CoDAS
ISSN 2317-1782 (Online version)

Case Report
Relato de Caso

Body and language: repercussions on a dysphasia case

Corpo e linguagem: repercussões em um caso de disfagia

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Keywords

Body
Language
Dysphagia
Apraxia
Speech Therapy

ABSTRACT

The human body is made of tissues and organs, and the body is mentioned by biology and medicine based on its anatomical and biomechanical architecture. However, there are different ways of understanding the human body. Based on the assumption that the body is the consistency of the speaker´s body-being, the psychoanalytic theory us that the body is crossed by language and affected by the word. In the field of swallowing disorders, even if it points to the repercussions of the rupture in eating pleasure and the deprivation of gustatory emotions, theoretical-clinical discussions that imply the relationship between body and language are still incipient. This work aimed to discuss the clinical consequences for the care of the dysphagic patient of taking into account the relationship between body and language. The presentation of the clinical case revealed that marks of neurological involvement highlighted the vulnerability imposed by the radical confrontation with the effects of the loss of the previous body condition, placing the subject in front of a malaise that advanced as the loss of the body implied in the loss of their position in language and in the social connection that involves the act of eating. Owing to this scenario, it was essential for evaluating the effectiveness of care to open up a dialogue and pay attention to clinical actions which guide the application of technologies aimed at organic functioning. This step was only possible because there was a recognition that the human body goes beyond the concept of a machine since it is identified with a speaking body.

Descritores

Corpo
Linguagem
Disfagia
Apraxia
Terapia Fonoaudiológica

RESUMO

Preenchido por tecidos e órgãos, o corpo é referenciado pela biologia e pela medicina a partir de sua arquitetura anatômica e biomecânica. Sabe-se, contudo, que há diferentes modos de compreender o corpo humano. Partindo do pressuposto de que se trata do corpo do ser que fala, a teoria e clínica psicanalítica nos mostra que o corpo é enlaçado pelo sujeito, atravessado pela linguagem e afetado pela palavra. No campo dos distúrbios de deglutição, mesmo que se aponte para as repercussões da ruptura no prazer alimentar e da privação de emoções gustativas, discussões teórico-clínicas que impliquem a relação entre corpo e linguagem são ainda incipientes. Esse trabalho objetivou discutir as consequências clínicas para o cuidado do sujeito disfágico de se levar em consideração a relação entre corpo e linguagem. A exposição do caso clínico revelou que marcas do acometimento neurológico colocaram em relevo a vulnerabilidade imposta pelo confronto radical com os efeitos da perda da condição corporal anterior, colocando o sujeito frente a um mal-estar que avançou na medida em que a perda do corpo implicou na perda de sua posição na linguagem e no enlace social que envolve o ato de comer. Diante desse cenário, foi fundamental para a eficácia do cuidado a abertura para o diálogo e para a escuta como ações clínicas norteadoras da aplicação de tecnologias dirigidas ao funcionamento orgânico. Esse passo só foi possível porque houve o reconhecimento de que o corpo humano ultrapassa a concepção de biomáquina já que é corpo falante.

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Received: April 29, 2020

Accepted: June 15, 2020

Trabalho realizado no Hospital Universitário Professor Edgard Santos – HUPES, Salvador (BA), Brasil.

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Financial support: nothing to declare.

Conflict of interests: nothing to declare.

INTRODUCTION

The human body is made of tissues and organs and is mentioned by biology and medicine based on its anatomical and biomechanical architecture[1]. This point of view, which privileges the *res extensa* or even better, the organic matter, appears in the clinical scenario due to the attentive view at the machine-body, focusing on "[...] chemical and/or biological therapies [...]" that guarantee the "[...] functioning of the human organism in precise conditions [...]"[2:12].

The centrality of clinical actions directed at the body-organism can be found in the most different disciplines and practices in health, with the hospital space as the privileged locus. In this environment, speech-language therapy is called upon to answer for the care of individuals with dysphagia from the conception of a diseased body described as a biomachine[1].

With its weight and measurement, the human body occupies space as matter in the sensitive world. However, as a living substance, this body interacts with other bodies making up a social body. According to this trend, the body appears like a stage for the beauty, aesthetics, and art of its time, being a historical body, i.e., the body is affected by material and cultural conditions that are always heterogeneous. Although the body is made of organic composition, it cannot be denied that the body is linked to the individual, it is crossed by language and affected by the word, as shown by Psychoanalysis[3,4].

In the area of Speech-Language Therapy, especially when dedicated to swallowing disorders, theoretical-clinical discussions in the relationship between body and language is still incipient. In this context, this study highlighted the indications found in the specialized literature about the rupture in the maintenance of eating pleasure, its repercussions on the quality of life of individuals with dysphagia, and its inclusion as one of the criteria to be analyzed in protocols for clinical assessment of dysphagia[5].

The pleasure of eating is connected to the several social functions that establish or shape the act of eating. Surrounded by affections and memories, eating is linked to commensality (*mensa*), i.e., that means eating together at the table, sharing food. This involves the presence associated with the other, the company (*companion*), with whom people share not only food, but commensal space is linked to a space of trust and sharing[6]. In this way, the act of eating/being fed highlights food sociability, with food as concrete support for the encounter with the other.

Thus, what about individuals with dysphagia when experiencing, among many affects, the deprivation of gustatory emotions, the lack of access to the smell, texture, and flavor of food? Under dysphagia, meals become solitary, or absent, and compromise the commensal and coexistence relationship. Therefore, the food (dis) pleasure can affect the individual's history in many cases due to the need for consistent adaptations or even alternative ways of eating. It is important to note that eating with pleasure is a relevant aspect among health-disease conditions, being associated to the relationships with life and death. At this point, the reflection that emerges for a clinician is whether the marks left by dysphagia on the body impose a destination on the subject.

For authors linked to the Language Clinic[1], the dialogue with Psychoanalysis "[...] illuminates a clinical practice affected by the fact that if anatomy imposes a certain cut and limitation, the individual's destiny is always very different [...]"[7:426]. Based on this proposition and the fact that the act of eating involves socio-cultural and subjective aspects, this study aimed to reflect on what would be the clinical consequences for the care of the individual with dysphagia when considering the body from the point of view of their connection with language.

To carry out this discussion, a case report was used as the methodological choice, as well as written in a narrative style. The choice reflects the approximation with the theoretical constructs proposed within the scope of the dialogue undertaken between the Language Clinic and Psychoanalysis, a field in which the case report is pointed out as a space that reveals the encounter with the singularity of the clinical event and, therefore, it can illustrate and support a theoretical elaboration[8].

PRESENTATION OF THE CLINICAL CASE

The study was approved by the Research Ethics Committee of the Professor Edgard Santos University Hospital under the number CAAE 18260919.2.0000.0049, carried out only after the express agreement of the recruited participant and the signing of the Informed Consent Form (ICF).

This was the report of Pedro's therapeutic process, the fictitious name of a 51-year-old man, regulated by the Emergency Care Unit (in Portuguese *Unidade de Pronto Atendimento* (*UPA*)), already using a nasoenteral tube (NET), for a University Hospital in the city of Salvador, in the state of Bahia (BA). On admission, he received the medical diagnosis of Ischemic Stroke in a bilateral nucleocapsular region and underwent speech-language assessment for the biomechanics of swallowing.

Two days after his arrival at the Neurology Ward of the hospital mentioned above, Pedro was admitted by the Speech-Language Therapy service. At the first meeting at the bedside, we observed moderate drooling contained with a small towel in Pedro's hand, and the expressive attempts at communication through gestures, orofacial expressions, and minimal vocalizations.

Next to the patient, the brother was able to tell about the level of education - incomplete elementary school - the previous history of functional independence, the profession of cook, and Pedro's active participation in dance and music activities. While his brother reported about his life before his illness, Pedro almost interrupting him, presented affirmative nods and vocalizations that showed agreement with his brother. At the same time, we noticed an insistence of indicative gestures that pointed in the direction of NET, as if inquiring about that unknown device that had crossed the barrier of his body.

After the initial reception, we clarified Pedro and his brother about the role of the alternative route of feeding and the contributions of speech-language therapy regarding difficulties in swallowing and communication. We started the speech-

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language therapy diagnostic process by evaluating the sensory motor-oral system, in which we observed: maintenance of the open mouth at rest, reduction in tone, mobility and coordination of lips, tongue, and cheeks, movement tests for the execution of oral praxis - with visible bodily effort towards the model, in attempts to perform the requested gestures. In movements such as protruding the tongue, for example, Pedro curved the cervical region and sought to perform the movement with the help of his hands, as if to compensate for the gesture that could not be engendered. The apraxia dominated the scene.

In the next step, the functional evaluation of swallowing was performed with a minimum volume of semi-liquid consistency, offered and in self-supply in the spoon and glass, with the following findings: inefficient oral intake, attempts to adjust with digital support in orbicularis of the lips and suprahyoid region, increased oral transit time, incomplete swallowing, sometimes with coughing episodes - indicating clinical signs of laryngotracheal penetration/aspiration. As a result, the need to maintain food/hydration/medication by an alternative route was reiterated.

When receiving this feedback, Pedro presented an attentive view, which showed understanding of his condition, but at the same time, it seemed to resist the fact that he did not eat orally. Based on the assessment findings, we designed therapeutic planning to enhance the biomechanics of swallowing, based on the involvement of the cortex in the modulation of oropharyngeal swallowing and the principles that govern motor learning directed to oral praxis[9].

We carried out speech-language therapy sessions with the use of tactile stimuli (metal spoon, spatula, gauze), thermal (cold) and taste stimuli (sour), visual stimuli (imitation of the therapist's model, use of the mirror, figures of the worked foods) and auditory stimuli (verbal commands), aimed at increasing the organization and oral control from the stimulation of multiple sensorimotor pathways. Isotonic and isometric exercises were performed to increase the range of motion and strengthen phonoarticulatory organs. We put an elastic bandage in the orbicular region of the mouth, masseter and suprahyoid, and neuromuscular electrostimulation in the suprahyoid and laryngeal region in association with swallowing training. In summary, we selected the applied techniques to favor the exercise of oral praxis, lip sealing, control, and oral ejection, contraction of the posterior pharynx wall, greater hiolaryngeal excursion and support, and an increase in the frequency of salivary swallowing. Also, mediating communication between patient, family, and multi-professional team permeated the established conduct.

Initially, therapy sessions required the participation of two therapists to facilitate the organization of the stimuli used. During the therapeutic process, carried out for 30 to 40 minutes, twice a day, his body reported signs of tiredness, obtaining two to three swallows per session, a number that is still insufficient to safely and effectively reintroduce oral feeding. Thus, the severity of oropharyngeal dysphagia and orofacial apraxia remained. Due to this scenario, the multi-professional team (Speech-Language Therapy, Nutrition, and Physician) opted for Gastrostomy, aiming at an alternative route that would offer safety and efficacy in the administration of medications, in the nutritional and hydration input.

We shared the decision with Pedro and his family (two brothers and his son). We explained the limited advances obtained with therapy by the strong influence of organic disorders that hindered the reintroduction of the oral route in a short term. As a way, we pointed out the permanence of the speech-language therapy service to achieve some food pleasure, even with a minimum volume of food. Pedro agreed with the approach adopted and, with the communicative possibility that remained, he was emphatic when saying about the privileged place that food occupied in his history, reiterating the desire to feel the smell, flavor, and texture of the food.

Deprived of commensality, which, according to his brother's initial report, has always been the stage for important affective representations, or rather, the central element in the family plot (often marked by reports involving food and meals), the field of pleasure food stood out in the therapeutic scene. We should note that a change in the care offered was notorious. As an organic limit was placed on the desired recovery, the therapist's listening was directed to Pedro's demands and history.

All the consultations were in the bed but as Pedro occupied a shared room during the interventions, he always seemed to be very attentive to the other patients and the professionals who circulated in that environment. This ended up dispersing him during therapy. In the 30th session, we suggested changing the location of the service to a balcony adjacent to the room. Pedro approved the proposal and every day when it was time for therapy, he quickly took the chair, went to the balcony, and stayed ready for another meeting. Such possibility also occurred through the improvement in the functioning of the global locomotor system and as evolving with physiotherapy maintaining functional independence for locomotion.

From then on, only one therapist was needed to conduct the case. The new space enabled to mark of the therapeutic setting, a new demarcation of the position in the transference game, a greater field of privacy, and a narrowing of the relationship of trust. The transferential dynamics enabled them to listen to the production of care, in which Pedro's history, experiences, and wishes were at stake. We selected the actions directed to the organic functioning, maintaining the intervention directed to the oral praxis related to swallowing. Along these lines, advances, albeit small, in the production of praxis and the function of swallowing also opened space so that listening to the therapist could pay more attention to the linguistic functioning present in the way Pedro could speak. Because of the condition of an impaired organism, doubts remained as to the existence of the aphasia associated with motor speech (apraxia/dysarthria of speech).

With the use of Augmentative and Alternative Communication (AAC) boards - - alphanumeric, activities of daily living and food - already available in the service, and musical resources provided by actions of an extension project that promoted musical sessions to hospitalized patients, we observed the integrity of the prosody contour, the possibility of identifying letters and forming words, even with graphemic substitutions. In the dialogues undertaken, support for indicative and representative gestures

for discourse production was evident, and the interpretation of the speech addressed to him seemed guaranteed. It was clear that the sequelae of the neurological event limited the appearance of orality, but not how the body was taken by the language and by the permanence of a subjective position that sought to sustain as a speaker. We can say that the body spoke.

Since the beginning of speech-language therapy, Pedro was receptive to shared therapeutic measures. However, it was evident that despite his nutritional needs being met by the alternative route of feeding, these devices have always been vehicles of subjective impasses, with reports from the nursing team that he had drunk tap and shower water, scenes also witnessed by companions of other patients admitted to the same room. With the use of the ACB board already integrated into the therapeutic process, listening to the vocalizations and gestures, engendered in concomitance when pointing out figures and letters, Pedro questioned: "When can I eat again? I have a long time without eating. I wish I could drink water!". These speeches involved speech-language therapy sessions and called to reflect on the narratives that were at stake in these statements: stories about being a cook, preparing food, selling food in a small store in his neighborhood, and eating together with the brothers.

Therefore, we agreed with the ward nutritionist about the use of passion fruit popsicle as a resource in speech-language therapy, replacing the stimuli with thickened powdered juice, which contributed to the subsequent gains: production of praxis, execution of oral capture, lip sealing, reduction in extra-oral escape, greater readiness to swallow. Despite this, we had to observe the use of the popsicle because due to the double consistency (solid and liquid), Pedro had episodes of coughing during swallowing, characterizing clinical signs suggestive of laryngotracheal penetration/aspiration.

We replaced the popsicle with the lollipop because, in addition to favoring the maintenance of gains in the oral phase of swallowing, it enabled an increase in the number of swallows, a greater hiolaryngeal excursion, clean cervical auscultation, and without clinical signs of laryngotracheal penetration/aspiration. We alternated this strategy with direct therapy in a semi-liquid and homogeneous pasty consistency (fruit smoothie, fruit cocktail, soup), contributing to the planning and organization of praxis movements, and the resumption of swallowing functionality. Faced with this new condition, we could reintroduce oral feeding into semi-liquid (honey) and homogeneous pasty consistencies, with self-supply.

The support of clinical dialogical work, permeated by the use of ACB and the crossing of language modalities (orality, writing, gestures), allowed the minimum vocalizations to be transformed into oral speech and when producing his first word, he did not surprise to hear his voice. Then, more words could be heard: *wait; I am a cook; eat and do; fish stew; caruru; vatapá*. Oral production took shape and existence, and there was an increase in loudness and, with a smile on his face, Pedro started calling the nursing team and the companions of other patients to witness the unprecedented speech and be recognized as the one who speaks, the talkative person.

Given the advances achieved in this period of speech-language therapy, the improvement in the general clinical condition, and socio-affective support, Pedro was discharged from the hospital after 36 days of hospitalization. The discharge was achieved with mixed feeding: oral in the semi-liquid (honey) and homogeneous pasty consistencies, in addition to the support of the Gastrostomy. Altogether, he had 39 speech-language therapy sessions and the patient was referred to an outpatient public service in the city, aiming to follow the therapeutic plan with a speech-language therapist, physiotherapist, and neurologist.

DISCUSSION

In the case report presented here, we triggered different technological levels in the care offered. Due to the diagnosis of oropharyngeal dysphagia, speech apraxia, and orofacial apraxia, light-hard technologies, represented by structured and specialized knowledge that underlie diagnostic and therapeutic processes[10], tended towards the delimitation of knowledge aimed at organic functioning.

In line with this treatment direction, the first interventions had Pedro's brother as an interlocutor to talk about him and through him, to report on the history of the disease. Pedro had important speech difficulties and ended up in a set of cases whose language changes and/or impairment in orality bring about situations of communicative vulnerability in the hospital setting, or rather, failures in the communication process between the patient and health professionals, leading to the deauthorization or deprivation of the individual to actively participate in his recovery, from admission to hospital discharge[11].

The presentation of Pedro's clinical case revealed that marks of neurological involvement highlighted the vulnerability imposed by the radical confrontation with the effects of the loss of his previous body condition, placing him in front of a malaise that advanced as the loss of the body implied in the loss of its position in the language and in the social bond that involves the act of eating.

It was not without reason that he insisted on speaking and that his repeated appeals for eating and drinking showed that the production of care required more than the application of technological tools aimed at organic functioning. There was an urgent need to offer a listening that could be structured, or better, that would make the indicative gestures, orofacial expressions, and pointing to figures and letters on boards of Augmentative and Alternative Communication, as spoken.

We can say that this was the turning point of the care offered. This is because the expansion of therapeutic listening enabled us to take "hunger and the desire to eat" not only as related to the number of nutrients provided to the organic body but as the hunger to relive the sensations provided by food and to make a presence in the territories sharing food.

Permeated by the exercise of dialogue and listening to food pleasure, so striking in Pedro's history, the box of technical tools accessed by the team of speech-language therapists/professionals then moved on to the tension between the hardness of organic knowledge and the effects of the singular clinical encounter. As an explicit manifestation of this, we observed the constitution of a specific therapeutic setting for speech-language therapy,

which guaranteed privacy and the consolidation of a bond of trust that propelled the observed clinical evolution.

In line with the interventions that considered the presence of the speaking body, the impact on the impaired organic structure did not occur in a way that was disconnected from the dialogic tissue. We can say that the clinical act of opening space for dialogue revealed from the moment that the patient's demand to speak and speak to the other was no longer ignored, in other words, when the montage was put into action textuality, offering support so that Pedro could sustain his condition as a speaker.

The clinical act also involved considering that the incidence of the symbolic on organic matter allows the emergence of gesture, praxis, or better, the movement in the field of meanings, of language[7]. Although there is a precariousness of the organic structure for oral production, the body speaks, produces text capable of being interpreted. It is not without reason that authors pointed to the possibility of the gesture being achieved from the construction of enunciative scenes[12].

Based on the relationship between the act of eating and commensality, the olfactory and gustatory references present in the consultations with Pedro updated the eating practices experienced in the family scenario. The commensal space - with whom one eats, the sharing of food on the table, calls for the strengthening of affective bonds because it is at the service of the symbolic value carried by the food, involved in the exchange of information and feelings belonging to this dynamic[6]. Thus, even if exercises added to the swallowing training aim to promote oropharyngeal swallowing in a safe, efficient, gradual, and pleasurable way[5], opening space for the individual to be heard shows the fact that the body is affected by the word of the other[3]. We found two clinical cases reported the same in the literature.

The case of Dona Laura, 82 years old, a victim of an Ischemic Stroke with oropharyngeal dysphagia and changes in the expression of oral and written language, and dysarthria shows the therapeutic construction of a plan that considered the execution of myofunctional exercises and discursive work as a direction to circulate a subjective position, modify the organic plan and produce new narratives around the illness[13]. We noted the same in the case study of a patient, 33 years old, a victim of severe traumatic brain injury, who considered therapeutic listening as a device for changes in swallowing disorders with possibilities in the reintroduction of oral feeding[14].

In the case of Pedro, the strategy of speech and listening enabled the construction of a path from the perspective of care as a practice that affects the experience of physical/psychic illness, in the unique form of illness that makes new forms of expression arise when dealing with ruptures of the body and the new way of moving on in life[15]. We can say that the articulation of the physiological-based technical framework on subjective implication, on the recognition of a speaking body, and the importance of commensality practices enabled to reintroduce oral feeding in the semi-liquid (honey) and homogeneous pasty consistencies, with self-supply.

The indication for gastrostomy, the maintenance of therapy, the embarrassment in the reintroduction of oral feeding, the fact that Pedro hides to drink water from the tap, the affections intertwined with food, all this was sewn into the complexity of his illness, betting also on light and relational technologies[10], permeable to the dimension of the encounter in the clinical scene and to the recognition that the body of the speaking-being is a body linked by language[1].

FINAL COMMENTS

The presentation of Pedro's case report showed that taking on the body from the point of view of its connection with language brought about a change in the direction of treatment initially proposed for the care of the individual with dysphagia. The focus on bodily functions was sewed by eating pleasure and commensality, from the opening of listening and dialogue that involved clinical actions committed to the inclusion of the individual and the vicissitudes of his illness process. This was only possible due to the recognition that the incidence of language on organic matter promotes the shift from the non-speaking position to a "body" text capable of being interpreted[4]. More than that, even when the body is affected, the individual can find resources to respond to the restrictions placed by the damages imposed on the organic substrate.

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Author contributions

JM - Design of the project, analysis and interpretation of data, writing of the article and relevant critical review of the intellectual content and final approval of the version to be published; MC - design of the project, analysis and interpretation of data, writing of the article and relevant critical review of the intellectual content and final approval of the version to be published.