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Brief communication

Cross-cultural adaptation of Communication Function Classification System for individuals with Cerebral Palsy

Adaptação transcultural do Communication Function Classification System para indivíduos com paralisia cerebral

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RESUMO

Objetivo: realizar a adaptação transcultural do *Communication Function Classification System* para a população brasileira e verificar a aplicabilidade da versão traduzida.

Métodos: o estudo foi constituído de duas etapas, a primeira relacionada com o processo de tradução e adaptação transcultural por meio da tradução, análise semântica dos itens, e retrotradução do instrumento. A segunda, à testagem do instrumento, foi realizada em 40 pacientes com diagnóstico de paralisia cerebral.

Resultados: a versão final recebeu a chancela da autora do instrumento original e foi publicada pela mesma, juntamente com a versão original e todas as demais traduções, no site <http://cfcs.us>. 60% (24) dos pacientes eram do sexo masculino e 40% (16) do feminino, as idades variaram entre dois anos e quatro meses à 28 anos e dois meses, e a idade média de 7,7 (±4,6). O instrumento foi de fácil e rápida aplicação, e todos os níveis de comunicação foram observados. Sendo que oito pacientes estavam no Nível I, nove no Nível II, dois no Nível III, treze no Nível IV e oito no Nível V.

Conclusões: a versão traduzida e adaptada para o Português Brasileiro do CFCS possibilitou a classificação do desempenho da comunicação diária de indivíduos com Paralisia Cerebral em um dos cinco Níveis de Comunicação. Entretanto, para que seja amplamente utilizado em ambientes clínicos e de pesquisa, ainda há necessidade de trabalhos futuros que verifiquem a sensibilidade e a especificidade do mesmo, além da validação das propriedades psicométricas da versão brasileira do instrumento.

Descritores: Tradução; Paralisia Cerebral; Comunicação; Testes de Linguagem; Fonoaudiologia

ABSTRACT

Purpose: to the cross-cultural adaptation of *Communication Function Classification System* for the Brazilian population and verify the applicability of the translated version.

Methods: the study consisted of two phases, the first of which relates to the process of cultural adaptation, and the second on the instrument testing. The first was made through translation, semantic analysis of the items, back translation and approval of the final version of the instrument's authors. The testing instrument was administered to 40 patients diagnosed with cerebral palsy.

Results: the final version received the seal of the author of the original instrument and was published by the same, along with the original version and all other translations, at <http://cfcs.us>.Of 40 patients 60% (24) were male and 40% (16) were female, ages ranged from 2 years and 4 months to 28 years and two months, with an average age of 7.7 (± 4 6). The instrument was fast and easy application as all communication levels were observed. And eight patients were at Level I, Level II in nine, two at Level III, Level IV in thirteen and eight in Level V.

Conclusions: the translated and adapted version for Brazilian Portuganduese of CFCs allowed the classification of the performance of daily communication of individuals with cerebral palsy in one of five levels of communication. However, to be widely used in clinical and research environments, there is still need for further work (research) to verify the sensitivity and specificity, in addition to the validation of the psychometric properties of the Brazilian version of the instrument.

Keywords: Translation; Cerebral Palsy; Communication; Language Test; Speech, Language and Hearing Sciences

INTRODUCTION

Cerebral palsy (CP) is described as a group of permanent changes in the development of movement and posture that limit daily life activities as a consequence of a nonprogressive injury to the central nervous system that may occur during the pre-, peri- or postnatal period. The motor disorders are frequently accompanied by disorders of sensation, perception, cognition, communication and behavior and by epilepsy, as well as secondary muscoloskeletal problems[1].

There is a current preference in the literature to classify children withCPaccording to their functional Independence regarding gross and fine motor functions. Patient assessment and documentation for the treatment of CP should use methods validated according to the International Classification of Functioning Disability and Health (ICF) inCPof the World Health Organization[2], using use a uniform language for the description of health problems or interventions all over the world. Thus, theGross Motor Function Classification System (GMFCS)[3]and the Manual Abilities Classification System (MACS)[4]have been developed in order to categorize the mobility and manual function of children with CP, respectively, and have already been translated into Brazilian Portuguese[5,6].

However, there used to be no similar instrument for the classification of the functional communication of patients with CP to be used both in clinical practice and for research. The lack of a reliable validated and easy to use instrument limits the comparison of the communication of patients with CP to descriptive epidemiological studies and the interpretation and generalization of the treatments.In order to fill ths gap, Canadian researchers have elaborated theCommunication Function Classification System (CFCS) in order to classify the performance of daily communication of individuals with CP into five levels using a language shared by professionals and lay persons[7].

Particularly in Brazil, there is a scarcity of commercially available formal and objective instruments, especially in the language area. Thus, the translation and adaptation of instruments to other languages has been seen as a possibility of minimizing this difficulty in clinical practice andof permititng the standardization and execution of transcultural studies that might provide better clarification and understanding of disorders of communication and their specificities in different languages[8].

The process of translation and adaptation of international instruments is a relatively recent practice in Speech Therapy although it is already a diffuse practice among Brazilian psychologists and neuropsychologists, thus representing a path to be still followed that has currently engaged several groups of speech therapists[9,10].

The objective of the present study was to translate and to perform the transcultural adaptation of the CFCS to the Brazilian population, and then to determine the applicability of the translated version.

METHODS

The study was approved by the Research Ethics Committee of the University of Sergipe (nº 002500/2013) and the parents or persons responsible for all subjects gave written informed consentfor their participation in the study. The study consisted of two stages, the first involving the process of translation and transcultural adaptation and the second consisting of the testing of the instrument. The translation into Brazilian Portuguese and the use of the instrument were solicited from the senior author (Mary Jo Cooley Hidecker)and authorized by her.

The translation of the instrument and its transcultural adaptation to the Brazlian population consisted of the following stages: translation, semantic analysis of the items and back translation of the instrument based on the studies by Beaton *et al*.[11], Herdman, Fox-Rushby and Badia[12]and Behling and Law[13].Three professionals participated in the translation of the instrument: a clinical speech therapist with command of English and experience in neuropediatrics (P1), a university professor and speech therapist with experience in neuropediatrics (P2),and an official public translator (P3).The back translation of version 1 of the instrument was performed by a linguist with a degree in letters, with command of English and experience in translations in the field of neuropediatrics (P4), who, however, did not know the original English version of the CFCS.Two professionals, a linguist (P4) and a speech therapist (P1), participated in theback translation stage of the final version of the instrument.

The initial translation of the original English version into Portuguese was performed by P1, checked by and discussed with P2, and revised byP3, producing version 1 of the instrument in Brazilian Portuguese.

Next, P4 performed the back translation of version 1 into the original language of the instrument (English). The back translation of version 1 was compared to the

original version of the instrument by P1 and P4 and version 2 was produced after discussions, content analysis and terminologic adjustments performed by P1 and P2.

A new version of the translation, denoted final version, was then elaborated and again translated into English by P1 and P4 and sent to the authors of the instrument for verification and approval. With approval of the final version by the authors, the instrument was applied to a random sample of 40 individuals with a diagnosis of CPregardless of motor involvement or classification of functionality. The subjects were males and females ranging in age from 2 years and 4 months to 28 years and 2 months, seen at a Medical Specialty Center.

All the forms of communication used by the individuals were first determined: speech, gesturing, behaviors, fixed eye gaze, facial expressions and augmentative and alternative communication (AAC). AACsystems include manual signs, pictures, boards, communication books and vocal systems – at times called voice output devices or speech-generating devices.

It was then explained to the persons responsible that the differences in the levels of communication are based on the performance of functions as a sender and receiver, on the rhythm of communication and on the type of conversational partner, i.e.: LevelI – Effective sender andreceiverwith unifamiliar and familiar partners;Level II -Effective sender andreceiverbut with a slower conversational rhythm, i.e., with more interruptions and a longer waiting time between these exhanges of communicative turns with familiar and unfamiliar partners; Level III –Effective senderandreceiveronly with familiar partners; Level IV-Inconsistent sender andreceiverwith familiar partners; LevelV–Seldom effective sender andreceivereven with familiar partners.

Each one of the above concepts was defined and the Diagram of the Classification Levels of the CFCS was presented to the caregiver, who, with the help of the speech therapist, determined in what level the patient was currently functioning.

RESULTS

Comparison of the original protocol, the tanslated version and the back translated version did not reveal discordance of semantic equivalence. The final version of the transcultural adaptation(Enclosure 1) maintained the five questions of the Diagram of the Levels of Classification of the CFCS in which positive (yes) or negative (no) responses determine the outcome of the five possible communication levels.The final version received the seal of the author of the original instrumentand was published by her on the free access <http://cfcs.us>site together with the original version and all the other translations.

Thus, as shown in the original protocol, the differences in levels are based on the performance of the individual in sender and receiver functions, on the rhythm of communication and on the type of conversational partner, with Level I indicating the most effective communication and Level V the least effective one. Some definitions should be considered when using this classification system:

1. **Senders and receivers**are consideredto be**effective** when they alternate the transmission and understanding of the messages in a rapid and easy manner. To clarify or resolve misunderstandings, effective receivers abd senders can use or solicit strategies such as repetition, reformulation, simplification or complementation of the message. To acceleate exchange during communication,especally when the AAC is used, an effective sender can use messages that are not so grammatically correct, leaving out or shortening words with familiar communication partners.

2. A **comfortable communication rhythm** is characterized when a person understands and transmits messages in an easy and rapid manner. A comfortable rhythm occurs when there are few interruptions and a short waiting time between communicative exchanges.

3. **Unfamiliar conversation partners** are strangers or persons that only occasionally communicate with the individual. **Familiar conversation partners**are relatives, caregivers and friends who can communicate more effectively with the individual due to previous knowledge and personal experiences.

The final version was applied to 40 patients with a diagnosis of CP,60% of them (24) males and 40% (16) females ranging in age from two years and four months to 28 years and two months (mean age: 7.7 ± 4.6 years).

Regardless of the various forms of communication that may be used by a person, only one CFCS level is attributed to him, thus characterizing his overall communication performance. The only form of communication not detected in the present subjectswas the use of voice output devices (Table 1).

Table 1. Characterization of the patients studied

Patient	Sex	Age	CFCS Level	Forms of communication
1	F	8	II	1;2;3
2	M	14	III	2;3
3	M	7	IV	2
4	M	4	IV	2;3
5	M	4	II	2;3
6	F	4	IV	2;3
7	M	2	V	2
8	M	12	II	1;3
9	F	5	IV	2;3
10	M	3	V	2
11	M	20	II	1;2;3
12	M	2	IV	2;3
13	M	8	I	1;3
14	M	10	I	1;3
15	M	10	I	2;3;4
16	F	14	III	2;3
17	M	3	IV	2
18	F	4	IV	2;3
19	F	12	I	1;3
20	F	13	V	2;3
21	M	6	IV	2;3
22	M	9	IV	3
23	M	7	IV	2;3
24	F	4	IV	2;3
25	M	10	II	3;5
26	M	6	V	2
27	M	17	II	2;3
28	M	5	V	2
29	F	10	II	2;4
30	M	6	I	1;3
31	F	4	I	1;2;3
32	F	10	II	2;3;5
33	M	19	IV	2;3
34	M	5	IV	2;3
35	M	2	V	2
36	M	5	V	2
37	F	4	II	2;3
38	F	6	I	1;2;3
39	M	6	IV	2
40	F	28	I	1;3

Legend: Forms of communication1: Speech; 2:Sounds. 3: Fixed eye gaze, Facial Expressions, Gesturing and/or Pointing; 4: Manual Signs; 5: Communication Books, Boards, Panels, Pictures; 6: Voice output device

Despite the small sample size, all levels of communication were detected among the individuals studied: 20% (8) werelevelI, 22.5% were levelII (9), 5%levelIII (2), 32.5% level IV (13), and20% level V (8). In addition, the instrument was easy to apply and was properly understood by all participants, permitting the classification of communication level by all patients and the persons responsible for them.

The difference between levels I and II concerns the pace of conversation. In level I, the person communicatesat a comfortable pace with little or no delay in understanding, in composing a message or in repairing a misunderstanding. In level II, the person needs extra time, at least occasionally. The differences between levels II and III concern pace and type of conversational partners. In level II, the personis an effective sender and

receiver with all conversational partners, but pace is an issue. In level III, the person is consistently effective with all familiar conversational partners but not with most unifamiliar partners.

The difference between levels III and IV is how consistently the person alternates between sender and receiver roles with familiar partners. In level III, the person is usually able to communicate with familiar partners as a sender and a receiver. In level IV, the person does not consistently communicate with familiar partners. This difficulty may occur in sending and/or receiving a message. The difference between levels IV and V is the degree of difficulty the person has in communicating with familiar partners. In level IV, the person has some success as an effective sender and/or receiver with familiar partners. In level V, the person is seldom able to communicate in an effective manner, even with familiar partners.

DISCUSSION

The use of formal and objective instruments directly affects the definition of the diagnosis and consequently the definition of therapeutic conducts and the elaboration of intervention plans, possibly compromising the efficacy and efficiency of treatment. Constant questionings are essential in clinical practice regarding the progress of a person submitted to speech therapy in terms of effectiveness, efficiency and effect[14,15].

Specifically regarding persons with CP, several studies have emphasized the need to monitor the development of communication in order to perform an early intervention in all children, but mainly in those with severe motor deficiency and in those born preterm. The American Academy of Neurology actually recommends the screening of speech and language in all children withCP[15-17].

However, comparison of studies on the development of communication in children with CP is difficult due to the differences in terminology and in the instruments used for assessment. Thus, it is within this context that theCFCS was developed in order to reduce this problem, providing a system for the classification of functional communication in children with CP using a language shared by professionals and lay persons[7,16]. Indeed, in a recent study the CFCS was identified as an appropriate system of epidemiological surveillance foi the classification of communication in children withCP[18].

The objective of the CFCS is to classify into one of five levels the performance of daily communication of persons with CP. The system deals with the levels of activity and participation according to the International Classification of Functioning Disability and Health of the World Health Organization, considering that communication occurs whenever a sender transmits a message and the receiver understands it. An efficient communicator alternates independently between sender and receiver roles regardless of the demands of a conversation, the communication partners or the topics. All forms of communication are considered when the CFCS levelis determined, including the use of speach, gesturing, behaviors, fixed gaze, facial expressions and augmentative and alternative communication(AAC).

The process of translation and transcultural adaptation of the CFCS to Brazilian Portuguese permitted the final version of the instrument to have an appropriate language pertinent to the the area of knowledge of speech therapy and neuropediatrics. The process also sought to make the instrument easy to understand for the different individuals that would use it. To determine the CFCS level it is not necessary to apply tests, with the parents or persons responsible or a professional familiar with the communication of the individual selecting the level of communication performance. Also, depending on the age and cognitive capacity of the patient, these persons can also clasify his performance.

The CFCS, however, cannot explain any reasons that might justify the degree of effective or ineffective communication and cannot provide a prognosis regarding patient improvement. On this basis, it is important to underscore that the CFCS does not replace the standardized language assessment by a speech therapist, since it is not its objective to evaluate the dimensions, the components or the units of language and it does not take into consideration the countless variables that Interact for its development.

In the present study, the CFCS classification was performed only by the caregivers, while in another study in which the investigators performed it, the interexaminer reliability was considered to be excellent and the investigators were able to easily classify the children using the CFCS[19]. The easy application of the instrument was also observed in the present study.

In another study carried out to determine the intra- and inter-observer reliability of the Dutch version of the CFCS and to investigate the association between CFCS level, the comprehension of spoken language and the form of communication most often used by CP children, in which both the parents and the speech

therapist applied theCFCS, the authors considered the CFCSto be a valid and reliable clinical tool for the classification of daily communication of CP children. The authors concluded that the professionals should preferentially classify the CFCS level of the child in collaboration with the parents in order to obtain more extensive information about the daily communication of the child in various situations involving both familiar and unifamiliar partners[20].

It is important to conclude this report by emphasizing that the Brazilian Portuguese version of theCFCS,in addition to providing a standardized terminology for the characterization of the communication of patients with CP at the various health care facilities and contributing to comparative studies with other countries since the instrument is currently available in 14 langages, can be used as an instrument in programs of evidence-based health practice. Such programs intend to promote the integration of clinical experience with the best available evidence obtained with standardized instruments and protocols used worldwide.

CONCLUSION

The translated version of the CFCS adapted to Brazilian Portuguese permitted the classification of daily communication performance of individuals with cerebral palsy into one of the five communication levels. However,further research is needed to determine the sensitivity and specificity of the Brazilian version of the instrument, in addition to the validation of its psychometric properties before it can be extensively used in clinical and research settings.

REFERENCES

1. Rosenbaum P, Paneth N, Leviton A, Goldstein M, Bax M. A report: the definition and classification of cerebral palsy: April 2006. Dev Med Child Neurol. 2007;49(6):8-14.
2. WHO – World Health Organization. International Classification of Functioning, Disability and Health: ICF. Geneva: World Health Organization, 2001.
3. Palisano R, Rosenbaum P, Walter S, Russell D, Wood E, Galuppi B. Development and reliability of a system to classify gross motor function in children with cerebral palsy. Dev Med Child Neurol. 1997;39(4):214-23
4. Eliasson AC, Krumlinde-Sundholm L, Rösblad B, Beckung E, Arner M, Ohrvall AM, Rosenbaum P. The Manual Ability Classification System (MACS) for children with cerebral palsy: scale development and evidence of validity and reliability. Dev Med Child Neurol. 2006;48(7):549-54.
5. Hiratuka E, Matsukura TS, Pfeifer L. Adaptação transcultural para o Brasil do Sistema de Classificação da Função Motora Grossa (GMFCS). *Rev. bras.* fisioter. 2010;14(6):537-44.
6. Silva DBR, Pfeifer LI, Funayama CAR. Sistema de Classificação das Capacidades de Manipulação (SCCM) 4-18 anos. [Internet] [cited 2014 Aug 15]. Available from: http//www.macs.nu/files/MACS_Portuguese_2010.pdf.
7. Hidecker MJ, Paneth N, Rosenbaum PL, Kent RD, Lillie J, Eulenberg JB, Chester K Jr, Johnson B, Michalsen L, Evatt M, Taylor K. Developing and validating the Communication Function Classification System (CFCS) for Individuals with Cerebral Palsy. Dev Med Child Neurol. 2011;53(8):704-10.
8. Giusti E, Befi-Lopes DM. Tradução e adaptação transcultural de instrumentos estrangeiros para o Português Brasileiro (PB). Pró-Fono R. Atual Cient. 2008;20(3):207-10.
9. Andrade LT, Rossi NF, Giacheti CM. Adaptação transcultural do Preschool Language Assessment Instrument: Segunda Edição. CoDAS. 2014;26(6):428-33.
10. Bento-Gaz ACP, Befi-Lopes DM. Adaptação do teste Clinical Evaluation of Language Functions-4th Edition para o Português Brasileiro. CoDAS. 2014;26(2):131-7.
11. Beaton DE, Bombardier C, Guillemin F, Ferraz MB. Guidelines for the process of Cross-cultural adaptation of self-report measures. Spine (Phila Pa 1976). 2000;25(24):3186-91.
12. Herdman M, Fox-Rushby J, Badia X. A model of equivalence in the cultural adaptation of HRQoL instruments: the universalist approach. Qual Life Res. 1998;7(4):323-35.
13. Behling B, Law KS. Translating Questionnaires and Other Research Instruments: Problems and Solutions. 2000.
14. Andrade CRF, Juste F. Proposta de análise de performance e de evolução em crianças com gagueira desenvolvimental. Rev. CEFAC. 2005;7(2):158-70.

15. Coleman A, Weir KA, Ware RS, Boyd RN. Relationship between Communication Skills and Gross Motor Function in Preschool-Aged Children With Cerebral Palsy. Archives of Physical Medicine and Rehabilitation. Arch Phys Med Rehabil. 2013;94(11):2210-7.
16. Sigurdardottir S, Vik T. Speech, expressive language and verbal cognition of preschool children with cerebral palsy in Iceland. Dev Med Child Neurol. 2011;53(1):74-80.
17. Himmelmann K1, Lindh K, Hidecker MJ. Communication ability in cerebral palsy: a study from the CP register of western Sweden. Eur J Paediatr Neurol. 2013;17(6):568-74.
18. Virella D, Pennington L, Andersen GL, Andrada MD, Greitane A, Himmelmann K et al. Classification systems of communication for use in epidemiological surveillance of children with cerebral palsy. Dev Med Child Neurol. 2016;58(3):285-91.
19. Ashwal S, Russman BS, Blasco PA, Miller G, Sandler A, Shevell M et al. Practice parameter: diagnostic assessment of the child with cerebral palsy: report of the Quality Standards Subcommittee of the American Academy of Neurology and the Practice Committee of the Child Neurology SocietyNeurology. 2004;62(6):851-63.
20. Vander Zwart KE, Geytenbeek JJ, de Kleijn M, Oostrom KJ, Gorter JW, Hidecker MJ et al. Reliability of the Dutch-language version of the Communication Function Classification System and its association with language comprehension and method of communication. Dev Med Child Neurol. 2016;58(2):180-8.

ERRATUM

In this article, “Cross-cultural adaptation of Communication Function Classification System for individuals with Cerebral Palsy”, with DOI number: 10.1590/1982-021620161840716, published in the journal *Revista Cefac*, 18(4):1020-1028, on page 1020:

Where it was:
Isabela Carolina Santos Bicalho

Read:
Isabella Carolina Santos Bicalho

Enclosure 1. Brazilian version of the *Communication Function Classification System*

Sistema de Classificação da Função de Comunicação (CFCS) para Indivíduos com Paralisia Cerebral

Objectivo

O **objetivo** do CFCS é classificar o **desempenho da comunicação diária** dos indivíduos com paralisia cerebral em cinco níveis. Este sistema aborda os níveis de atividade e participação de acordo com a Classificação Internacional de Funcionalidade, Incapacidade e Saúde (CIF) da Organização Mundial de Saúde (OMS).

Instruções de uso

Os pais, os responsáveis ou um profissional familiarizado com a comunicação do indivíduo irá selecionar o nível de desempenho da comunicação; sendo que os adolescentes e adultos com PC também podem classificar o seu desempenho. A **total eficácia** do desempenho da comunicação deve ser **baseada no modo pela qual os indivíduos geralmente participam das situações cotidianas que requerem o uso de comunicação**, e não na sua melhor performance. Estas situações podem acontecer em casa, na escola ou na comunidade.

Algumas situações de comunicação podem ser difíceis de serem classificadas se o desempenho for incluído em mais de um nível. Nestes casos, escolha o nível **que mais se assemelha** ao desempenho rotineiro do indivíduo, **na maioria dos lugares**. Ao selecionar um nível, não considere a capacidade de percepção, de conhecimento ou de motivação.

Definições

A **comunicação** ocorre quando um **emissor** transmite uma mensagem **e** o **receptor** entende a mensagem. O **comunicador eficiente alterna,** de modo independente, **seu papel de emissor e receptor,** não importando as demandas de uma conversação, incluindo os lugares (e.g. comunidade, escola, trabalho e casa), os parceiros da comunicação e os assuntos.

Todas as formas de comunicação são consideradas quando se determina o nível do CFCS. Eles incluem o uso da fala, gestos, comportamentos, olhar fixo, expressões faciais e a comunicação alternativa e aumentativa **(CAA)**. Os sistemas da CAA incluem sinais manuais, figuras, pranchas e livros de comunicação, e vocalizadores – às vezes chamados de aparelhos de emissão de voz ou aparelhos geradores de fala.

As diferenças entre os níveis baseiam-se no desempenho de **funções como emissor e receptor,** no **ritmo da comunicação** e no **tipo de parceiro na conversação**. As seguintes definições devem ser consideradas quando este sistema de classificação for usado.

Emissores e receptores eficientes alternam de forma rápida e fácil a transmissão e a compreensão das mensagens. Para esclarecer ou resolver mal entendidos, os receptores e emissores eficazes podem usar ou solicitar estratégias tais como repetição, reformulação, simplificação ou complementação da mensagem. Para acelerar a troca durante a comunicação, especialmente quando a CAA é usada, o emissor eficaz poderá utilizar mensagens gramaticalmente não tão corretas, deixando de fora ou encurtando palavras com os parceiros conhecidos de comunicação.

Um **ritmo confortável** de comunicação se caracteriza como aquele em que um indivíduo entende e transmite as mensagens facilmente e rapidamente. Um ritmo confortável ocorre quando há poucas interrupções e um curto tempo de espera entre essas trocas.

Parceiros desconhecidos de conversação são pessoas estranhas ou aquelas que só ocasionalmente se comunicam com indivíduo. **Parceiros conhecidos** de conversação são parentes, cuidadores e amigos que podem se comunicar mais eficazmente com o indivíduo devido aos conhecimentos prévios e experiências pessoais.

Sistema de Classificação da Função de Comunicação (CFCS) para Indivíduos com Paralisia Cerebral

Esclarecimentos

- Determinar o nível do CFCS **não requer testes,** e ele não substitui as avaliações padronizadas de comunicação. O CFCS não é um teste.
- O CFCS **classifica os indivíduos pela sua eficácia** no desempenho atual de comunicação. **Ele não explica quaisquer razões** subjacentes para o grau de eficácia, tais como os problemas de origem cognitiva, motivacional, físicos, de fala,
- O CFCS **não determina o potencial de melhora do indivíduo.**
- O CFCS pode ser **útil para a pesquisa e para prestação** de serviço, quando a classificação de eficácia da comunicação for importante.

Os exemplos incluem:

1) Descrever o desempenho funcional da comunicação, utilizando uma linguagem comum entre os profissionais e leigos;

2) Reconhecer o uso de todas as formas eficazes de comunicação, incluindo a CAA;

3) Comparar como os diferentes ambientes de comunicação, os parceiros, ou as tarefas de comunicação podem afetar o nível escolhido,

4) Escolher as metas para melhorar a eficácia de comunicação do indivíduo.

- Ver página 3 para a descrição dos cinco níveis.
- Ver página 4 para o gráfico auxiliar na distinção entre os níveis.
- Perguntas mais frequentes podem ser encontradas no site http://CFCS.us

Formas de Comunicação

Independentemente das diversas formas de comunicação utilizadas pelo individuo, **apenas um nível do CFCS lhe é atribuído, caracterizando o desempenho global da comunicação.**

A lista de todas as formas de comunicação que podem ser utilizadas é apresentada abaixo.

As seguintes **formas de comunicação** são utilizadas por este indivíduo:
*(Por favor, marque **todas** que se aplicam)*

- ☐ Fala
- ☐ Sons (como "aaaah" para chamar a atenção do parceiro)
- ☐ Olhar fixo, expressões faciais, gestos e/ou apontar (com alguma parte do corpo, uma vara, laser)
- ☐ Sinais manuais
- ☐ Livros, pranchas de comunicação, painéis, figuras
- ☐ Vocalizador
- ☐ Outro(s)

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Referências para o aprimoramento do CFCS:
Hidecker, M.J.C., Paneth, N., Rosenbaum, P.L., Kent, R.D., Lillie, J., Eulenberg, J.B., Chester, K., Johnson, B., Michalsen, L., Evatt, M., & Taylor, K. (2011). Developing and validating the Communication Function Classification System (CFCS) for individuals with cerebral palsy, Developmental Medicine and Child Neurology. 53(8), 704-710. doi: 10.1111/j.1469-8749.2011.03996.x, PMC3130799.

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Sistema de Classificação da Função de Comunicação (CFCS) para Indivíduos com Paralisia Cerebral

I. Emissor e receptor eficaz com parceiros desconhecidos e conhecidos.
O indivíduo **alterna independentemente seus papéis de emissor e receptor** com a maioria das pessoas, em vários lugares. A comunicação ocorre facilmente e em um **ritmo confortável** com **parceiros desconhecidos e conhecidos.** Equívocos de comunicação são resolvidos rapidamente e não interferem na eficácia geral da comunicação.

II. Emissor ou receptor eficaz, mas mais lentos com parceiros desconhecidos ou conhecidos. O indivíduo **alterna independentemente seus papéis de emissor e receptor** com a maioria das pessoas, na maioria dos ambientes, mas o **ritmo de conversação é lento** e pode dificultar a interação na comunicação. O indivíduo pode precisar de mais tempo para entender as mensagens, compor mensagens ou resolver mal-entendidos. Os equívocos de comunicação muitas vezes são resolvidos e não interferem com a eventual eficácia da comunicação do indivíduo com **parceiros desconhecidos e conhecidos.**

III. Emissor e receptor eficaz com parceiros conhecidos. O indivíduo alterna seus papéis de emissor e receptor com parceiros conhecidos de conversação (mas não desconhecidos) na maioria dos ambientes. A comunicação **não é consistentemente e eficaz** com a maioria dos **parceiros desconhecidos**, mas é geralmente **eficaz com os parceiros conhecidos.**

IV. Emissor e/ou receptor inconsistente com parceiros conhecidos. O indivíduo **não** alterna consistentemente seu papel de **emissor e receptor.** Este tipo de inconsistência pode ser visto em diferentes tipos de comunicadores, incluindo: a) um emissor e receptor ocasionalmente eficaz; b) um emissor eficaz, mas receptor limitado; c) um emissor limitado, mas receptor eficaz. Às vezes, a comunicação é eficaz com parceiros conhecidos.

V. Emissor e receptor raramente eficaz, mesmo com parceiros conhecidos. O indivíduo é **limitado** tanto como **emissor quanto receptor.** A comunicação deste é difícil para a maioria das pessoas entender. O indivíduo parece compreender pouco as mensagens emitidas pela maioria das pessoas. A comunicação é **raramente eficaz**, mesmo com parceiros conhecidos.

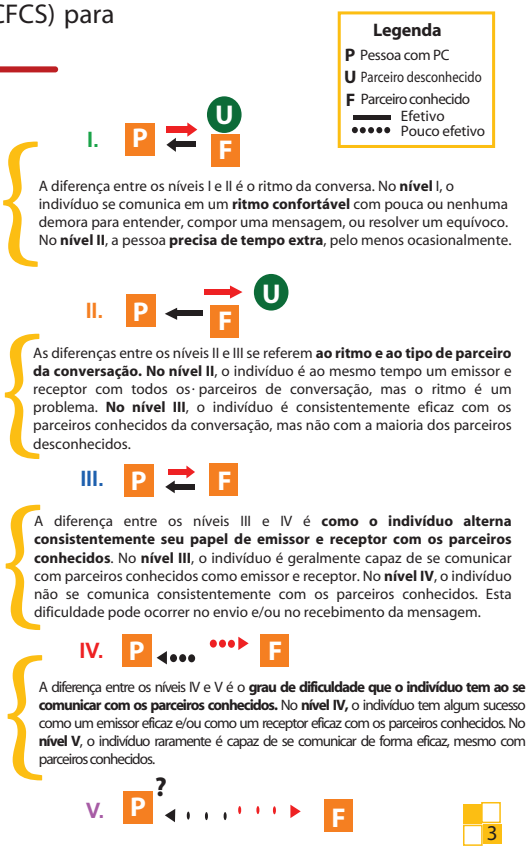

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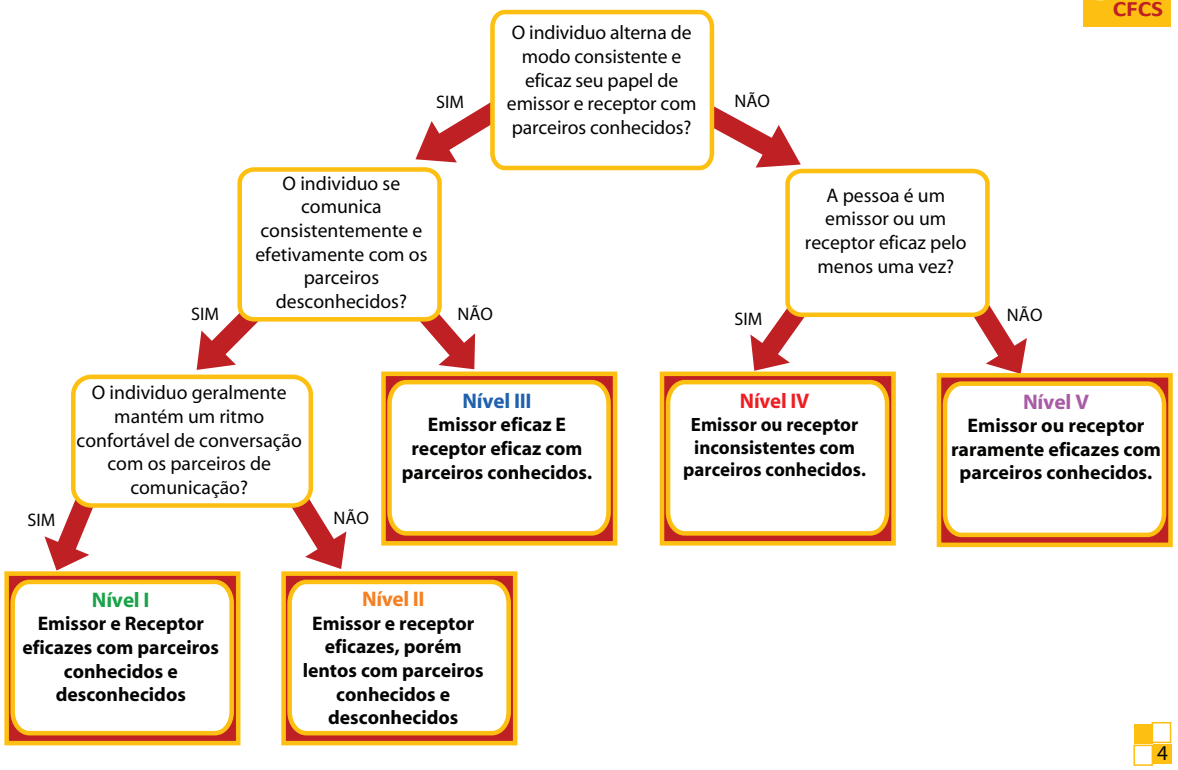
Diagrama dos Níveis de Classificação do CFCS



4