CLINICAL RISKS INDICATORS FOR THE CONSTITUTION OF THE SPEAKING SUBJECT

Indicadores clínicos de risco para a constituição do sujeito falante

Fábia Regina Evangelista Verly [1], Regina Maria Ayres de Camargo Freire [1]

ABSTRACT

Purpose: to propose clinical risk indicators of the constitution of the speaking subject. **Methods**: From the risk indicators for child development and from the operating model of language symptoms, four axes were drawn that support the constitution of the speaking subject: the assumption of a speaking subject, recognition of the speaking subject, recognition of the significant and responsiveness of the speaker to the speech of the other. Parental information mentioned during speech therapy interviews of users of three Basic Health Units were grouped by similarity, classified, and analyzed according to each of the four axes of the constitution of the speaking subject. **Results**: The analysis allowed us to establish twelve preliminary clinical indicators for the constitution of the speaker. These indicators point to a possibility that the subject might present speech and language disorders, supporting not only their intervention but also measures to promote the health of the speaker. **Conclusion**: The results suggest the importance of the speech therapist in the primary health care of the population and in promotional health measures.

KEYWORDS: Risk Indicator; Child Language; Speech Therapy; Public Health

INTRODUCTION

To suggest clinical indicators in the field of speech therapy is not a simple task -- we must consider the peculiarities of this practice in its dealing with subjective aspects, noting that a speech diagnosis does not establish a direct relationship between symptom and disease, due to the nature of language in its differentiation with the nature of the organic body. The therapist, in making his/her commitment to the patient's speech, faces unique productions whose specificity needs a listener that recognizes them.

In this way, the indicators in clinical speech therapy that are dedicated to the symptoms of language "must be considered indication or clues that lend credibility to the construction of hypotheses about movements that are completely subjective and unique"[1]. The indicators in this case are accompanied by the adjective "clinical" since that is the nature of the speech therapy practice, which comprises the uniqueness of the subject and its functioning in or through language.

The clinical speech therapy here in focus conceives the symptoms of speech and language as signs of the presence of a speaking subject, composed mainly of listening and speech. Symptoms of speech and language characterized by grammatical, vocabulary, and syntax constraints occur largely due to failure of the position of the subject in the language. The model of structural multi-stratification of the symptoms of language[2] can sustain the structure of clinical speech therapy based on the idea that the sanction or the establishment of language laws that govern the speakers is the relationship between the structure and the functioning of the language. The retroactive effects of the sanction of one speech over another generates both the constitution and the reversal of the symptoms of language[3].

The clinical indicators for the speaker's constitution were anchored on the four axes for the constitution of the subject[4], supported by the organizational model of language symptoms and developed for this research. It is worth mentioning

[1] Pontifícia Universidade Católica de São Paulo, São Paulo, SP, Brasil.

Source of Assistance: CAPES/OBEDUC

Conflict of interest: non-existent

that each axis is part of a structure and, as such, is synchronic to the others:

The assumption of a speaker -- the constitution of the child as a speaker is tied to his/her anticipation of the discourse of the other. A baby is surrounded by language even before conception. It is from this assumption that the other (mother or caregiver) interprets the baby's first signs (vocal or not) and meets his/her demands. This way, the baby's encounter with the language occurs through the other that connects him/her to the symbolic order, that is, to the order of language.

Speaker recognition -- for the child to speak it is necessary that the cries, sounds, gestures, and muscle spasms be understood by someone as speech or a message addressed to him/her. The speaker's recognition depends on the assumption of hearing significants where, strictly speaking, there is only one unidentifiable sound as linguistic element.

Recognition of the significant -- in the constitution of the speaker the child's speech is limited to the speech of the other, and from that speech, the child incorporates fragments of adult speech that, in turn, interprets such fragments giving them a meaning. For instance, the child says "boh" and the adult responds "Oh! You want the ball." This movement to adopt a speech segment and put it in combination gives grammatical character to the child's speech, and promotes effects on the network of syntax and of the senses.

Responsiveness to the speech of the other -- suggests that the child occupies the position of a speaker and that he/she responds to the speech of the other. The speech of the child will be under the effect of the speech of the other to the point where he/she will be affected and will respond, sustaining a dialogue. To talk is to speak to the other; therefore, the child tells stories, recounts events, expresses wishes, and "gives voice to characters" in symbolic activities. In this manner, the presence of this axis presumes that the subject recognizes him or herself and is recognized by the other as the speaker, while listening to his/her own speech and the speech of the other.

For the Speech Therapy to continue receiving due respect and recognition, it is necessary to establish and promote indicators that can guide speech therapy measures in Public Health[5]. The objective of this work is to propose clinical indicators of risk for the constitution of the speaking subject.

METHODS

This is a retrospective study of a clinical qualitative nature conducted in three Unidades Básicas de Saúde (Basic Health Units) having a speech therapy department located in the East Zone of the city of São Paulo. It was approved by the Ethics Committee of the Municipal Health Department of the city of São Paulo (authorization number 333/10) and carried out under the ethical principles established by the National Commission on Research Ethics for research involving human beings.

The sample was initially composed of 422 speech-language reports, from which were selected those that met the selection criteria: subjects in the age range of two-six years, speech assessment, initial diagnostic hypothesis of articulation disorder, stuttering, and oral language delay. At the end of this process, 88 reports were included in the sample.

For the analysis, a spreadsheet was elaborated containing the categories of information furnished by family members. This cut was supported by the hypothesis that the signs that might be used as indicators would appear in the family information about the child and his/her constitution as a speaker.

Criteria for data interpretation

To achieve or purpose the four theoretical axes were taken into consideration: the assumption of a speaker, speaker recognition, recognition of the significant, and responsiveness to the speech of the other, which guided the development of clinical indicators for the constitution of the speaking subject. Interpretation of the data focused on the information given by the family about the child. After the first analysis of this information, it was observed that they could be grouped by similarity. In this way, the construction of the preliminary clinical indicators for the constitution of the speaking subject came from the complaints of family members as to what was disturbing, extrapolating from this what would be normal. In other words, normal would be the asymptomatic and, therefore, without any demand for the speech therapy.

Data analysis

The constitution of the speaking subject implies the anticipation of the other and the position of the subject himself in relation to his own speech and the speech of the other, which makes it feasible to use the four axes for the constitution of the speaking subject as benchmarks for the analysis of information from the parents. The first axis – to assume a speaking subject - is presumed in all the information, because in bringing a speech complaint, the parents confirm their assumption that their child is speaking.

The parental information below was linked to the first axis -- recognition / denial of the speaking subject:

- *Has difficulty speaking;*
- *Almost does not speak;*

- *Speaks little and in a strange way;*
- *Speaks fast and stutters;*
- *Does not formulate complete phrases;*
- *When he speaks, his tongue sticks out;*
- *My son does not speak and does not swallow his saliva.*

The child's other – his/her caregiver - (based on the psychoanalytic theory in which the small other is the peer, the equal in the human species, and the big Other is from the symbolic field of language, where the subject will constitute itself), denies the speaking subject by denying his speech, since it is impossible to separate subject and speech. When derogating the speaking subject, the other promotes the operation of sanction that "[...] is, at the same time, to validate or veto an act and to recognize or ignore a subject. Be it by the affirmative gesture, or by a negative inference, be it by silence or by questioning [...] "[3].

Since the recognition of the speaking subject is tied to its anticipation by the other, the parental information shows how those responsible conceive the language symptom and how this manifests itself in the speech of the subject.

From these observations, the constitution of the speaking subject alludes to the baby's representations as interlocutor for the other, whose status instigates the subjectivation process, in which the birth of the human subject occurs when the speech of the other attributes meaning and interprets its wishes, capturing the child in the symbolic network of language. Seen in this way, language as a discursive activity has a role that is prior to its expressive function.

The following parental information is linked to the second axis, ie: recognition / denial of the signifier:

- *Speaks the wrong way;*
- *Speaks a lot, but speaks wrongly;*
- *He likes to talk, but mispronounces his words;*
- *She exchanges letters, mispronounces her words, and speaks very softly;*
- *Says everything the wrong way and does not say much;*
- *Speaks wrongly like his brother.*

This information conveys denial of the signifier. In other words, the other recognizes the speech of the subject, but considers it faulty, wandering, and deviant, so it is banned and sanctioned in the translation mode. However,

(...) The speech of a child indicates that she entered into a field that goes beyond that of speech -- the field of language. This field includes other significant manifestations, but is not limited to them. The entrance of the child into the field of language is not only measured by skills of vocabulary, syntax and grammar, or by skills in other language manifestations, such as gestures, for example. This entry is measured mainly by the place from which the subject is represented in the language system, revealing his ability to situate himself in relation to the meanings of the world, his ability to sustain relationships with others, to recognize in language the demands and desires of others, and of producing, in turn, new meanings[6].

Considering that the Other precedes the subject, the adult places the child in a position in which he/she will respond, i.e., the adult anticipates the presence of a speech and language disturbance, as do other members of the family. Therefore, "listening to from which position the child responds with his/her symptom to the effects of a certain position in the family makeup will be a guide in the search for a reference for the differential diagnosis"[7].

In the information of this axis, those responsible for the child enunciate the complaint due to the strangeness that the speech of the subject causes, exposing the suffering caused by the language symptom, compatible with the notion of "[...] sanction that recognizes and symbolizes the indetermination between recognizing the subject or recognition of the significant [...]. Here the symptom appears as refractory to the sanction of the Other "[3].

According to the multi-stratified model of the symptoms of language[2] the "error" marks the relationship that the subject has with language in an attempt to reshape his speech seeking his recognition as Other.

In parental speech, the denial of the signifier (in the Lacanian sense, which is always different) contained in the subject's speech will exclude the opening or listening to his/her speech. However, "the child, by his/her condition of *infans*, greatly depends on what is said about him/her"[8] and, according to this author, "the inhibition of the child to articulate his/her speech is not only a symptom that communicates, from a social standpoint, a family malaise. It testifies to the impotence of the child to identify himself/herself, in recognizing himself/herself in an identification, and in distinguishing himself/herself socially"[8].

It is worth noting the baggage that clinical speech therapy "carries" due to the proximity to clinical medicine, where the symptom of the disease is observed as a quantitative phenomenon, where universal knowledge about the health/disease process predominates. However, the symptoms of speech and language should not be seen in light of clinical medicine because the symptom status in clinical speech therapy "is dependent and inseparable from its way of enunciation and its language

structure. Only for this reason can it be changed, deconstructed, or transformed by linguistic operations"[9].

Therefore, the structure of a child as speaking subject of a language is founded in the position that, as a subject, he/she occupies in the discourse to the extent that the Other attributes interpretation, meaning, and recognition to the significant.

The following parents' information are indicators linked to the **responsiveness to the speech of the other** axis:

- When I call, he does not answer;
- He does not like to talk and does not make complete sentences;
- He does not develop his speech; he does not carry on a conversation;
- She participates in games, but when someone asks her to say something, she remains quiet and observing;
- He does not make up stories; he just repeats what he sees and what he hears.

From *infans* to speaking subject, the child's speech undergoes changes according to the discursive position he/she occupies in relation to the speech of the other, to the language, and in relation to his/her own speech[10]. Parental information presented in this axis leads us to concepts about the symptoms of language. In other words, it is information that infers that the child, besides not listening to the speech of the other, in the presence of the Other becomes paralyzed in a given discursive position. When this happens, we can say that the speaker's relationships (the child - to the speech of the other, parents or caregivers) or rather, the relationship language and speech, is compromised. It is important to remember that the constitution of *infans* in speaker, as previously stated, occurs in capturing his/her speech by the language (Other) as speaker.

In clinical speech therapy, complaints related to children who do not cross the threshold of the functioning of the language and are not responsive to the speech of the other (thus, "do not speak") are recurrent.

As subject, the child is structured by the language, that is, the linguistic discursive functioning is what will matter to the child and allow him/her to distance himself/herself from the other. The speech of the other in which the language is already operating will insert the child in its functioning "[...] since the child sees himself/herself the way he/she is seen"[11].

The non-responsiveness to the speech of the other is directly linked to the otherness of the language, in which the other plays a fundamental role of interlocutor and produces a bonding effect on the subject. Furthermore, it is

> [...] I still need to add the paradoxical dimension of the temporal act or from individual speech events, as someone's speech addressed to the Other. Talking is not simply the agent or user of a language; speaking is also being an author. Talking is to accept and modify a rule, is to perform the universal of the language in the singular of a subject using the particulars of a language[3].

From the information of this axis it can be inferred that the responsiveness to the speech of the other requires the child to move from the condition of interpreted and re-signified by the other to interpreter of his/her own speech and the speech of the other.

RESULTS

In spite of the sample being small, the material analyzed allows us to observe that the preliminary clinical indicators for the constitution of the speaking subject, seen as signs and clues, may be present in the parental information. "Seeing how the adult deals with the child or how he/she narrates daily happenings can be a way of discovering signs"[1]. It is a confirmation "that it is possible to use de indicators of subjective order in clinical speech therapy, if they are investigated using the relationships that the subject establishes with his/her peers and with the language"[12].

The analyzed data shows that there is a "proximity" in the parental information given of the subjects with speech and language symptoms that come to the speech therapy clinic and that these symptoms may be linked to an act of sanction — the recognition or deletion of the speaking subject by the other. Therefore, the preliminary clinical indicators for the constitution of a speaking subject should be seen as indicators that the subject might one day present with speech or language disturbance. This being the case, starting with the axes of the speaking subject's constitution – **assumption of a speaking subject, recognition of the speaking subject, recognition of the significant, and responsiveness to the other's speech** – it was possible to elaborate twelve preliminary clinical indicators for the constitution of a speaking subject. The indicators were not separated by age because they did not occur at times in which it was possible to order them chronologically.

Preliminary Clinical Indicators for the Constitution of a Speaking Subject

1. The parents talk to the baby because they suppose he/she understands.
2. The parents interpret verbally the bodily manifestations of the child (laughter, cries, gestures, and gaze).
3. The parents receive the child's speech as directed toward them.
4. The parents put the child's speech segments in a language context, giving value to the child's message.
5. The parents do not constrain the child when they do not understand him/her.
6. The parents hear the child and answer his/her questions.
7. The child asks and answers questions.
8. The child's speech is not dependent on the speech of the other – the child does not need someone else's speech to say what he/she wants to say.
9. The child reacts (smiles, looks, vocalizes, and turns) when someone speaks to him/her.
10. The child responds when called.
11. The child shows interest in speaking to the other.
12. The child maintains a dialogue.

When one or more of the above statements is negative, they become indicators of risk for the constitution of a speaker.

DISCUSSION

The indicators were organized in a protocol format of for use as a tool for public health awareness. In the protocol intended for use by a community health agent or a health professional (Figure 1) the preliminary clinical indicators for the constitution of a speaking subject were described using sentences that are understandable both by the health professional as well as by the families visited. These protocols contain data extracted from the twelve preliminary indicators for the constitution of a speaking subject, elaborated in the form of a questionnaire followed by Yes "Y ( )" and No "N ( )". It is important to note that for the analysis of the "presence" or "absence" of an indicator, the health professional needs to watch for both the passive signs that come from observation as well as information gathered from the information given by the parents. These indicators point to the risk for speech and language disturbances since the presence of one or more indicators requires early attention and/or intervention. It is suggested that health professionals use this protocol in their home visits and if they confirm the presence of one or more indicators, they refer the child to the speech therapy department. The speech therapist will then evaluate the case and make a diagnosis, offering the subject therapeutic assistance and/or giving the parents orientations as to their participation in the language acquisition process.

When seen from this angle, the indicators proposed in this study have the objective of promoting the speaker's health using the results as a tool for the early detection of the risks and intervention in the acquisition of language and, therefore, contributing to meet the need for public health measures and planning in speech therapy.

It is suggested that the preliminary interviews (Figure 2) serve as data collectors for the clinical investigation of the subjective position of the child's speech. With this in mind, a script was created – with the goal of writing the speaking subject's history during the interview(s), incorporating the parents' words about the child and his/her speech – based on the axes of the speaking subject's constitution, that facilitated the acquisition of information about the subjects' speech and language.

Speech Therapy Protocol

Family Health Team – Community Health Workers
Date:_____/_____/_____ UBS: _____

Identification
SUS card number _____ Patient record number_____

Patient History
Name:_____
Mother's name: _____
Date of birth: _____/_____/_____ Age: _____ years _____ months ____ days
Gender: ( ) Male ( ) Female Phone: (__) _____
Address: _____
Neighborhood: _____ City: _____St: _____
Educational level: _____
Race/Color (self-declared): ( ) Caucasian ( ) Mixed ( ) Black ( ) Asian ( ) Amerindian
Person accompanying _____
Relation: ( ) Mother ( ) Father Other: _____
PSF: Area: _____ Micro-area: _____

Complaint
Note here any complaints that the parents have concerning the child:
_____
_____
Do the parents talk to the baby because they think he/she understands? ( ) Y ( ) N
Do the parents understand the gestures of the child and meet his/her request? ( ) Y ( ) N
When the child speaks, do the parents believe he/she is speaking to them? ( ) Y ( ) N
Do the parents take the child's speech fragments and form a complete phrase? ( ) Y ( ) N
Do the parents fuss at the child when they do not understand what he/she says? ( ) Y ( ) N
Do the parents pay attention to what the child says and respond to his/her questions? ( ) Y ( ) N
Does the child respond to questions? ( ) Y ( ) N
Does the child only repeat someone else's speech? ( ) Y ( ) N
Does the child react (smile, look, vocalize, turn) when someone speaks to him/her? ( ) Y ( ) N
Does the child respond when someone calls him/her? ( ) Y ( ) N
Does the child show interest in speaking to other people? ( ) Y ( ) N
Does the child continue a conversation? ( ) Y ( ) N

Notes

CHW _____
TEAM _____

Figure 1 – Speech Therapy Protocol

SCRIPT FOR SPEECH THERAPY INTERVIEWS

1. How did the parents interpret the child's first signs? How did they "understand" what he/she wanted?
2. Did the parents interpret the child's bodily manifestations (laughter, crying, gestures, and looks) and answer verbally?
3. Did the parents talk to the child since pregnancy or only after he/she was born?
4. Did the parents give a history of the child, telling when the child began to talk, what the first words were, how he/she reacted to the adults' interpretations? Observe what and how the parents talk about the child's speech.
5. Do the parents demonstrate knowledge of the child's speech?
6. Do the parents speak to the child in "baby talk"?
7. Do the parents interpret the child's sounds such as babbling and gibberish as speech?
8. When the parents speak of the child, do they realize that he/she understands?
9. Are the parents able to inform how the child communicates in social environments with different people, such as at school, at a party, etc.?
10. Observe if what is said about the child's speech matches the way the child speaks.
11. Observe the dialogue between the parent and the child.
12. Do the parents provide times for speech interaction during the daily routine (for example, invite the child to play)?
13. Do the parents respond to the child's questions?
14. Observe how the parents view the child's possible speech disturbances.
15. Do the parents show concern in understanding what the child is saying?
16. How do the parents react when they do not understand what the child is saying?
17. If the child tries to say something but encounters "difficulties", how do the parents react?
18. Does the child speak in the first person?
19. Does the child show interest in telling his/her parents his/her discoveries or not?
20. Does the child play with dolls (figurines) and create stories during symbolic activities?
21. Does the child pay attention to what is being said during the interview and react to it or does he/she remain distant and quiet in a corner?
22. When the child is called, does he/she turn and look or make any kind of expressions that demonstrate that the speech was directed toward him/her?
23. Is the child's speech dependent on someone else's – does the child need someone else's speech to say what they want to say?
24. Is the child able to ask questions? Does he/she ask "why" questions?

Figure 2 – Script for Speech Therapy Interviews

FINAL CONSIDERATIONS

During this study, the term "**indicator**" was explored in different clinical environments. In clinical psychoanalysis, even though the subject has not been around for very long, the study *"Clinical Indications of Risk for Child Development"* has already created considerable discussion. In clinical speech therapy, however, studies that link clinical indicators to the constitution of the speaking subject are still insipient. The clinical speech therapy in focus here implies that the subject is endowed with language and relates to the other, since speech, counterpart of the language, even though an individual act is always addressed to the other.

According to the idea that the subject is endowed with and by speech in articulation with the language, four axes were developed – **the assumption of a speaker, recognition of the speaking subject, recognition of the significant, and responsiveness to the other's speech.** They give direction to the speaking subject and sustain the analysis of the parents' information of subjects with speech and language symptoms in articulation

with the multi-stratification model of the symptoms of language[2] presented in the introduction.

The end result was the formulation of twelve preliminary clinical indicators for the constitution of a speaking subject that can predict signs of speech and language disturbances. From this point of view these indicators should be seen as early warning signs that the subject may present speech and language disturbances. They can serve to promote the health of the speaker as well as highlight the importance of the speech therapist at the level of basic health delivery to the population before the speech and language symptoms develop.

The results of this research show an important opportunity for initiating preventive health measures in the area of speech and language therapy in which universal principals may be linked to the individuality of the subject and the unique functioning of his language. Health professionals – community health agents, physicians, and speech therapists – are invited to test the indicators developed in this research conducted during home visits and/or office visits to evaluate their feasibility and pertinence. It needs to be clear that only after the indicators have been tested will it be possible to undergo the statistical analysis necessary to validate them.

RESUMO

Objetivo: propor indicadores clínicos de risco para a constituição do sujeito falante. **Métodos:** dos indicadores de risco para o desenvolvimento infantil e do modelo de funcionamento dos sintomas de linguagem foram deduzidos os quatro eixos que sustentam a constituição do sujeito falante: suposição de um sujeito falante, reconhecimento do sujeito falante, reconhecimento do significante e responsividade do falante aos dizeres do outro. Dizeres parentais referidos durante as entrevistas fonoaudiológicas de usuários de três Unidades Básicas de Saúde foram agrupados por relações de semelhança, classificados e analisados segundo cada um dos quatro eixos de constituição do sujeito falante. **Resultados:** a análise permitiu estabelecer 12 indicadores clínicos preliminares para a constituição do falante. Estes indicadores apontam para uma possibilidade de que o sujeito venha a apresentar perturbações de fala e linguagem, sustentando tanto a intervenção como ações de promoção de saúde do falante. **Conclusões:** os resultados permitem concluir pela importância do fonoaudiólogo na atenção básica à saúde da população e nas ações de promoção.

DESCRITORES: Indicador de Risco; Linguagem Infantil; Fonoaudiologia; Saúde Pública

REFERENCES

1. Palladino RRR. A propósito dos indicadores de risco. Disturb Comum. 2007;19(2):193-201.

2. Gouvêa G. Por uma multiestratificação estrutural dos sintomas de linguagem [dissertação]. São Paulo (SP): Pontifícia Universidade Católica de São Paulo; 2007.

3. Gouvêa G, Freire RM, Dunker C. Sanção em fonoaudiologia: um modelo para organização dos sintomas de linguagem. Cad Est Ling. 2011;1(53):7-25.

4. Kupfer MCM, Jerusalinsky A, Wanderley DB, Infante DP, Salles L, Bernardino LF, et al. Pesquisa multicêntrica de indicadores clínicos de risco para a detecção precoce de riscos no desenvolvimento infantil. Rev Latinoam Psicopatol Fund. 2003;6(2):7-25.

5. Goulart BNG, Chiari BM. Construção e aplicação de indicadores de saúde na perspectiva fonoaudiológica: contribuições para reflexão. Rev Soc Bras Fonoaudiol. 2006;11(3):194-204.

6. Kupfer MCM, Jerusalinsky AN, Bernardino LMF, Wanderley D, Rocha PSB, Molina SE et al. Valor preditivo de indicadores clínicos de risco psíquico para o desenvolvimento infantil: um estudo a partir da teoria psicanalítica. Lat Am J of Fund Psychopath. [periódico na internet]. 2009 [acesso em 16 set 2014];6(1):48-68. Disponível em:

7. http://132.248.9.34/hevila/Latinamericanjournaloffundamentalpsychopathology/2009/vol6/no1/4.pdf

8. Rafaeli YM. Do diagnóstico diferencial à direção do tratamento. In: Pavone S, Rafaeli YM, organizadoras. Audição, voz e linguagem: a clínica e o sujeito. São Paulo: Cortez; 2005. P.130-40.

9. Vorcaro A. A clínica psicanalítica e fonoaudiológica com crianças que não falam. Disturb Comum. 2003;15(2):265-87.

10. Dunker CIL. Clínica, Linguagem e subjetividade. Disturb Comum. 2000;12(1):39-61.

11. Lemos CTG. Das vicissitudes da fala da criança e de sua investigação. Cad Est Ling. 2002;42:41-70.

12. Brandão P, Meira AM, Molina S, Jerusalinsky A. Abordagens do imaginário na cena terapêutica em estimulação precoce. In: Centro Lydia Coriat. Psicomotricidade. 2.ed. Porto Alegre: Escuta; 1997. P. 08-21. (Escritos da criança, n.3).

13. Reis BP, Freire RM. Indicadores preliminares para a constituição do sujeito leitor/escritor. Rev Saúde Soc. 2014;23(2):592-603.

Received on: July 15, 2014
Accepted on: October 11, 2014

Mailing address:
Fábia Regina Evangelista Verly
Avenida Cláudio Besserman Vianna, 3,
Barra da Tijuca,
Rio de Janeiro – RJ – Brasil
CEP: 22775-036
E-mail: fabiaevangelista@hotmail.com