic structure of simple sentences in home language (mother tongue) contrasts radically with that of English. A child with a Pakistani heritage background growing up in the UK typically acquires a home language (mother tongue) other than English. They then go on to acquire English as an additional language (EAL). In common with most bilingual children in the UK, these children are sequential bilinguals. He or she is therefore faced with acquiring two radically different language codes. It would indeed be remarkable if the bilingual child did not show differences in patterns of acquisition when compared to the monolingual English child.

Since the sequential bilingual child is faced with the task of learning two or more languages, it is likely that they will be at a different stage to their monolingual English-speaking counterparts in the early years of education. This should not be considered 'delayed language development', since they have often completed their home language acquisition. *English as an Additional Language* (EAL) learning is not a disorder and, if the child's home language is developing as expected, should not be treated as a clinical disorder by speech and language therapists.

That being said, most children from this community are living in areas of high socio-economic deprivation. This means that *in general*, their language development as a whole (including home language and EAL) may be less advanced than their peers living in relatively affluent areas (Law *et al.* 2013). Other risk factors for language development must also be considered (Vernon-Feagans *et al.* 2011). Bilingual children are just as likely as their monolingual peers to experience language disorder (Winter, 2001). Bilingualism itself will never be the cause for this impairment.

If language disorder is present, it will be evident in both/all languages the child is exposed to/speaks (Paradis, Genesee & Crago, 2011). If the child has well-developed home language, then by definition they are not language disordered since they have 'cracked the code' for at least one language. Given sufficient exposure to English, they will be able to acquire that language with ease and without additional help. It is important to remember that basic language skills develop in the first few years of exposure to an additional language, but that the ability to understand and use an additional language such as English for formal educational purposes may take as long as seven years. See Cummins (2000) for a full discussion of Basic Interpersonal Communication Skills (BICS) and Cognitive Academic Language Proficiency (CALP).

Assessment for language disorder must therefore be carried out in both/all languages, and difficulties should be evident in both/all the languages spoken by the child, not just their additional language (Kohnert, 2010).

It is important to recognise that children are likely to hear a code-switched model of language from their parents and siblings. Pakistani heritage languages have been in contact with English for several generations and there have been borrowings from English into the home language (mother tongue). For example, 'ball' is now fully integrated into this community of speakers, and although a home language lexical item exists ('gend'), it is rarely encountered. This phenomenon is of course a two-way process; English acquires lexical items from other languages. Consider 'bungalow' and 'pyjamas', Urdu words of Indian origin (Yule & Burnell, 1994).

Similarly, it is likely that children will treat content items (nouns and verbs) from their home language and in English as synonyms (Pert, 2007). Young children when asked, would consider items such as 'girl', 'chair' and so on in English as home language words. It is likely that children will insert content words into a sentence frame, with the content being drawn from either the home language lexicon *or* the English lexicon. The spoken sentence must therefore be considered according to the sentence frame and which language has set that frame. This is discussed in more detail, below.

Code switching has in the past been seen as a sign of linguistic confusion. Research has shown that bilingual children are able to code switch, following a fixed grammar from the age of around 3;6, in the same way as adults (Pert and Letts, 2006). Children with recognised language disorder are not able to code switch in this way. Contrary to what was previously thought, **an absence or difficulty with code switching is indicative of language disorder, while the frequency of code switching increases with age in children and young people with typical bilingual language development** (Pert, 2007; Pert & Letts, 2006; Greene, Peña & Bedore, 2012).

Code switching will, of course, be most frequently observed in bilingual-to-bilingual communication when both speakers can understand both/all languages. Even young children are aware that speakers from a different community will not be able to understand them if they speak home language, and so monolingual English speakers are likely to elicit very limited English only utterances from children. Children are aware of pragmatic rules governing language use. This is why working alongside interpreters is crucial to obtaining an accurate and holistic language sample encompassing bilingual utterances.

Recently the terminology around language difficulties has been debated. It was highlighted that the myriad terms for language difficulties, including *Specific Language Impairment* (SLI), *Language Disorder* and other permutations was both confusing and hampering research and public awareness of this common condition. *Language delay / Delayed language* are frequently used diagnostic labels for young children with language difficulties. This term is linked to the observation that some young children have very limited language skills and then are 'late bloomers'. Research has shown that children will have 'bloomed' by 2;6. As such, language delay is not an appropriate diagnostic label, and *Language Disorder* and *Developmental Language Disorder* should be used instead. This is true, even if the language difficulty is associated with socio-economic deprivation. The label of language delay suggests that the difficulties will spontaneously resolve given time, and this is clearly not the case (Bishop *et al.,* 2016a, 2016b).

Bilingualism and multilingualism

For the purposes of this manual, 'bilingual', in reference to a child, is where the child is exposed to more than one language during the course of everyday life. A child may already have some ability in two or more languages, or may be *monolingual in a home language* and expected to develop an additional language.

Client group

This assessment is designed for children with a Pakistani heritage background from the ages of 2 years 6 months to 6 years of age, suspected of having an expressive language disorder. This wide age range is included as the assessment was developed in an area of recognised high socioeconomic deprivation.

The assessment may be used descriptively with other communities **with caution**. Speech and language therapists should consider developing their own culturally appropriate assessments for local bilingual communities in order to achieve best results. It is recommended that SLTs use the Translation Protocol and this assessment as a model for such assessments.

Aims of the screening assessment

1. To screen early expressive language skills

The assessment aims to assess the development of early expressive language skills by examining a child's ability to produce simple sentences when describing culturally appropriate picture stimuli.

The assessment examines a child's ability to produce simple sentences, in home language (mother tongue) or English, or both in the same utterance (Intrasentential code-switching), as deemed appropriate. The home language (mother tongue) may be Mirpuri, Punjabi or Urdu (See *Assessment Languages*, below).

Assessment is both qualitative and quantitative. The qualitative analysis yields information on how the child is forming sentences. The quantitative assessment allows the therapist to compare scores over time, plotting development or outcome of therapeutic input compared to the initial baseline as a form of dynamic assessment. See ASHA, 2019 for further details on dynamic assessment: https://www.asha.org/practice/multicultural/issues/Dynamic-Assessment/

Note that beyond the early stages of language development, other features of language development become important. Linguistic encoding of concepts such as size, number, prepositions and so on are not assessed by this simple screen. Therefore, if a child is already beyond this foundation stage of language development, other means of assessment must be identified.

Criteria for assessment
Children suspected of having Developmental Language Disorder (DLD) will have atypical language development (Bishop *et al.* 2016: 10):
- Between 3 and 4 years of age…At most two-word utterances;
- Between 4 and 5 years of age…At most three-word utterances

2. To differentiate EAL from central language disorder
The assessment will allow the child's expressive language skills to be evaluated across both / all languages. This will assist in deciding if the child has difficulties in mother tongue *and* English (a central language disorder) or in English only (English as an additional language acquisition).

It is not the role of speech and language therapists to develop a child's additional language skills (RCSLT, 2018). Children who have successfully acquired a home language (mother tongue) have shown that they can decode a language and map their intentions onto a surface grammar. It follows that, given enough exposure, they will do the same with English (or any other additional language).

For bilingual children, any language disorder would be observed in both/all languages the child is exposed to (RCSLT, 2018: 4).

3. To facilitate joint working between the SLT and the bilingual interpreter
The assessment is designed for use by:

- a bilingual speech and language therapist. Although it is rare to encounter a speech and language therapist with sufficient proficiency to assess and provide intervention in home language, there are a small number of SLTs working in the UK who meet this criterion.
- a monolingual English speech and language therapist working with an interpreter, bilingual co-worker or bilingual speech and language therapy assistant. This situation is by far the more common scenario in England (RCSLT, 2018: 27). RCSLT clinical guidelines state that 'SLTs should ensure that professional interpreters are involved in all aspects of assessment' (2017: 3). Please note that other children under 18 years of age, friends and relatives should **not** act as interpreters   (RCSLT,   2018).

  Details on how the assessment may be administered using careful transcription skills by the speech and language therapist together with the interpreting skills of the bilingual co-worker are given below.

Thematic roles

Please note that the terms 'Subject' 'Verb' and 'Object' are not used in this assessment. This is because these terms refer to surface forms. It is thought that all languages express common ideas that are mapped onto a surface form.

In English, the subject is first, followed by the verb and then the object (if required by the verb). This is commonly called SVO. For example, in the sentence 'The man is throwing a ball', 'the man' is the subject, the verb is 'to throw' and the object is 'a ball'.

In other languages, such as the Pakistani heritage languages, this phrase order (sometimes called word order) is different. For these languages, we find the subject, then the object and then the verb final, or SOV.

However, surface forms can change this. For example, in the passive form, English may have the item which is usually the object as the subject. For example, 'The ball was thrown by the man'. In this example, the relationship between the objects has not changed at all, just the surface pattern. The man was still the person who was throwing, and the ball was still thrown.

To avoid this contrast between surface and the underlying meaning, thematic roles may be employed. These indicate the role of each element. These terms then are not subject to change during translation, as they relate to the deep meaning and not the surface form.

Agent

An agent is 'the initiator of some action, capable of acting with volition' (Saeed, 2003: 149). This is usually a person, or animal such as 'man', 'woman/lady', 'boy', 'girl' and so on. This replaces the traditional 'Subject' label (when the person is the initiator).

Action

This is the verb.

Patient

The patent is 'the entity undergoing the effect of some action' (Saeed, 2003: 149). This replaces the surface category of 'Object' for most simple sentences.

Examples from BASS

In English, 'pointing' and 'clapping' are intransitive verbs; that is, there is no object. However, the surface form of Mirpuri means that 'a clap' and 'a point' are 'things' which are done or performed. This leads to two common verb phrases:
1. 'kar-na' (doing+ male) or 'kar-ni (doing + female) with 'point' (a noun or object); 'Pointing' involves no contact, in contrast with the second type of 'dummy verb':
2. 'mar-na' (doing+contact+male) or 'mar-ni' (doing+contact+female) for 'a clap' – since clapping involves contact of both hands

Item 4 'The girl is pointing' is an SOV utterance in Mirpuri, and is an SV in English. Similarly, Item 5 'The lady is clapping' is an SOV utterance in Mirpuri and is an SV in English. This

highlights that surface forms (syntax and grammar) can contrast in different languages expressing exactly the same meaning.

However, if we consider that the girl is the AGENT and that 'Doing a clap' is the ACTION, the underlying thematic roles are the same in both Mirpuri and English. We cannot consider 'clap' or 'ishara' a PATIENT as it undergoes no change.

Assessment Languages

Mirpuri

Mirpuri is a form of Punjabi spoken in the Mirpur District of Azad Kashmir in Pakistan. It currently has no written form. Mirpuri is generally spoken in more rural areas of Pakistan and speakers of Mirpuri are often regarded as having a lower social status than Punjabi or Urdu speakers.

Mirpuri has also been referred to as Mirpuri-Punjabi, Kashmiri and Mirpuri-Pahari and Potohari (Mirpuri). The Office for National Statistics (ONS)(2013: 2) reported that 'Half (10,800) of those who reported Pakistani Pahari (with Mirpuri and Potwari) as their main language lived in Birmingham. Lothers and Lothers (2012:1) found that 'At least 75 percent of Pakistani immigrants have come from Mirpur' and estimate some 500,000 to 600,000 speakers in the UK.

Some practitioners have questioned the status of Mirpuri as a unique and separate language to Punjabi. However, the local community where data were collected perceived a clear difference between Punjabi and Mirpuri.   There are large Mirpuri speaking populations reported in Birmingham, Bradford, Oldham, Luton and Slough. The distinction between Punjabi and Mirpuri is recognised by the Local Education Department and interestingly, the BBC also recognises and promotes separate Mirpuri and Punjabi programmes in their local and national radio broadcasts.

For English speakers, 'dialect' implies a form of language which has the same syntax and grammar, but with a few minor differences, e.g. the name for a bread roll and perhaps some minor vowel differences. However, this is not the case when discussing Mirpuri, Punjabi and Urdu. The very different verb phrase structures and grammar mean that these languages are not completely mutually intelligible. For SLTs, it is therefore more helpful to regard Mirpuri as a different language, but with a large proportion of vocabulary shared with Punjabi and Urdu.

In brief summary, Mirpuri has:

- an SOV structure, more accurately described as AGENT+PATIENT+ACTION
- Noun phrases but no articles ('a', and 'the' may occasionally be expressed as the number one, that is 'ik', but this would be in a speaker heavily influenced by English)
- Masculine suffix 'a', so 'mur**a**' (boy) and 'jen**a**' (man) are recognisably male due to the ending vowel.

- Feminine suffix 'i', so 'kur**i**' (girl) and 'dzanan**i**' (lady/woman)
- Verb phrases where the lexical verb or a 'dummy do' verb agrees with the agent,
  i.e. '-a' for male agents and '-i' for female agents. This agreement, unlike in Punjabi and Urdu, is also present on the auxiliary verb.
  e.g. kur**i** beht**i** v**i,** *girl sit-ing+female is+female*
  e.g. jen**a** kalt**a** v**a,** *man stand-ing+male is+male*
- Other nouns do not carry the masculine or feminine suffix but are still assigned one of the genders, For example:
  o 'chumuch' *spoon* – feminine
  o 'gend' *ball* – masculine.
  o The gender of nouns is important as it dictates the form of certain adjectives, although this is not explored in the BASS.

For a full description of Mirpuri, see Pert (2007).

Punjabi

Panjabi is spoken in both India and Pakistan. In these countries, different scripts, Gurmukhi and Perso-Arabic respectively are employed. Confusingly, both the label 'Punjabi' and 'Panjabi' has been used to refer to this language.

It is important to note that the Punjabi used in the North West of England, and hence the assessment and remediation package described in this manual is not the same dialect as that used elsewhere in the UK. For example, contrasts can be made between the Panjabi as described in other language assessments such as the Sandwell Bilingual Screening Assessment (Duncan, 1989). Although grammatically very similar, phonological forms, verb forms and lexical items were found to vary. It may therefore be helpful to use the terminology 'Panjabi' when referring to the Indian origin language and 'Punjabi' when considering the Pakistan origin variants.

Urdu

Urdu is the official language of Pakistan. It has both an oral and written form and is the medium through which education is conducted in Pakistan. Urdu therefore conveys a perceived higher social status on those who speak it.

Misreporting of the language spoken by the child

Self-reporting of the language/s spoken by an individual may be influenced by factors such as the prestige, ethnicity and political affiliation which are associated with a language (Romaine, 1995). Some authors have particularly highlighted the tendency for languages perceived to be of economic significance to dominate languages which are perceived to be of lesser value in the international market place (Li Wei, 2000, Clyne, 2003).

Stow (2006) reported that only 45% of Pakistani heritage language children had their language correctly described on the referral form. This is thought to be caused by several complex factors including:

- Low status languages such as Mirpuri reported as 'Punjabi' or 'Urdu' by families wishing to be seen as higher status language speakers
- Referring agents who are monolingual English speakers unfamiliar with the different languages spoken by the local community, hence selecting 'Punjabi' or 'Urdu' as this is the only language they know. In some cases, 'Pakistani' was the language reported!
- High status Urdu or Punjabi speakers incorrectly informing monolingual English referring agents that Mirpuri is a 'dialect' or 'slang', and therefore not to be described as a language.

Defining Home Language (Mother Tongue)

Due to the complexity of language reporting, families should always be offered a choice of language spoken, rather than being asked to name or label their language. This avoids misreporting, especially if the family think that the speech and language therapist will not be familiar with Mirpuri. This is likely, as most SLTs are white British, and predominately monolingual English speakers (McKinson, 2007, Greenwood, 2006).

Most children will have one clearly identifiable mother tongue. However, others are exposed to several languages at home (see *Assessment Language*, above).

It is important to carefully check who speaks which language(s) to the child. For example, a mother who spoke only English brought her child to clinic for assessment. However, on discussion it became apparent that it was the child's grandmother who provided most of the childcare while the mother was working. The child was therefore exposed to more Mirpuri than English.

The languages listed above are from the same family of languages and code switching often occurs. Careful language profiling is an important prerequisite to assessment and should form part of the case history gathered at the first appointment with the family. Telephone triage with an interpreter should help to identify the correct language/dialect prior to face-to-face contact and will save considerable time and cost to the service.

Shared lexical items

Although Mirpuri, Punjabi and Urdu are estimated to share a high proportion of lexical items, there are significant and notable differences between the three languages, even for high frequency nouns.

Table 1. Examples of differences between Mirpuri, Punjabi and Urdu in some high frequency nouns

English	Mirpuri	Punjabi	Urdu
boy	mura	munda	lerka
girl	kuri	kuri	lerki
man	jena	banda	admi
car	gadi	gadi	gari

Note that although many lexical verb stems are the same or similar, the three languages also differ in their verb phrase morphology, including auxiliary.

Managing code-switching during the assessment

Code switching, where the speaker changes language code during a conversation, is a pragmatic function (Duncan, 1989). In the past it has been viewed by some authors as a problem for the bilingual child. Code switching is a skill, which the bilingual child must master. Awareness of code switching will vary from speaker to speaker and develops as the child becomes more proficient.

Code switching should be differentiated from *borrowed words* or *absorbed lexical items.* It is recognised that languages in contact with other languages will absorb or exchange items (Crystal, 1997).

An example of Urdu, Punjabi and Mirpuri borrowing from English is the word 'apple'. In Mirpuri this is 'seb'. However, even when using Mirpuri, a child or adult may use 'apple' (with home language phonology 'apil'). The intonation of the sentence and the distinction from the English version of the word 'apple' suggests that this is a lexical item which has been absorbed into UK Mirpuri, and is not an example of code switching, i.e. borrowed lexical items are *phonologically adapted* to the home language.

During assessment such borrowed items should be accepted as normal language use (as this reflects the model the child is hearing from adults).

Where the child uses only English, this should initially be ignored and a prompt given again in mother tongue. If the child persists in English, s/he may not have sufficient skills in mother tongue to respond. Such a child, who comes from a bilingual family, but has been spoken to entirely in English may be viewed as linguistically monolingual English. The child may benefit from assessment in English, where the child will hopefully identify with the culturally relevant picture stimuli, facilitating more expressive output than standard English assessment materials.

Care needs to be taken to differentiate these children from the child who attempts to use English in the assessment based on a pragmatic decision that with an English monolingual therapist present, English will be the required language; as it is in school.

Keeping a record of the child's utterances

Delivering a service to bilingual children and their families presents a unique challenge to the speech and language therapist in many respects. Transparency of assessment data and resulting therapeutic decisions are essential. Assessments carried out in mother tongue and their analysis should ideally be comprehensible to all the members of the team. In addition, languages such as Mirpuri do not currently have a written script.

Discarding the raw data and only keeping a record of the translated utterances can lead to misleading or erroneous conclusions. For example, an interpreter may translate 'pi-ni' as 'She's drinking' (See Item 10 of BASS). This is technically correct, but ignores the fact that the child used only one word, and that a word ending, which is a gender agreement morpheme was employed, and not a female pronoun. There is no contraction, and no pronoun at all. This information is lost if only the translation is recorded (and the original source language utterance discarded) and makes tracking progress and developing outcome measures impossible.

These factors make the use of a universal code desirable. This assessment utilises the International Phonetic Alphabet as all speech and language therapists are trained in its use. Co-workers unfamiliar with the code may receive training or be encouraged to transcribe the child's responses using English script in a phonetic manner.

As this assessment is **not an assessment of speech** then the transcription is a record of the words and morphemes used by the child, not an accurate phonological sample.

Three different recording styles are possible:

1. **Assessment carried out by the bilingual co-worker under the supervision of a speech and language therapist**
   The speech and language therapist should carry out all recording. If this is not possible, or the speech and language therapist is unfamiliar with working with the target languages, the bilingual co-worker should transcribe using English script (transliteration).

2. **Assessment by a bilingual speech and language therapist**
   Transcribe the child's utterances using the International Phonetic Alphabet.

3. **Assessment in Urdu only**
   If either the bilingual speech and language therapist or the bilingual co-worker wishes to use Urdu script for the assessment of Urdu only, this script may be transcribed into English text at a later time. It is **not appropriate** to record in Urdu script for the assessment of Mirpuri or (Pakistani origin) Punjabi.

Analysing children's spoken sentences

The assessment recording forms and recording procedure are based on a translation protocol (Pert, 2003). A survey of the attendees reported that most speech and language therapists did not currently use a structured recording method and that most would choose to use the suggested protocol or one similar in methodology.

The Translation Protocol

Source and Target Languages

Target sentence	SAMPLE
Client's sentence	SAMPLE
Word-by-word translation	SAMPLE
English translation	SAMPLE
Comments	SAMPLE

This protocol considers mother tongue to be the SOURCE LANGUAGE and English to be the TARGET LANGUAGE of the translation process, as this is the most likely scenario in the assessment / therapy situation.

During the session:
The bilingual therapist / bilingual assistant writes down the child's utterances in the 'Client's sentence' box in the language used by the child.
- **Transliteration**:
  Use *either* IPA script *or* English letters (Roman script) to resemble home language (mother tongue) so that the therapy team all have access to the recording.
    o This overcomes the difficulty of some languages having no written form, e.g. Mirpuri.
    o If the child code-switches or uses an assimilated word write this down exactly how the child says it.

After the session:
The bilingual therapist / bilingual assistant translates each word (and related grammatical morpheme) in a literal manner, **preserving the phrase/word order of the child's utterance**.

The bilingual therapist or bilingual assistant and monolingual English therapist discuss issues arising from the literal translation (comments may be noted at this point). A final translation, which attempts to produce the best English version of the sentence, is agreed and noted in the 'English translation' box.

Notation
The notation should try and convey meaning in the target language *but not* attribute structures or syntactic arrangement which the child did not produce. Using brackets, the translation produced attempts to make this clear, directing the therapist in further assessment according to the area of concern, e.g. vocabulary, syntax, grammatical form etc.

The following is a list of notation which may be useful:

Routine notation	
(f/a)	Forced alternative given.
Ⓒ	Copied from the therapist.
Ⓟ	Prompt given.

Code Switching / Borrowed items	
(E)	Child working in home language (mother tongue): English word(s) used by the child in the context of a sentence in home language.
(M)	Child working in English: Mirpuri word(s) used by the child in the context of a sentence in English.
(P)	Child working in English: Punjabi word(s) used by the child in the context of a sentence in English.
(U)	Child working in English: Urdu word(s) used by the child in the context of a sentence in English.

Mirpuri Source to English Target	
+ male ➜ (he)	Grammatical element of present progressive agreeing with the gender of the AGENT (subject) of the sentence.
+ female ➜ (she)	Grammatical element of present progressive agreeing with the gender of the AGENT (subject) of the sentence.
+ respect ⬅ (they)	Respectful grammatical marker with literal translation of 'they' is not translated literally, but marked for function.
(the) or (a)	Articles which are included in the translation to provide a complete sentence and indicate that there is **no omission** in the source language but that determiners and articles **do not exist** in the source language.
()	Any item which has meaning marked in the source but has no analogue in the target language.

Areas to be Considered During the Translation Process

Lexical Items (Semantics)
- What's the nearest referent, most commonly used?
- Is the choice of word influenced by other items in the utterance?
- What are the other choices?
- Is the word part of an idiom or phrase where the meaning is best conveyed, e.g. "She put up the picture" / "She put up with the picture"

- Is the word / phrase a religious or cultural formality?

Grammatical features (Morphology / Phrase level)

- Where are grammatical features indicated?
  - At the beginning of words?
  - At the end of words?
  - As separate words? (Are these perceived as separate words by native speakers?)
- Are there variations according to time (tense), gender (of the subject / object etc) and number?

Context, Social Norms or Acceptability

- Ellipsis and Context – consider that the source language may also be able to indicate features in different ways e.g. In English, an adult may replace the sentence "Would you like a cup of coffee?" with the single word "Coffee?", the intonation and social context making the speakers intentions clear.
- In an assessment situation, children may omit the subject of a sentence if s/he thinks the adult can see the stimulus picture, or if the subject is given in a question such as 'What's the man doing?' - "(he's) eating a banana"
- Mirpuri speakers would be aware of the gender of the subject of a sentence (i.e. if it were a male or female) from the verb ending and auxiliary form. Omitting the subject may be an acceptable form and not necessarily a sign of language disorder.

The translation process is not linear – all these levels influence each other.

Normative data

Participants: Languages spoken

167 Pakistani heritage children aged 2 years 6 months to 7 years 5 months were assessed. The languages spoken were:

- Mirpuri speakers n=104
- Punjabi speakers n=27
- Urdu speakers n=32
- English monolingual n=4

This shows Mirpuri was the most frequently spoken home language (62%).

Participants: Non-responders

It is rare to find data on non-responders to assessment. Most assessment publishers do not include these data and the normative data is presented with the non-responders excluded from the analysis. This is unfortunate; if non-responding is common, this is useful for the clinician to know.

However, most experienced SLTs have encountered children who remain silent when asked to name or describe pictures. Stow (2006) found that only children aged 5;0 to 5;05 named every item on a 21-word confrontational picture naming task, with a total of 23 children from a sample of 246 (9.35%) providing no responses at all. Stow commented that 'These children remained silent throughout the assessment, failing even to make a verbal comment such as 'Don't know' or a non-verbal response such as a headshake, which could be interpreted as a communicative attempt.' (2006: 176).

For the BASS, 23 children provided no response (13.8%). This slightly higher percentage may reflect the difficulty of producing spoken sentences over single-word naming.

Examples of the Translation Protocol in the Clinic Situation

Example 1

Gender: Girl
Age: 6;10
Language: Mirpuri
Diagnosis: Language disorder

Target sentence	the man is laughing
Client's Sentence	hasna. (P) Jana hasna
Word-by-word translation	laugh-ing + male. [Prompt: Who's laughing?] man laugh-ing + male
English translation	(the) man laughing
Comments	• Correct use of gender agreement on the present progressive • Omission of the auxiliary verb 'is' (and the gender agreement)

Translation issues:
- 'hasna' cannot be directly translated – is it 'laugh' or 'smile'? [Semantic choice]
- Articles and determiners do not exist in this sentence in Mirpuri so there is no 'omission'. To signal this, the word 'a' or 'the' is placed in brackets in the final translation.
- Is the omission of 'is' and the AGENT (subject) of the sentence an acceptable form / language acquisition issue / situational?

Example 2

Gender: Boy
Age: 3 years 10 month
Language: Urdu
Diagnosis: Language disorder, phonological delay, non-fluent speech.

Target sentence	the girl is hopping
Client's Sentence	bagh raha he (f/a) lerki
Word-by-word translation	run do-ing + male is [Forced alternative given: Is it a **boy** or a **girl**?] girl
English translation	(he) is running
Comments	• Incorrect lexical verb • Incorrect gender agreement?

Translation issues:
- 'hopping' is difficult to translate - no direct satisfactory analogue in Urdu
    - it may mean simply 'jumping'
    - the literal translation, 'jump' + 'put on' does not map onto English,
    - some speakers may choose to use the English word 'hop' in this context, i.e. code switch

- The male gender ending does not really take the AGENT (subject) slot, i.e. the child used a Verb Phrase, not a Subject + Verb Phrase. The final translation therefore shows this in brackets. Similarly, if casually translated as 'he's running', this may appear a more complex utterance involving contraction. The full translation protocol avoids such confusions, separating semantic, morphological and syntactic decision-making.

Example 3

Gender: Boy
Age: 3 years 10 month
Language: Urdu
Diagnosis: Language disorder, phonological delay, non-fluent speech.

Target sentence	the lady is cooking rice
Client's Sentence	handi bana rehi he (E) aunty
Word-by-word translation	pan make doing + female is (English) aunty
English translation	(she) is making (a) meal aunty
Comments	Word order error? using the Subject sentence final

Translation issues:
- 'handi' literally means 'pan' but has a wider semantic usage, e.g. 'meal', 'curry'.
- Subjectivity and context are crucial – is the child having genuine word order difficulties or has he simply remembered the subject, e.g.
  - making a meal – (it is) aunty
  - making   a   meal   aunty
    Further assessment is therefore indicated to clarify this issue.

Scoring

Please see the recording form for both transcribing the child's responses and the scoring sheet.

The aim of the assessment is to analyse any errors or omissions. Unlike English, all morphemes are obligatory. Children are therefore unable to omit morphemes in the same way an English monolingual child might reduce 'running' to 'run'.

For these basic sentences, the verb phrase **must** agree with the AGENT's natural gender. Therefore for girl and women AGENTS you will find an '-i' ending on either the lexical verb, or the 'dummy do' verbs 'kar-' and 'mar-'. The same is true for male AGENTS, but this time the '-a' verb is found. This can only occur if the verb has a present progressive morpheme.

Two phenomena occur due to this obligatory AGENT gender – ACTION (verb phrase) agreement:
1. Code switching – insertion of an English verb, under specified as a noun with a 'dummy do' verb 'kar-' or 'mar-' to carry the AGENT-ACTION gender agreement, e.g. Code switching into English:
   '**colour** kar-na' (colour do-ing+male) – *He's colouring*
   '**brush** mar-ni' (brush do-ing+contact+female) – *She's brushing*

2. Rather than omit the present progressive and the auxiliary, these tend to be included, but a child may not realise the AGENT gender agreement and consistently use one form, male or female, regardless of the gender of the AGENT, or as in this example, use both!
   * 'kuri beth-a va' (girl sit-ing**+male** is**+male**) – *(The) girl he is sitting*
   * 'janani kitab par-ni pija' (lady/woman book read-ing+female is**+male**)
   – *The lady she/he is reading*.
   Children may also have gross errors with large omissions,
   * 'mum clap pi' (mum clap is+female) -omission of the 'dummy do' verb.

Mean Length of Utterance - Morphemes

An MLU(m) score sheet has only been provided for Mirpuri, as there are a reasonable number of typically developing children for each age band (highlighted in green). The other languages have insufficient data to be reliable, but are included as they are the only data available to our knowledge. The BASS can still be used descriptively for children speaking Punjabi and Urdu.

Mean Length of Utterance usually requires 50-100 utterances (Johnston, 2001). However, young children, especially from the Mirpuri in the UK community seldom encounter books prior to school entry, since the language has no written form (Stow, 2006; Raynor, 2008). Assessment requiring the child to verbally describe pictures is therefore quite unfamiliar to these children, and typically takes longer than the same language sample for monolingual English children, who are much more likely to encounter printed materials.

We therefore took the pragmatic approach to assessment, using a shorter assessment with people featured from the local community. In this way the assessment has cultural validity and is more likely to elicit an accurate language sample than an assessment aimed at white monolingual children of the same age.

Data collection

The data were collected between 2001 and 2006. Just as English is constantly evolving, with new lexical items and new ways of speaking, so the bilingual Pakistani community may have changed since that time. SLTs working with any bilingual community should consult adult informants and update their cultural and linguistic knowledge.

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Appendix 1 – Mean Length of Utterance MLU(m) Morphemes for Mirpuri, Punjabi and Urdu Speaking Children

Age range Years; Completed months	No response Number of children refusing to describe the pictures			Remaining number of children Those who did provide a description			Mirpuri MLU(m)	Mirpuri MLU(m) Standard Deviation	Punjabi MLU(m)	Punjabi MLU(m) Standard Deviation	Urdu MLU(m)	Urdu MLU(M) Standard Deviation
	M	P	U	M	P	U						
0 – 2;5	-	-	-	0	0	0	No data	No data	No data	No data	No data	No data
2;6 – 2;11	-	-	3	0	0	0	No data	No data	No data	No data	No data	No data
3;0 – 3;5	5 = 33.3%	-	-	10	1	4	3.39	0.84	1.13	No data	5.12	2.91
3;6 – 3;11	6 = 17.6%	-	1	28	2	6	3.57	1.31	1.96	0.20	3.15	1.68
4;0 – 4;5	4 = 12.5%	1	1	28	2	3	3.98	1.18	3.85	1.03	5.33	1.34
4;6 – 4;11	-	-	-	7	6	3	3.64	1.37	3.98	1.36	4.76	1.01
5;0 – 5;5	1 = 11.1%	-	-	8	3	3	4.00	1.23	4.30	1.81	4.68	0.43
5;6 – 5;11	-	1	-	1	5	5	4.96	No data	9.93	1.74	6.06	1.47
6;0 – 6;5	-	-	-	4	5	2	3.60	0.92	4.57	2.01	3.88	4.07
6;6 – 6;11	-	-	-	0	1	1	No data	No data	5.545	No data	6.88	No data
7;0 – 7;5	-	-	-	2	0	0	6.19	2.87	No data	No data	No data	No data
TOTALS	16 children 15.38%	2 children 7.41%	5 children 15.63%	88 children	25 children	27 children						
	23 children (16.42%)			140 children								

Key

	No data
	Norms based on 8-28 children
	Norms based on <8 children – Use with caution!