PhenX Toolkit

Data Collection Worksheet

Please Note: The Data Collection Worksheet (DCW) is a tool to aid integration of a PhenX protocol into a study. The PhenX DCW is not designed to be a data collection instrument. Investigators will need to decide the best way to collect data for the PhenX protocol in their study. Variables captured in the DCW, along with variable names and unique PhenX variable identifiers, are included in the PhenX Data Dictionary (DD) files.

[alink[CAPE-V_Form.pdf|Link to CAPE-V Form]]

Refer to CAPE-V form as you administer the following steps.

Task 1: Sustained vowels. Two vowels were selected for this task. One is considered a lax vowel (/a /) and the other tense (/ i /). In addition, the vowel, /i/, is the sustained vowel used during videostroboscopy. Thus, the use of this vowel during this task offers an auditory comparison to that produced during a stroboscopic exam.

The clinician should say to the individual, “The first task is to say the sound, /a/. Hold it as steady as you can, in your typical voice, until I ask you to stop.” (The clinician may provide a model of this task, if necessary.) The individual performs this task three times for 3 to 5 seconds each time. “Next, say the sound, /i/. Hold it as steady as you can, in your typical voice, until I ask you to stop.” The individual performs this task three times for 3 to 5 seconds each time.

Task 2: Sentences. Six sentences were designed to elicit various laryngeal behaviors and clinical signs. The first sentence provides production of every vowel sound in the English language, the second sentence emphasizes easy onset with the /h/, the third sentence is all voiced, the fourth sentence elicits hard glottal attack, the fifth sentence incorporates nasal sounds, and the final sentence is weighted with voiceless plosive sounds.

The clinician should give the person being evaluated flash cards, which progressively show the target sentences (see below) one at a time.

The clinician says, “Please read the following sentences one at a time, as if you were speaking to somebody in a real conversation.” (Individual performs task, producing one exemplar of each sentence.) If the individual has difficulty reading, the clinician may ask him or her to repeat sentences after verbal examples. This should be noted on the CAPE-V form. The sentences are: (a) The blue spot is on the key again; (b) How hard did he hit him? (c) We were away a year ago; (d) We eat eggs every Easter; (e) My mama makes lemon jam; and (f) Peter will keep at

the peak.

Task 3: Running speech. The clinician should elicit at least 20 seconds of natural conversational speech using standard interview questions such as “Tell me about your voice problem” or “Tell me how your voice is functioning.”

Data Scoring

Although the PDF scale is accurate, printer configurations vary. Please verify that your paper copy has accurate 100-mm lines before reproducing the CAPE-V form. The clinician should have the individual perform all voice tasks—including vowel prolongation, sentence production, and running speech—before completing the CAPE-V form. If performance is uniform across all tasks, the clinician should mark the ratings, indicating overall performance for each scale. If the clinician notes a discrepancy in performance across tasks, he or she should rate performance on each task separately, on a given line. Only one CAPE-V form is used per individual being evaluated. In the case of discrepancies across tasks, tick marks should be labeled with the task number. Tick marks reflecting vowel prolongation should be labeled #1 (see form). Tick marks reflecting running speech (i.e., sentence reading) should be labeled #2. Tick marks reflecting spontaneous speaking should be labeled #3. In the rare event that the clinician perceives discrepancies within task type (e.g., /a/ vs. /i/), he or she may further label the ratings accordingly, such as 1/a/ versus 1/i/ to reflect the different vowels, or 2(a)-(b)-(c)-(d)-(e)- or (f) for the different sentences. Unlabeled tick marks indicate uniform performance. See examples below. (Note: Using labels to indicate discrepancies/variation across tasks in the severity of an attribute is different than indicating that an attribute is displayed intermittently [I]. If an attribute is judged to have equal severity whenever it appears, but it is not present all the time, “I” should be circled to indicate that the attribute is intermittent, and no additional labeling needs to be done.)

After the clinician has completed all ratings, he or she should measure ratings from each scale. To do so, he or she should physically measure the distance in millimeters from the left end of the scale. The millimeters score should be written in the blank space to the far right of the scale, thereby relating the results in a proportion to the total 100-mm length of the line. The results can be reported in two possible ways. First, results can indicate distance in millimeters to describe the degree of deviancy; for example, “73/100” on “strain.” Second, results can be reported using descriptive labels that are typically employed clinically to indicate the general amount of deviancy; for example, “moderate-to-severe” on “strain.”

We strongly suggest using both forms of reporting. It is strongly recommended that for all rating sessions following the initial one, the clinician have a paper or electronic copy of the previous CAPE-V ratings available for comparison purposes. He or she should also rate subsequent examinations based on direct comparisons

between earlier and current audio recordings. Such an approach should optimize the internal consistency/reliability of repeated sequential ratings within a patient, particularly for purposes of assessing treatment outcomes. Although difficult, clinicians are encouraged to make every effort to minimize bias in all ratings.

Protocol source: https://www.phenxtoolkit.org/protocols/view/201701