COMPARISON OF SPEECH TASKS AND RECORDING DEVICES FOR VOICE BASED AUTOMATIC CLASSIFICATION OF HEALTHY SUBJECTS AND PATIENTS WITH AMYOTROPHIC LATERAL SCLEROSIS

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ABSTRACT

We consider the task of speech based automatic classification of patients with amyotrophic lateral sclerosis (ALS) and healthy subjects. In this context, we examine the role of different speech tasks and various recording devices on the classification accuracy. Sustained phoneme production, diadochokinetic task and spontaneous speech (monologue) have been used as different speech tasks. The chosen five recording devices include a high quality microphone as well as built-in microphones in smartphones at various price ranges. Experiments are performed using speech data from 25 ALS patients and 25 healthy subjects using support vector machines (SVM) and deep neural network (DNN) as classifiers and suprasegmental features based on mel frequency cepstral coefficients (MFCCs). Experimental results reveal that diadochokinetic task consistently performs better than spontaneous speech and sustained phoneme production across all devices for discriminating ALS patients and healthy subjects. Considering diadochokinetic task, the best classification accuracy of 92.2% is obtained using the high quality microphone but the accuracy drops if there is a mismatch between the microphones used for training and test. However, a classifier trained with recordings from all devices together performs more uniformly across all devices.

***Index Terms*—** Amyotrophic lateral sclerosis, support vector machines, deep neural networks

1. INTRODUCTION

Amyotrophic lateral sclerosis (ALS) is a progressive neuro degenerative disorder causing upper and lower motor neuron degeneration. Patients suffering from ALS have an average survival of 2 to 4 years with a worldwide annual incidence of about 1.9 per 100,000 [1, 2] and a median diagnosis time of 14 months [3]. Only 5-10% of all patients survive beyond 10 years [4]. In India, ALS has a prevalence rate of 4/100,000 with an annual incidence of 1/100,000 and a male to female ratio of 5:7 [2]. Currently, Revised El Escorial criteria is used for the diagnosis of ALS [5], whereas for the monitoring of progress of the disease, ALS Functional Rating Scale-Revised (ALSFRS-R) is used [6]. Patients with ALS experience symptoms of progressive muscle atrophy and weakness leading to problems including dysphagia, dyspnoea, orthopnea and dysarthria [4]. Dysarthria in case of ALS patients occurs frequently with increasing severity as the disease progresses [7]. About 30% of all ALS patients experience dysarthria as the first symptom [8, 9]. Often, the assessment of speech impairment is done based on clinician's auditory perception which is subjective. These judgements can be inconsistent too [10]. Therefore, automated methods for early detection of speech impairment due to ALS could avoid clinicians' subjectivity in diagnosis of the disease, and could also reduce the mean diagnosis time for the patients.

The speech impairment due to ALS is known to be caused by the muscle disorders which, in turn, affect the speech articulators. There have been several attempts to use Electromyography (EMG) to assess neuromuscular disorder [11], and perform automatic classification using features extracted from EMG signal [12, 13]. Similarly, rates and ranges of articulatory movement in the case of ALS patients have been studied [14] [15], and they were found to be lower than those of healthy subjects. On the contrary, there are few works that use impact of ALS on voice and use cues from voice to perform automatic classification of ALS patients. For example, Kent et al. [16] studied the relationship between speech intelligibility on a single word identification test using the average second-formant (F2) slope and found that F2 slope index is an useful acoustic measure of speech proficiency in ALS. Another study by Kent et al. [17], using 25 patients, showed that the most disruptive phonetic features in speech, impaired by ALS, involve phonatory function, place and manner of articulation for lingual consonants and regulation of tongue height for vowels suggesting their potential use as an index of bulbar muscle impairment in ALS. Tomik et al. [18] have studied the most significantly affected vowels for ALS patients in order to detect and monitor the progression of the disease based on the acoustic analysis of specific sounds only. Gomez et al. [19] used running speech segments to infer articulation kinematics to detect early symptoms and monitor the evolution of the ALS. Yamini et al. [20] have observed a reduction in the vowel space area in case of bulbar ALS patients compared to that of healthy controls. Using syllable rate and maximum phonation duration, Yamini et al. [21] have also found that diadochokinetic rate and phonation tasks are efficient ways to discern between healthy subjects and ALS patients. Pedro et al. [22] proposed a speech articulation biomechanical model to assess the state and progress of ALS. Taylor et al. [23] attempted automatic classification of ALS patients based on fractal analysis and

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Table 1. ALSFR-S Score versus Age for all subjects

ALSFR-S Score	0	1	2	3	4	Total ALS	Total Healthy
Total patients	5	5	5	5	5	25	25
Mean Age	52	59.2	59.4	53.2	60.2	56.8	51.8
Standard Deviation	8.2	12.1	11.0	6.5	11.6	9.9	7.7

Table 2. Language wise distribution for all subjects

Language	Bengali	Hindi	Kannada	Odiya	Tamil	Telugu
ALS Patient count	5	5	5	3	3	4
Healthy Control count	5	5	5	3	3	4

using diadochokinetic (DDK) rates as speech tasks.

Different speech based studies for ALS have used a variety of speech tasks. For example, Kent et al. [17] used different vowels, consonants and fricatives as tasks. Green et al. [24] in their study used read speech using bamboo passage, sustained vowel, repeated words, and rehearsed speech. While different tasks have been used in various studies in the past, there have been no investigations on relative role of each task for automatically classifying healthy subjects and patients with ALS. The ALS patients considered in this work come from different parts of India. The work presented here is part of a project that aims to develop a smartphone application for Indian population that can detect and monitor the degree of ALS for providing treatment at an early stage. In this regard, it is important to determine speech task that has required discriminatory power for achieving good classification accuracy as well as is suitable given the diversity in terms of the different vernaculars being spoken in the context of Indian demographic. In this work, we have chosen spontaneous speech (SPON), diadochokinetic rate (DDK) and sustained phoneme production (PHON) as three types of speech tasks. In addition, due to different socio-economic backgrounds in India, there is a great variety in the phones used by the target users. This, in turn, requires investigation of the robustness of classifiers across different recording devices. For this reason, we have experimented with five recording devices: Apple iPhone 7 (referred to as IPH), Moto G5 Plus (MOT), Xiaomi Redmi 4 (XIA), Zoom H-6 recorder with XYH-6 X/Y capsule high-quality unidirectional microphone [25] (ZOO) and Dell XPS 15 Laptop (LAP). The smartphones have been chosen such that they represent popular brands at various price ranges in India. Recordings from 50 subjects (25 controls and 25 ALS patients) are used for comparing the classification accuracy across all speech tasks and recording devices. We begin with the description of the dataset used in this work.

2. DATASET

For all experiments in this work, speech data is considered from 25 male patients and 25 male healthy subjects. All patients had been recruited from National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, India. The data collection has been approved by the ethics committee of NIMHANS and informed consent forms were signed by the subjects prior to the data collection. All patients included in this study were confirmed as having ALS by Neurologists at NIMHANS as per the El Escorial criteria. The details of age are provided in Table 1 for each ALSFRS-R score as well as healthy subjects. The native languages of patients & controls are provided in Table 2. The selected subjects are matched for age, gender and language for uniformity.

The recording setup using five devices (IPH, MOT, XIA, ZOO, LAP) is shown in Fig. 1. Speech data was recorded at a sampling rate

Fig. 1. Recording setup used in this work

of 44.1kHz. The distance between the patient and the recorders was kept constant for all the recordings. Throughout the paper, PHON is referred to as Task #1, DDK as Task #2 and SPON as Task #3. While SPON would provide samples of various sounds, DDK and PHON would provide targeted sounds used in those tasks. Although read speech has been typically chosen as a stimulus in previous works, we prefer to choose SPON over read speech due to poor literacy level of the patients recorded.

In case of Task #1, subjects were instructed and demonstrated to produce a sustained phoneme of five vowels, namely, /a/, /i/, /o/, /u/, /æ/, and three fricatives, namely, /s/, /sh/, and /f/. Subjects were asked to do this upto 5 seconds at a comfortable pitch and loudness level, after taking a deep breath. The same process was repeated three times in succession for each of the vowels. Vowel prolongation is a task which isolates the respiratory-phonatory system for speech [26]. PHON depends on the respiratory function and reflects information on respiratory abilities, voice quality and phonatory support. The fricative prolongation requires the respiratory- articulatory competence which could be affected by ALS. The total duration of recording for PHON is 7.9 hours considering all fifty subjects across all devices.

Task #2 consists of two parts: (a) Alternating Motion Rates (AMRs), which include rapid repetition of monosyllabic targets- 'pa','ta','ka'. It is used for assessing speed and regularity of rapid and repetitive articulatory movements. (b) Sequential Motion Rates (SMRs) measure the ability of articulators to move quickly and in a proper sequence from one articulatory position to another [26]. AMR and SMR were captured through monosyllabic targets such as 'pataka' and 'badaga' for a duration of upto 5 seconds. Thus, Task #2 is used to measure articulatory precision in the movements of jaw, lips, anterior and posterior tongue, phonatory support, adequacy of velopharyngeal closure, and respiratory support for sustaining the task. As it is known that the speed and precision of the articulators is low in case of ALS patients unlike in case of healthy subjects, we expect the corresponding speech recording to reflect such characteristics, cues from which could be used to discriminate ALS patients from healthy subjects. Subjects were asked to repeat the syllables for three trials. The total duration of recording for this task is 5.36 hours considering all fifty subjects across all devices.

For Task #3, subjects were instructed to spontaneously talk about a festival celebration and a recent place they have been to. Preparation time of a few minutes was given to the subjects before they could start speaking spontaneously. Following this, the subjects would articulate a monologue in their native language thus eliciting a natural response. The total duration of recording for this task is 7 hours considering all fifty subjects across all devices. Task #3 is an informal assessment measure but is said to have a good representation of the natural speech of a subject, thus making it an useful task for assessing a subject's articulation [27]. It is also useful in evaluating an integrated function of all components in speech production (respiration, phonation, articulation, resonance, and prosody) [27]. For all experiments in this work, the begin and end time for each task were noted down separately using which the speech segments of interest were obtained from the entire recording. A MATLAB graphical user interface (GUI) was designed for this purpose.

3. ALS VS HEALTHY CLASSIFICATION

The ALS patient and healthy subject classification consists of training and test phases. The first step in both phases is computation of the acoustic features from the speech recording. The acoustic features are the 12-dimensional MFCC (after excluding the energy co-efficient) along with their velocity and acceleration co-efficient, resulting in a 36-dimensional feature vector computed using a window size of 20 ms and a frame shift of 10 ms [28]. The speech recordings are downsampled from 44.1kHz to 16kHz before computing MFCC features. Cepstral mean variance normalization (CMVN) has been applied to the raw MFCCs. These are referred to as low-level features. For the classification experiments, we extract suprasegmental features from the low level features, and use these higher-level, long-term features as input to the classifier instead of providing the low-level, short-term frame-based spectral features. This is because para-linguistic information, such as ALS disease condition, could be embedded in subtle cues present in long-term features and this, in turn, can increase the performance of the classifier [29, 30]. The suprasegmental features considered are the mean, median, and standard deviation (SD) of each MFCC computed for an analysis window of N_w seconds with a shift of N_{sh} seconds. Thus, the dimensions of the suprasegmental feature vectors become three times that of the original MFCC feature vector. In the training phase, the suprasegmental features obtained from every analysis window along with their class labels (ALS & Healthy) are used to train the classifier (model). In this work, we use two models for classification - support vector machine (SVM) and deep neural network (DNN). $N_w = \{0.5, 0.8, 1, 2, 3\}$s with $N_{sh} = 0.1$s have been used for the analysis.

4. EXPERIMENTAL SETUP

For classification, a five-fold cross-validation setup is used. Five groups, each having ten subjects are formed. Subjects in each group is chosen in a manner such that they are balanced in all aspects as mentioned earlier. It is ensured that the subjects belonging to both healthy population and ALS patients are equally present in each group. In every group, five ALS patients are chosen in a way that there is equal representation of ALSFR-S scores. In each fold, four groups are used for training, and the remaining group is used as the test set in a round robin fashion. 15% of the training data has been used as a validation set.

The SVM classifier with radial basis kernel has been trained using the libsvm package [31]. Optimal values of C and γ have been selected by maximizing the performance on the validation set. For DNN, the optimal choice of the activation function (AF) corresponding to each hidden layer, number of hidden layers (HL), and the number of neurons (NN) in each hidden layer are determined by the validation loss. The parameters, that result in the least validation loss are chosen for the experiments. The candidate AFs, HLs, and NNs for which the validation loss is minimized are {'sigmoid', 'tanh', 'relu'}, {1, 2, 3}, and {64, 128, 256, 512} respectively. The optimal

Table 3. Average accuracy (SD) for SVM and DNN classifiers for N_w = 0.8s. The bold entries indicate higher classification accuracy between the two classifiers for every speech task and recording device combination

Device	Classifier	SPON (%)	DDK (%)	PHON (%)
MOT	SVM	**81.84 (7.51)**	**90.40 (9.10)**	79.88 (3.23)
	DNN	81.79 (7.67)	88.80 (11.01)	**80.13 (3.62)**
ZOO	SVM	79.79 (0.47)	90.40 (6.23)	**82.98 (4.04)**
	DNN	**83.84 (9.60)**	**92.20 (4.71)**	77.90 (9.35)
IPH	SVM	79.74 (6.41)	**89.20 (7.16)**	**80.93 (3.44)**
	DNN	**79.79 (7.09)**	88.40 (7.13)	78.45 (9.54)
XIA	SVM	**84.89 (4.87)**	**87.60 (3.85)**	78.38 (6.55)
	DNN	82.89 (11.97)	86.40 (5.37)	**78.57 (7.12)**
LAP	SVM	83.89 (5.34)	**88.80 (8.56)**	78.80 (2.03)
	DNN	**87.95 (9.70)**	87.60 (8.17)	**81.15 (5.62)**
Avg	SVM	82.03 (4.92)	**89.28 (6.98)**	**80.19 (3.86)**
	DNN	**83.25 (9.20)**	88.68 (7.28)	79.24 (7.05)

DNN architecture was found to have tanh as the AF irrespective of the speech task and the recording device chosen. The trained model is then used to obtain a decision on every suprasegmental feature for the test data. The utterance level decision is obtained by majority voting on the decisions using the suprasegmental features. The training of the DNN has been done using cross-entropy as the loss function with Adam optimizer [32]. Keras library has been used for the implementation. The performance of the automatic classification is determined by the classification accuracy which is computed as the number of test utterances for which the decision from the classifier matches with that of the ground truth class label.

5. RESULTS AND DISCUSSION

Table 3 shows the utterance level classification accuracies averaged across all folds using SVM and DNN classifiers separately using N_w = 0.8s. The number in the bracket indicates the SD of the accuracies across all folds. The last two rows (indicated by 'Avg') in Table 3 report accuracies averaged across all recording devices for each speech task. From the 'Avg' accuracies, it is clear that the highest classification accuracy is achieved in the case of DDK task using both SVM and DNN classifiers. In particular, SVM performs better than DNN classifier by an average classification accuracy of 0.6%. When DDK is used as a speech task, SVM performs better than DNN in case of all devices except ZOO where SVM yields an average classification accuracy of 90.40% while DNN achieves a classification accuracy of 92.20%. Across all devices, the highest SVM-based average classification accuracy of 90.40% is obtained using MOT and ZOO in the case of DDK task. This suggests that these devices are superior than the remaining three in terms of preserving cues for healthy subjects and ALS patients classification.

It is interesting to observe that in the case of SPON task, the highest classification accuracy of 87.95% is obtained using LAP. However, it is still lower than the classification accuracy (88.80%) obtained using DDK task recorded in LAP. This indicates more discriminatory power of the DDK task compared to SPON task. When averaged over all devices (Avg case), unlike DDK task, DNN performs 1.22% better than SVM classifier. On the contrary, considering Avg case, SVM performs 0.95% better than DNN classifier in the case of PHON task. However, the Avg accuracy of 80.19% in the case of PHON task using SVM is 9.09% lower than that using DDK task suggesting the superiority of the DDK as a task for healthy subject and ALS patient discrimination.

Ranking the device wise performance for each of the three tasks, it is observed that LAP performs the best (87.95 %) among all devices for SPON followed by XIA, ZOO, MOT and IPH (79.79 %). Similarly, for DDK, it is seen that ZOO performs the best among all devices (92.20%) followed by MOT, IPH, LAP and XIA (87.60 %). In the case of PHON, ZOO (82.98 %) performs the best followed by LAP, IPH, MOT and XIA (78.57%). From the above data, it is observed that the range of classification accuracy is 8.16% for SPON task, 4.6% for DDK and 4.41% for PHON task. This range highlights the robustness of the DDK task since it consistently achieves the highest accuracy across devices with a small variation. From the above data, Table 4 is constructed where a device was ranked based on its relative performance. Rank 1 (5) indicates the best (worst) performing device in each column in Table 4. It is observed that no device was found to be ranked identically across three tasks. Total score is calculated by adding the ranks among all speech tasks. It is to be noted that a lower total score would indicate a better performance. ZOO achieves the least total score (it tops the rank order for all tasks except SPON) followed by LAP, MOT, IPH and XIA.

Table 4. Rank and score of each device for different speech tasks

Device	MOT	ZOO	IPH	XIA	LAP
Rank using SPON task	4	3	5	2	1
Rank using DDK task	2	1	3	5	4
Rank using PHON task	4	1	3	5	2
Total score	10	5	11	12	7

Microphone characteristics vary from device to device and provide varying performance under different stimuli. In order to check which device has robust characteristics, we compare the performance of one device model on recordings from other devices as test set. Table 5 shows the accuracies for DDK task for N_w = 0.8s averaged across all folds for each device model against test data of all devices (including matched case). It is seen that apart from XIA (where test data of ZOO secured highest accuracy), the model and the test data for the matched case perform the best among all the test devices.

Table 5. Performance comparison using device model on all devices. Bold entries indicate higher classification accuracy for each device model and italics indicate the best averaged performance for a device model

Model	Test (Accuracy(%) and SD)					Avg
	MOT	ZOO	IPH	XIA	LAP	
MOT	**90.40 (9.10)**	90.00 (7.35)	88.40 (5.37)	85.84 (7.87)	88.80 (8.67)	88.69 (7.67)
ZOO	89.20 (4.60)	**90.40 (6.23)**	87.20 (3.63)	76.80 (4.60)	87.64 (2.94)	86.25 (4.40)
IPH	**89.20 (9.44)**	**89.20 (7.16)**	**89.20 (7.16)**	82.80 (6.26)	88.00 (8.12)	87.68 (7.63)
XIA	86.40 (10.62)	**89.60 (7.40)**	88.80 (4.60)	87.60 (3.85)	86.40 (9.10)	87.76 (7.11)
LAP	87.20 (10.64)	87.20 (10.06)	85.20 (7.56)	78.00 (8.12)	**88.80 (8.56)**	85.28 (8.99)
ALL	89.20 (8.79)	91.20 (9.12)	90.00 (6.32)	87.60 (5.55)	87.60 (8.65)	***89.12 (7.69)***

A combined model with training data taken equally from all devices is built (referred to as ALL in Table 5). It is observed that the performance of any model on XIA drops when compared to their matched case (except XIA). Considering the average accuracy across different devices for test, it turns out that MOT based model is the most robust model (next to ALL that achieves the highest averaged accuracy of 89.12%). For a particular device as test, ALL model is not always the best choice. For example, MOT and LAP show a reduction in accuracy levels when compared to their individual accuracy score. Observing the range of performance of a device as test, it is seen that MOT (86.4 to 90.4%), ZOO (87.2 to 90.4%), IPH (85.2 to 89.2%) and LAP (86.4 to 88.8%) show minimal variation in performance across models (2.4 to 4%) as opposed to XIA (76.8 to 87.6%) with a range of 9.8%.

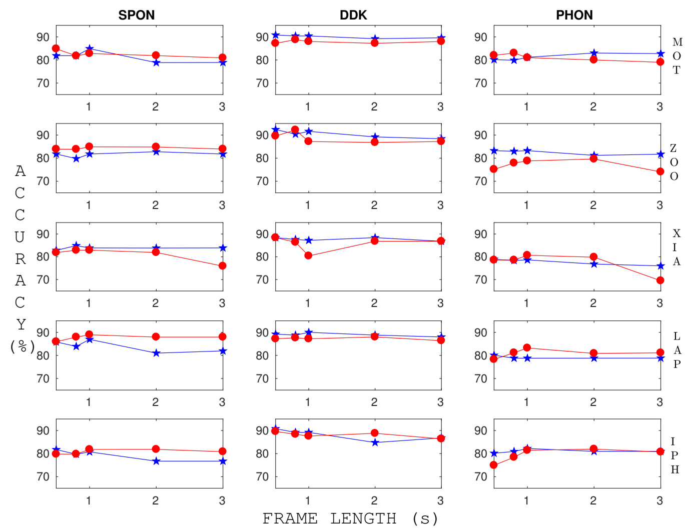

Fig. 2. Classification accuracy by varying N_w. ⋆ SVM, ● DNN. Each column and row correspond to one speech task and recording device.

To check if there is a change in classification accuracy for different choices of N_w, the classification experiments are repeated for $N_w = \{0.5,1,2,3\}$s. Fig. 2 shows the device wise performance for each speech task with varying N_w. The trend observed in Table 3 is seen here with DNN performing better than SVM for SPON task (except XIA). For DDK, SVM performs better than DNN (except IPH). SVM performs better for PHON in the case of MOT, ZOO and IPH while DNN performs better in XIA and LAP. In case of SPON, it is observed that for all devices, the accuracy rises from 0.5s to 1s and then either decreases or remains the same. In DDK, it is seen that the accuracy reaches a maximum at N_w = 0.8s for MOT, ZOO and LAP while it is second best for XIA and LAP, for which N_w = 0.5s has a higher accuracy. For PHON, it is observed that the accuracy reaches the maximum at N_w = 1s (except MOT) while N_w = 0.8s was second best. Although N_w=1s yields the best accuracy among all choices of N_w for most of the task and device combinations, N_w=0.8s with DDK task and ZOO device achieves the best performance among all combinations.

6. CONCLUSIONS

In this work, we compare three speech tasks, viz. spontaneous speech, diadochokinetic rate and sustained phoneme production with recordings using five devices for ALS / healthy subjects classification. The experiments with 25 ALS patients and 25 healthy subjects show that diadochokinetic rate consistently performs better than other two tasks for discriminating ALS patients and healthy population. Comparison of classification accuracy using different devices reveal that high-quality microphone performs better than smartphones, in general. However, when a classifier is built using recordings from all devices, the classification on the smartphone recordings improves.

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