CAPS-A Frequently Asked Questions

1. Should poor quality recordings be included in audit?
   This is at the discretion of the listener(s) bearing in mind that we aim to include as many patients as possible. Include if you feel able to make perceptual judgements.

2. Are we meant to rate intelligibility/distinctiveness?
   In 2013 it was agreed at a CEN meeting that this would no longer be part of routine audit. However, recent research by the CCUK team found good/moderate agreement between the CAPS-A articulation and structural scores and intelligibility/distinctiveness scores, with strong evidence of centre level variation in the intelligibility/distinctiveness scores (Sell et al 2017)*. Therefore, it might be that for specific projects it is decided that intelligibility/distinctiveness is included.

3. Intelligibility/Distinctiveness Scalar points 3 and 4 - are we meant to rate as an SLT or as a stranger?
   An SLT.

4. Children often do not know nursery rhymes; they tend to repeat the rhyme, so this becomes a repetition task rather than automatic speech. More children nowadays know the days of the week at 5 years. Can days of the week be used instead of a nursery rhyme? This would further standardise the sample, as if children choose different rhymes, this is less standardised.
   Agreed to include days of the week instead of a nursery rhyme. This would be more standardised than a rhyme.

5. Please can we clarify if nasal emission and turbulence is counted on sentences only (10 or more examples on the target sentences) or on counting and sentences?
   The 10% rule applies to your perception across the standardized speech sample (counting, days of the week, sentences). There are 102 pressure consonants in the standardised sentences, so as a guide to your decision, it is advised to note how many instances of nasal turbulence or audible emission you perceive on the target sentences. If you perceive turbulence approximately 10 or more instances on the sentences, this equates to approximately 10% or more of the sample. However, this rule is a guideline and must be used in conjunction with the qualitative definition of highly pervasive or highly distinctive throughout the full sample (counting, days of the week and sentences). If this was felt to be the case, this would be rated as a 2. Nasal emission or turbulence seldom perceived and on approximately less than 10% of the oral pressure consonants in the sentences, and, not perceived as being highly pervasive/distinctive throughout the sample (counting, days of the week and sentences) would be rated as 1.

6. How do you rate audible nasal emission/nasal turbulence if there are no pressure consonants in the speech sample.
   You rate as '8' and note that there are no pressure consonants in the sample.

7. Which word initial /s/ do you transcribe on I saw Sam sitting on a bus?
   You transcribe all realizations if they differ.

8. Glottal stop for word final /t/ in 'hat' – is this considered accent or should we decide on a regional basis?

Usually this is considered dialectal but your judgement would probably be influenced by the overall pattern.

9. Is one instance of gliding of an affricate/ fricative rated as developmental or CSC?
   You would need to take a view based on the overall pattern - usually it will be included as a CSC but may be recorded as a developmental problem.

10. Which realization counts?
    eg; 'daddy' => double articulation [d͡g] and 'door '=> velar [g]
    You would transcribe both and both would be counted as described in the training.

11. Do you ever include medial consonants in the list of CSCs?
    No, these are not included in this outcome tool.

12. Active Nasal Fricatives – should we be testing for production of active or passive production of /s/ on the video by nose holding?
    This would be ideal at the time of recording because ALL nasal fricatives are not active. Where nose holding is not included in the recording this is the guideline: if there are no other signs of VPD, categorise as an active nasal fricative. If there is nasal emission accompanying other consonants and/or a rating of hypernasal resonance of either 2 or more, then consider categorising as nasal realization of fricative in the passive category, or both active and passive.

13. Previously it has been agreed by authors that to facilitate the judgement as to whether productions are active or passive, we should use nose holding on the video. Few units are doing this when taking the sample. Should the nose holding be undertaken during the sample on video (for consensus judgements) or at the end of the sample (videoed or not videoed) or does it not matter?
    This is easier to do at the end. It should be optional but not mandatory. There should be the option for child to decline as it can feel intrusive. E.g. "Would it be ok if I hold your nose…."

14. How do we categorise 's' clusters affected by a CSC?
    If the CSC is rated on /s z/ consonants, then its occurrence on /s/ in 's'-clusters is not marked as an additional occurrence. Where occurrence on 's'-clusters has not been noted on /s z/, then occurrence on 's' clusters would be counted as one consonant affected. Even if it occurs on more than one s-cluster then this is still counted as one consonant affected.

15. For consonant repetition, why do we only transcribe initial and final positions and not medial positions when we use medial positions for nasal emission judgements? e.g. 'putting, washing'
    This is a limitation, but the CAPS-A tool is not designed to be a full phonological assessment. The audit tool is picking up what we need to know. If it were to include medial sounds, the tool would require a re-test of validity and reliability and an updated publication. We also need to be cautious with any proposed changes due to issues with data comparison over time e.g. data submitted to CRANE.

16. The influence of a grammatical active /s/ for "is" can compromise listening. If unsure, can we ask the child to repeat the sentence without the "is" i.e. "A puppy… playing with a rope"

If we can present it grammatically, this is ok to do, for example as above.

17. There was lots of discussion surrounding the definitions of the hyponasality scale on the CAPS-A. The definitions differ on the paper form between the CAPS-A and the GOSSPASS leading to confusion from delegates (**GOSSPASS 2 is de-nasalisation** so /m>b/ but **CAPS-A 2 is marked denasalisation** but not oral replacements). Additionally, on the training video Triona describes a 2 on the CAPS-A as nasal **replacements** which differs slightly with the CAPS-A form. Could we re-define CAPS-A hypo 2 as total de-nasalisation? (at least verbally in the training).
    The authors discussed this and decided we should not define CAPS-A hyponasality grade 2 as **oral replacements** rather than **marked denasalisation**. Their justification for this was as follows:

    The CAPS-A scale is a descriptive scale, based on reliability and validity studies done using the Temple Street Scale (Sweeney 2011) and not on the GOS.SP.ASS. The scales are intended to be used as a guideline for deciding on the severity of the parameter.
    For a rating of 1, some nasals are partly denasalised. You can use the 2015 Ext IPA diacritic [ˈm̃ˈ]
    For a rating on 2 there is frequent and prevalent denasalisation and the denasalisation can be partial [ˈm̃ˈ] or complete i.e. nasal replacement with oral consonant [m̃ ñ ŋ̃].
    Perceptually these realisations may sound like oral plosives but it is likely that transitions to vowels are distinct from the counterpart oral consonants. To avoid inaccuracy the 'denasal nasal ' transcription [m̃ ñ ŋ̃] will be more accurate than transcribing the target nasal as the oral phoneme. The emphasis here is that it is frequent and/or prevalent.

18. My colleagues recently did the refresher course and don't recall being told that single words elicited as part of the sample could not be taken into account (e.g. when SLT asks for repetition such as, "What's the puppy playing with?" Maybe because the SLT didn't quite hear what the child said 1st time around, and needs to hear it again to transcribe it) Most of the samples shown today re-elicited a phrase, but there were one or 2 instances of single words. Am I right in thinking we cannot transcribe anything to do with those single words on our forms? They weren't very happy about it!!
    We should be advising SLTs not to use single words. If the child hasn't heard, the SLT should encourage the child to repeat the whole sentence. E.g. if the child says "who?" We can say, "Gary…. can you say, 'Gary has a bag of lego' "
    SLTs should be aware that this may not be a comfortable activity for the child; It could be distressing to be asked for repetitions.

19. We had some patients who were doing linguolabials and wondered if these should be classed under dental?
    Linguolabials should be counted under dental/interdental. This is a recent change in thinking, but this is now agreed with all CAPS-A trainers.
    (NB. Clicks, ingressives, retroflex articulation should be noted under observations in section 6b).

20. We have understood that CAPSA is observational, not diagnostic. Does this mean we should categorise nasal realisations as a passive CSC, even if we suspect they are not symptomatic of a current (or historical) structural problem? (Although appreciate it is probably not possible to rule out historical structural influences as a possible factor…)
    The nasal realisation may be a phonological error and the rest of the sample shows no evidence of VPI (i.e. vowels are not nasalised) . If the vowels are oral, do not rate as a 4 hypernasal in section 3a.
    If nasal replacements for plosives are present with no other evidence of VPI these should still be reflected in the passive category; rate in section 11.
    The interpretation of this type of data would benefit from research studies.

21. Similarly, should we categorise gliding of fricatives/affricates as a passive CSC in a child with normal resonance, normal airflow, and no other passive CSCs (even though this would mean they fail standard 2a)?
    As above, even if considered phonological with no other symptoms of VPI, this still needs to be categorised in section 12 (with a comment in 7c.)

22. If two or more phonemes are produced as the same CSC due to a suspected phonological process, should these be counted individually or just once, e.g. if /t/ is produced as [t̪] and /s/ is produced as [t̪] because of stopping, should we count this as one weak consonant (t) (because this reflects a developmental process) – or should we count this as two weak consonants, one as the realisation for phoneme /t/ and one as the realisation for phoneme /s/?
    Counted as two, as two consonants are affected.

23. Is it accepted that a glottal plosive realisation for word-final /t/ might be a dialectal feature and therefore, where this is suspected, it does not need to be recorded as a non-oral CSC, or should it always be recorded as a non-oral CSC regardless?
    It should be considered as a dialectal feature if only heard to replace a final /t/, and it is not categorised as a CSC. But if the final glottal /t/ is part of a glottal pattern, it should be counted as a glottal.

24. Is it correct that to rate hypernasal resonance as severe/4, the listeners must have perceived and recorded nasalised consonants or nasal realisations of plosives (as well as nasalised vowels)?
    Correct. Need to perceive nasalised vowels and nasal consonants to rate as a 4 in section 3a.
    Nasal replacements of plosives only with normal vowels is not categorised here, but on section 11.

25. Can hypernasal resonance be rated as anything less than severe/4 when the listeners perceive/record nasalised consonants or nasal realisations of plosives?
    Both vowels and consonants need to be affected to be rated as a 4. If thought to be a phonological problem, with normal resonance rate in section 11, not a 4, for section 3a

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