SUPPLEMENTARY AND ALTERNATIVE COMMUNICATION IN THE PHYSIOTHERAPY SESSIONS

A comunicação suplementar e/ou alternativa na sessão de fisioterapia

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ABSTRACT

Purpose: to analyze the speech of physiotherapists on the use of Supplementary and Alternative Communication (AAC) with patients with chronic non-progressive encephalopathy (CNPE) during physiotherapy session. **Method**: individual interviews were conducted with five professionals concerning questions relevant to the topic in the form of open questions. Data analysis occurred through grouping ideas and selecting the most relevant topics through relational and critical analysis. **Results**: the five interviewed physiotherapists say that they know and emphasize the importance of using AAC in their sessions but they didn't have theoretical formation on the topic. The contact and the use of this approach were made through interdisciplinary exchange with the speech therapist from the institution where they work. This fact, added to the specific demands of the physiotherapy session, limits the incorporation of this approach in daily practice by four of the interviewed professionals. Only one has incorporated it to her daily routine. **Conclusion**: all the interviewed professionals claimed having improvements in using AAC, specifically in improving the interaction with CNPE patients, but they also claimed having difficulties with instrumental aspects that limit the use of AAC, such as the size of the AAC board, the way it is individually build for each patient and the dynamics of the physiotherapy session. They attribute the difficulty of relatives' acceptance to the social limitation in using AAC. The presence of the speech therapist in the team seeing the person with CNPE was essential for those professionals to use AAC.

KEYWORDS: Communication; Cerebral Palsy; Language; Humanization of Assistance

INTRODUCTION

The benefits brought by the daily technological development make available to individuals new tools which provide and streamline communication, mobility, work, leisure, personal care and health[1]. When this technological development brings answers to functional problems found in people with disabilities, in order to streamline, expand and promote skills in everyday life it is an assistive technology[1]. This technology allows patients with disabilities to have an independent life and social and educational inclusion[2].

The assistive technology can be used in patients with restriction and/or lack of spoken language. Once this language deficit affects 49% of children with Non-Progressive Chronic Encephalopathy Evolutionary (NPCE)[3], it is necessary alternatives which allow this child to express feelings and desires. From this context, the Augmentative and Alternative Communication (AAC) comes in order to insert the child with NPCE in school, and promote some social independence for her/him [4].

AAC systems are composed of strategies which complement or replace spoken language, allowing the communication to be established through "alternative systems based on pictographic, ideographic and arbitrary signs/symbols " ranging from gestures, vocalizations, facial expressions, look direction, boards with alphabet symbols or

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graphics (photographs, prints and/or drawings) to sophisticated computerized systems that synthesize and digitize speech[5]. The AAC, through low-tech resources, is the reality of developing countries, which, for financial reasons, do not have access to high technology; a communication board is a possible reality for many users[6-8].

The communication board is one of the features of AAC of low cost; it must be made in accordance with the individuality and needs of each patient[5]. As for the symbols used on AAC boards, Bliss semantography and PCS are the most commonly used in the construction of the resource. There are two major types of symbols: the pictograms (having as more formal systems known, PIC – *Pictogram Ideogram Communication Symbol* and PCS – *Picture Communication Symbols*) and ideograms (*Bliss*). The pictograms have iconic figures that have more transparent meaning for the physical similarity. Systems such as Bliss, given its more abstract feature, may be less appropriate for individuals with cognitive limitations as some cases of brain lesions (NPCE, aphasic, etc..) and dementia[9]. In view of this, it is known the superiority of using the AAC through pictographic symbols in aid of children with NPCE[10].

Expanding in Brazil, the augmentative communication through features such as boards are not yet widely known among the many health professionals who work with patients with NPCE[11], although it has its value in the socialization and interaction of the patient with difficulty or absence of oralization[9] and its benefits in the expression of subjectivity, in communication with each other and increase the repertoire of responses demonstrated by several studies[9,12-14].

Despite considerable use of this feature in the pediatric population, there is little specialized training on the subject in the academic envirionment[15], showing the need for professionals who want to work with the AAC to put the language in operation, going beyond the point/trigger a symbol or key[11]. For this they need to do a deeper reflection on the concepts of language, language and subject which support the use of this feature with patients[9].

Besides this analysis, there should be emphasized the importance of an interdisciplinary team working in assessment and intervention with the NPCE child as early as possible. Professionals in the field of health, such as a neurologist, pediatrician, traumatologist, occupational therapist, physiotherapist, speech therapist, psychologist, educational psychologist have much to contribute to the optimal development of the child in question, and give expert support to the family[16]. The integration of different professional disciplines is needed, and the professionals who use assistive technologies should have extensive knowledge, willingness to learn and sensitivity about the family and cultural values of the subjects in treatment[17].

It is therefore important to strengthen to the health professionals and education the need for early implementation of AAC systems not only for expressive skills, but to invest in the construction of the language[14].

In order to seek a better intervention through features that allow an effective communication process in therapeutic practices, this research proposes to examine what physiotherapists refer in the speech on the use of the AAC during the physiotherapy session with NPCE patients. We tried to identify the time of use, knowledge about AAC and the changes observed with the use of AAC in physiotherapy sessions both in terms of benefits and limitations.

We also observed the professionals' reports about their practice and the unique aspects of the therapist that may interfere with the successful treatment with AAC.

METHOD

Five physiotherapists with clinical experience of at least one year participated in this study; they had knowledge of the AAC and used it during physical therapy sessions with patients affected by NPCE. To do so, known clinics were sought in Santa Maria and Porto Alegre, those which were considered specialized in assisting individuals with NPCE. The indication of these clinics was given by experts by the local universities contacted for this purpose. From the identification of physiotherapists working with NPCE, we selected those who knew the AAC.

After explaining the objectives and procedures of the study and the signing of the Informed Consent Form, the implementation of a structured interview by the researcher started, which was prepared with open questions (Figure 1). The theme of the questions was relevant to the knowledge of the AAC and its use during the physiotherapy session. This script served as a guide for data collection and, as the narrative unfolds, the researcher would pursue other issues, not limited only to the questions outlined in the initial interview script. Every interview was recorded on a Sony TCM 359V handset, on cassettes, with each interview lasting an average of one hour. At the end of the collection, the tapes were subjected to transcription by the researcher. Data collection was carried out in May 2010.

1) What is your educational background?

2) How long have you been graduated?

3) How long have you worked at the physiotherapy clinic?

4) Did you have any discipline which dealt with communication with individuals in general? How about non progressive chronic encephalopathy (NPCE)?

5) How do you communicate with a patient with NPCE with restricted or absent oralization during the physiotherapy session?

6) Do you know and use the Augmentative Alternative Communication (AAC)with patients with NPCE during your physiotherapy session

7) How long have you used the AAC with subjects with NPCE?

8) How was this resource inserted in the physiotherapy session?

9) Have you noted any difference with the use of AAC during the physiotherapy session?

10) Have you noted any difference in the results of the physiotherapy in the subject who uses this kind of communication? Which ones?

11) Do you consider that the AAC can be a limitation in its use to the patient with NPCE?

12) How do you evaluate the AAC?

13) Why do you think this resource of therapist-user interactions is not used by every physiotherapist?

14) Do you consider the AAC to be indispensable in the treatment with the patient with NPCE with restricted or absent oralization?

Figure 1 – Interview script with physiotherapists

From the full transcript of the tapes and the reading of the material, it was performed the analysis of data according to the Minayo's (2008) thematic analysis. Care was taken with the cuts made, to extract the most significant statements as they were presented. Thus, we sought to identify the similarities and differences between the speeches of physical therapists, as well as the contradictions, and signal latent meanings in interviews. Parts of the material were selected and grouped according to the similarity of the respondents' report performing the thematic cuts in order to develop a critical analysis and the relational data gotten to reveal the gotten answers from the addressed questions[18]. The sequence of questions was maintained during the analysis of the results so that the answers were kept logic.

This study was approved by the Ethics Committee in Institutional Research under case number 23081.013051/2009-91 and Certificate of Presentation for the Ethic Appreciation – CAAE number: 0223.0.243.000-09

Throughout the article we will use the "F" (*fisioterapeuta* – physiotherapist), then the corresponding Arabic numerals (F1, F2, F3, F4 and F5) to refer to informants and to make reference to the utterances of this *corpus*.

RESULTS

The sample consisted of 1 male and 4 female physiotherapist.

Figure 2 shows the profile of the study sample:

SAMPLE	ACADEMIC BACKGROUND INSTITUTION	GRADUATION TIME	PROFESSIONAL PRACTICE TIME
F1	A	1 YEAR AND A HALF	1 YEAR AND A HALF
F2	A	3 YEARS	3 YEARS
F3	B	12 YEARS	12 YEARS
F4	C	4 YEARS	4 YEARS
F5	D	5 YEARS	4 YEARS AND A HALF

Figure 2 – Sample profile of physiotherapists and the variability of academic institution (4 institutions), while graduation time and professional practice time

It can be noted that only one participant has more than 5 years of professional experience and that most of the sample has from 1 year a half to 4 and a half years of professional experience.

The five physiotherapists believe and invest in the CSA board resource, although four of them did not routinely include it in the therapy session: "*Those who have, we use it, but I can't say I always use it, only when we got time [...] most simple questions and we do not even use it. And sometimes it end up falling into disuse, because we are already so used to the patient that we already know what he means [...], but of course it would be important that we use it more.* "(F1)," [. ..] *sometimes during therapy we have so much to hold plus the board.* "(F2)*," [...] I only use it [...] when the patient brings it to physiotherapy.* "(F3), *"[...] I do not use it much because you have to pick up the board and sometimes it has little to do with what we are making in the management, but I could learn to use it better, perhaps faster [...].*"(F5). The opposite emerges in F3speech: *"[...] when the therapy is on the ground it is used a lot. They ask the folders.* "

It should be emphasized that the ones who graduated from 1998 to 2009, most in the group says, during graduation, it was not offered a specific discipline on AAC (F2, F3, F5), even being an area known in Brazil since the late 1970s[19]. Only one of the physiotherapists emphasizes the knowledge of the topic of assistive technology by reporting personal experiences from a teacher in the Neurology I discipline, but without any major theoretical bases and planning in the course syllabus (F4). From this physiotherapist's speech, one notes a strong sensitivity to the use of resources for the subject to express a more elaborated and subjective communication. He recognizes the AAC to strengthen the therapeutic bond, once the patient has active participation in the session. F4 criticizes the physiotherapy training with mechanistic view, in which the subject is seen as an injury or motor condition alone, without a global vision. Thus, it is clear that the institution where F4 studied, unlike the others, has already a certain perception by faculty of the need to study and disseminate the theme.

The usage time of the AAC by the five physical therapists who used it with their patients with NPCE ranged from 2 and a half years to 8 years, F1 uses it since his knowledge in practice internship in an institution and F4 uses it since his initial professional experience (graduated for four years and working for 4 years).

Every therapist reported having known about it through institutions or clinics with multidisciplinary teams present, AAC being inserted in the session by the phonoaudiology team. Therefore, it is denoted, from the reports below, the importance of the multidisciplinary team within institutions and clinics in order to promote the exchange of knowledge of the subject being treated: *"I have learned about it through the institution I work, through the phonoaudiologists who prepare the folders and sometimes we go in the phonoaudiologists' session and they show us what the child is capable of doing.*"(F1*);"I've only met it when I had contact with the work with a multidisciplinary team."* (F3) .

As for the difference observed during the physiotherapy session with the use of the AAC, most of the physiotherapists reported, as exemplified below, the use of the AAC's help in the interaction and in the improving of the physiotherapist-subject bond: *"[...] we can communicate more and give more attention to the patient, he can demonstrate and tell what else he wants, sometimes he does not want to just do the physiotherapy, he wants to talk."(*F1); "*[...] whenever the child can express herself she can choose what she wants, it is always better, right? she always interacts more. [...] The benefit comes from interacting with the child [...]."* (F2), *"Communication, particularly strengthens the therapeutic bond, it will increased patient's participation. Understanding that he is also partly responsible of the rehabilitation process and communication is also a determining factor to increase his level*

of functional independence."(F4),*"[...] this bond we create with the child in the long-term makes outcomes in therapy better, the goals are achieved because the child is improving her self-esteem."* (F5).

The referred differences in the results of physical therapy through the use of AAC in patients with NPCE can be found in the speeches which emphasize that the subject feels active and happier from the moment he is understood: *"The physical difference comes because they become more encouraged, because they were talking about how they feel."*(F2); *"they are happy to exchange, communicate and make themselves understood.*"(F3*),"the patient begins to participate more actively in the session understanding their responsibility and increasing the will and desires of evolution not only with motor, but also in their overall development that allows better communication in all environments."* (F4).

On the other hand, F1 says there is no difference in the outcome of the therapy session, but in the interaction with the subject, who can be understood. It can be seen in this statement, a view that the results achieved in the physiotherapy session are associated only with motor gain, while the emotional and affective attachment separated in these results. It stands out in this report, the mechanistic view in which the academic education of physiotherapists is grounded.

In regards to the limitations of the use of AAC patients with NPCE, these are stated as dependent on the severity of motor impairment of the patient, the family and professional acceptance with which this feature will be used, as seen in excerpts: *"Look, I'm a bit doubtful when the patient's condition is more serious, I would not know how well Phonoaudiology could access this patient, the communication."* (F5); *"There are mothers who do not use it because they think they understand everything that the children do and leave the folder as an ornament [...]."* (F1*),"Some patients, families and professionals have some difficulty in accepting immediate resource, which hampers their use primarily outside the therapeutic environment."* (F4).

One of the interviewees referred to his work environment of therapeutic intervention, which is water, as limiting the use of AAC: *"In my case yes, because I work in the water, the conversation is cut short, but that's no reason to avoid communication."*(F3). In contrast, F5 said that "*even in hydro which is a different environment we have at least some short boards to yes, to no, for the pain, for the pee."*

It is observed in the reporting of F1, that even with limitations in the use of the AAC by impairments stemming from NPCE, he circumvents without difficulty: *"[...] the only thing is for children who cannot focus with the eye or not to go with the hand, then we have to keep asking: is this it? is this it?"* (F1).

Given these limitations of children with neurological NPCE, F2 stresses the fact that there isn't a choice of the most appropriate AAC resource for the child which may become a limiting factor due to the difficulty to transport and use it.

The value attributed to the use of the AAC during the physiotherapy session received positive connotation. The words used to express such value were "*very important*" (F1, F4, F5); "*extremely important*" (F2); "*essential*" (F3) and "*fundamental*" (F5). So it turns out that all research professionals consider the AAC relevant in the care provided to patients with NPCE, and its importance can be identified in the promotion of freedom of expression and action to the subject being treated, according to the following statements: *"I think it is essential so that we can go beyond the "yes" or "no" and so they can expose themselves and the put their ideals out there.*" (F1), *"[...] when you see very smart people who actually have what to say and want to have a good conversation and use alternative communication for that."* (F2).

Other benefits mentioned by physiotherapists using the AAC are: *"when they want to tell you something more specific" (F1); "good conversation"(*F2), *"[...] to tell what's new every day."* (F3) and *"[...] to the life of quality and social participation*." (F4). According to these expressions, physical therapists seem to be sensitive to the need of using the AAC, but they do not use it as a routine during physical therapy session with the NPCE patient.

According to the group's speech, the AAC board is not used with the subject with NPCE during physical therapy session for lack of knowledge related to its use (F1, F2, F3, F4) and the absence of an interdisciplinary team (F1, F3), especially the phonoaudiologist who has the knowledge of the use of the AAC board, as shows this excerpt: "Perhaps for lack of knowledge, because some do not interact with the phonoaudiologists, right? There are several institutions and clinics that have no phonoaudiologist to explain to you how to use it and how to make it." (F1).

Among other reports, the shortage in academic education is also mentioned: "*First I think the issue needs to be more widespread and valued in clinical training and physiotherapy."* (F4); "*For lack of academic knowledge, we often do not explore and practice what we have in the institutions [...].*"(F5).

Limitations of the physiotherapist are also expressed in its use as: *"[...] the therapy lasts 45*

minutes and we'll rush out doing [...] sometimes we do not stop to think about the importance of communicating with the child." (F1), *"[...] a little lack of wanting from some physiotherapists where there is no nothing to work [...]."* (F2).

Furthermore, there was reference regarding the therapy being so technicality, result of an academic training focused on the mechanism and to the exclusively biomedical vision, as seen in the passages*: "[...] some place more importance only to the body itself and the language is not exploited." (F2),"[...] the physical therapy still has a very mechanistic point of view. The look of the patient should be expanded with a perspective of their global always trying to hear their intentions and providing opportunities for a greater social participation."* (F4).

Whether it is the communication through the AAC or not, all physiotherapists consider indispensable its effectuation in the treatment of patients with NPCE (F1, F2, F3, F4 and F5), and the vast majority considers the AAC as required in the treatment of the problem, as it was exemplified in F3: *"It`s impossible to treat a patient without exchanging information and AAC allows it."*. In disagreement with the others, F1 says that *"In the global treatment yes [...], but only for physiotherapy, if the child can say yes and no [...]"* in this, F8 contradicts himself, because he had previously reported the essential value of AAC *"[...] so we are not stuck in yes or no [...]."*

Some considerations should be highlighted: *"[...] I think all of them should have to be somehow embedded in this type of communication."* (F5). With this speech, the physical therapist expresses the necessity and importance of using the AAC for him.

In the passage "*[...] it is still very little known and little used, that`s why people are still working without it. [...] as soon as we get the hang of it and really discover the way to work with it and see that it is easier with it, then sure."* (F2), it turns out that the physiotherapist in question reinforces that the practice of AAC during the physiotherapy session will be effective as get to learn more about its theoretical and practical knowledge.

Given the this analysis, we can conclude that physical therapists participating in the survey, even stressing the importance of AAC in the improvement of the bond and interaction with the patient with NPCE, do not have as a routine the use of AAC board during the physiotherapy session .

DISCUSSION

The assistive technology is a reality in interaction with the subject with NPCE in physiotherapy, and AAC is a common approach to the population who needs assistive technology and presents major difficulty in communication[4].

The benefits of AAC, by using the board, for the subject with NPCE during therapeutic action are shown in several studies[11,19-21]. These benefits can also be seen in the statements of the research physiotherapists, who claim it improves the relationship and interaction with the subject with NPCE. These results got with the sample group show that the introduction of AAC favored the expansion of language, corroborating the findings of other studies [8,12,14,21,22].

This form of communication allows the individual with restricted and/or absent oral from the choice of his food[23] to more sophisticated life choices[8.24]. The AAC allows the subject the expression of his feelings and desires, and enhances the process of social and escolar inclusion[25]. In agreement with these authors, the sample group of the research highlights that as the patient begins to be understood, he produces better therapeutic results for being happier and more active.

Even with such benefits and possibilities, the limited use of the AAC by individuals with NPCE can occur due to the lack of family support and health professionals regarding the use of the AAC. In one study, professionals and parents were afraid to adopt the AAC for believing that such an intervention could prevent users from developing speech[26]. Studies indicate that it is common for the mother of the individual with NPCE to believe being possible to understand her child's messages via gestures, facial expressions and vocalizations, and therefore the use of AAC being unnecessary and time-consuming in her point of view[9, 27]. This was evident in the speech of some physical therapists in the study, which reported that the everyday makes facial and body interpretations become clearer, not requiring the use of AAC. However, both the family and the professionals do not realize that reading body language has important limitations for the expression of feelings and desires that are not in the immediate context of enunciation[9].

It can also be highlighted as limiting points of the inter-relationship between the health professional and the subject in therapy, the anxiety in the daily routine of the professional with the serious patient, the impersonal attitudes used as a defense mechanism [28], lack of professional preparation, mechanization and the large number of therapies done by the profissional[29]. Other authors[12] also claim that there is the need for patience, understanding and ability to interact with the use of AAC with the subject with NPCE, as the AAC is not yet widely known in practice, even though its expanding in the country[1, 11]. According to this view,

the physiotherapists in this research mentioned as causes of disuse of the AAC during the therapy session the session time, the mechanistic approach and the lack of theoretical knowledge and practical approach.

In a study[13] carried out through inquiries with professional teachers, therapists and phonoaudiologists, working for an institution that attends children with NPCE and users of AAC, it was found that professionals consider the AAC as a means of communication that is efficient and provides better life quality for its users. However, these professionals used it very little in their daily routine of care. This fact can also be seen in the speeches of physiotherapists who are part of this research, who, while emphasizing the importance of the AAC for child with NPCE during the progress and the results of the session didn't use it a lot in their routine.

It's worth noting that the professionals who intend to work with the AAC need to put the language in operation, going beyond the point/trigger a symbol or a key, requiring a deeper reflection on the concepts of the subject, language and idiom[9]. The subjects of the sample group showed some thought and sensitivity to the use of AAC in situations where the patient may require greater, more specific and personal dialogue, but do not have the necessary training to fully assume such an approach.

Therefore, for the success of AAC to occur, there must be an integrated and complementary action of a team made up of professionals from different fields, with different instrumental goals, united by the goal of meeting the needs of users with disabilities in all spheres of their personal, domestic and community performance[2.30]. This team should work in health and must have as its focus the humanization and the subjective aspects of the human condition, because the interaction of technical and scientific knowledge with the affective, cultural, social and ethical aspects in the relationship between professional and patient service ensures a greater efficiency[31].

The character of the interdisciplinarity is being contemplated by the changes in the profile of those who make up the professional rehabilitation team[32]. The interest in family involvement and the motivational processes that facilitate the evolution and development in the treatment, as well as relations of the triad family, child, therapist demonstrate the large interface between the areas of health sciences and the humanities, revealing, thus new perspectives for training professionals who emerge from the Cartesian view seeking their social rehabilitation[33].

Specialized institutions have a significant role in the production of knowledge about methodologies of working with people with special needs and contribute to the further training of profissionals[34]. In this study, it was noted that the presence of an interdisciplinary team in the institutions was the differential to increase the AAC use in physiotherapy session.

In this multidisciplinary team, the phonoaudiologist is the expert able to select the most appropriate type of AAC to each user, as its focus is the rehabilitation/habilitation of communication and language[9]. Holders of this knowledge, the phonoaudiologists have conducted research and expanded the vision of this feature for a better social interaction of children with diseases such NPCE, autism, and other disorders of language and development[4, 8,9,12]. In agreement with these authors, all physiotherapists from this study mentioned the institutions' phonoaudiologists as promoters of the use and introduction of AAC in the therapy session with the patient with NPCE.

Also active in this team, the physiotherapist is seen as a key professional in the rehabilitation of patients with neurological deficits. The way this professional relates to the patient with NPCE has direct implications in his development. If he gives the patient a more active and involved role; it may improve more his evolution than a merely passive role in the psicomotor work[35]. Therefore, the AAC can be an important communication approach, whereby the physiotherapist can learn about the perceptions and feelings of the subject both in relation to the physical therapy process itself (pain, dissatisfaction ...) as to get to know better the patient he attends.

Through a broad and humanized vision, the Physiotherapy aims to promote the general welfare of the subject with NPCE as a human person, worrying positively to supply their diverse needs from different circumstantial natures which exceed its biophysical size[36]. One of the possible ways to achieve this goal can be the creation of a Physiotherapy based on level I evidence[37], which can compare these traditional techniques when applied in isolation to therapy that, in addition to the instrumental aspects, are considered aspects such as subjectivity and functionality of the treated subject.

Therefore, there is a need to change the focus of the "therapeutic eye" of the disease to the subject, recognizing him as an enunciator immersed in the language through linguistic functioning between the interlocutors in a given context of intersubjectivity. Overcoming thus the limit imposed by the lack or difficulty of organic speech disorders, promoting the individual with NPCE, the status of "speaker"[9].

It was concluded that the sensitivity of physiotherapists, as verified in a study[9], partially offset potential theoretical deficits becoming an effective praxis in many cases but lacks theoretical foundation. It's

suggested AAC themed disciplines to allow the construction of knowledge both from the theoretical and practical point of view as an undergraduate. One should keep in mind the care of the subjects with restricted or absent oralization, as individuals with NPCE, in order to expand training in physiotherapy and health services.

CONCLUSION

It is noteworthy that health professionals must possess the "sensitivity" that their actions with patients undergoing treatment should go beyond proper techniques and anatomophysiologic knowledge; it should consider the type of relationship established with the subject. Once the current exclusively biomedical model in the curricula of different areas of health is left behind, the multidisciplinary team should be established to promote quality in the subject treatments.

The AAC is an approach that fits the concept of humanization to the individuals restricted to express their desires and wills due to the deficit in speech. There are several studies demonstrating their importance, benefits and quality that promotes the subject's life with NPCE. As the cane, a wheelchair and other assistive technology tools to the subject with a disability, the AAC should be part of the theoretical knowledge and practice of the physical therapist who seeks rehabilitation of the subject under a global point of view and not only the motor one. This fact was evident in the interviewed phonoaudiologists, i.e., while recognizing the importance of the resource and trying to use it, they need to deepen their training to do so.

Every professional stated there are great gains in the use of the AAC, the improvement of the relationship and interaction with the patient with NPCE. As difficulties, they pointed instrumental aspects that limit the use of AAC (size, manner of construction of the resource for each individual subject and dynamics of physical therapy session), as social limitation and family acceptance. The presence of the phonoaudiologist in the team to a subject with NPCE was a crucial aspect for these professionals to have access to this communication approach. The phonoaudiologist is the professional responsible for structuring and implementing the AAC intervention, since it refers to the study of language, but other professionals such as physiotherapists, can and should be involved in the work. Thus, it is for professionals involved in AAC elective patients seek theoretical foundation for their application in their practice of the use of CSA.

It reaffirms, punctuated by the aspects, that the discussion of communication through the AAC constitutes a reflection of what the physiotherapist should make towards the humanization and skills to care for subjects with NPCE with restricted or absent oralization. Therefore, participation in multidisciplinary team, with the presence of phonoaudiologists, it seems to be a necessary path in the process of training and professional practice.

RESUMO

Objetivo: analisar o que fisioterapeutas referem no discurso sobre o uso da Comunicação Suplementar e/ou Alternativa (CSA) durante a sessão de fisioterapia com sujeitos com Encefalopatia Crônica Não Evolutiva (ECNE). **Método:** foram efetuadas entrevistas individuais com cinco profissionais, por meio de questionamentos pertinentes à temática em forma de perguntas abertas. A análise dos dados ocorreu com o agrupamento de ideias e a seleção das ideias mais relevantes sobre o tema. **Resultados:** os cinco fisioterapeutas entrevistados referem que conhecem e ressaltam a importância da utilização da CAA em suas sessões, mas não tiveram formação teórica sobre o tema. O contato e a utilização de tal abordagem ocorreram por meio da troca interdisciplinar com o profissional de Fonoaudiologia da instituição na qual trabalham. Tal fato, somado às demandas específicas da sessão de fisioterapia, limita a incorporação de tal abordagem na prática diária por quatro profissionais entrevistadas. Apenas um incorporou o recurso em sua rotina diária. **Conclusão:** todos os profissionais pesquisados afirmaram ter ganhos no uso da CSA, especificamente na melhora do vínculo e da interação com o paciente com ECNE, mas também afirmaram ter dificuldades com aspectos instrumentais que limitam o uso da CSA, como tamanho da prancha de CSA, seu modo de construção individualizado para cada paciente e a dinâmica da sessão de fisioterapia. Atribuem à dificuldade de aceitação familiar a limitação social de uso da CSA. A presença do Fonoaudiólogo na equipe de atendimento ao sujeito com ECNE foi aspecto fundamental para que tais profissionais fizessem uso da CSA.

DESCRITORES: Comunicação; Paralisia Cerebral; Linguagem; Humanização da Assistência

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