Group treatment in the context of aphasia

Grupo terapêutico no contexto das afasias

Grupo Terapéutico en Contexto de la Afasia

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Abstract

Research on group treatments began at the end of last century. Studies have shown that the interaction between people with aphasia is important for their treatment. The aim of this paper is to discuss the particular factors that affect the setup of a group in cases of aphasia. Therefore, the object of analysis of this research is a group of aphasic individuals at the Tuiuti University of Paraná observed for a period of three years. This group is made up of nine aphasic individuals, and practices are held from an enunciative-discursive perspective. This perspective is based on a historical-cultural approach. All the sessions were transcribed for analysis. The results showed that the setup of the group and the participation of the subjects are directly related to several factors: social places, relationship between language/subject/symptom, discursive practices within and outside the group, images constructed by the subjects of discourse and the role of the group for each subject. It follows, therefore, that the treatment should focus on all these aspects so that it can cope with the multiple facets of language: biological, interactive, subjective and social.

Keywords: Speech therapy; Aphasia; Group.

RESUMO

A pesquisa sobre terapia em grupo iniciou-se no final do século passado. Os estudos apontam a interação entre os afásicos como importante para o processo terapêutico. O objetivo desse artigo é discutir a especificidade dos fatores que influenciam a constituição de um grupo nas afasias. Para tanto, tomarei como objeto de análise o grupo de afásicos da Universidade Tuiuti do Paraná durante o período de três anos. Esse grupo é constituído por nove afásicos e as práticas são realizadas a partir de uma perspectiva enunciativo-discursiva. Essa perspectiva é baseada em uma abordagem histórico-cultural. As sessões foram todas transcritas para a análise. Os resultados apontam que a constituição do grupo e a participação dos sujeitos no grupo estão diretamente relacionadas a vários fatores: aos lugares sociais, à relação linguagem/sujeito/sintoma, às práticas discursivas dentro e fora do grupo, às imagens construídas pelos sujeitos do discurso e ao papel do grupo para cada sujeito. Conclui-se, assim,

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que o processo terapêutico deve incidir sobre todos esses aspectos para que se possa dar conta das multifacetas da linguagem: o biológico, o interativo, o subjetivo e o social.

Palavras-Chave: *Fonoaudiologia; Afasia; Grupo Terapêutico.*

Resumen

La investigación acerca de la terapia de grupo comenzó a finales del siglo XIX. Los estudios indican la interacción entre afásicos como importante para el proceso terapéutico. El objetivo de este trabajo es discutir la especificidad de los factores que influyen en la formación de un grupo en las afasias. Para eso, tomaré como objeto de análisis el grupo de afásicos de la Universidad Tuiuti del Paraná durante el período de tres años. Este grupo está integrado por nueve afásicos y las prácticas se llevan a cabo desde una perspectiva enunciativo discursiva. Esta perspectiva se basa en un enfoque histórico-cultural. Todas las sesiones fueron transcritas e analizadas. Los resultados indicaron que la composición del grupo y la participación de los sujetos en el grupo están directamente relacionados con varios factores tales como: las ubicaciones sociales, la relación lenguaje / sujeto / síntomas, las prácticas discursivas dentro y fuera del grupo, las imágenes construidas por los sujetos del discurso y el papel del grupo para cada sujeto. Por lo tanto, se concluyó que el proceso terapéutico debe centrarse en todos estos aspectos para que pueda hacer frente a las múltiples facetas del lenguaje: biológica, interactiva, subjetiva y social.

Palabras clave: *Fonoaudiología; Afasia; Grupo Terapéutico.*

Introduction

A group speech therapy began to meet public health demands in the 1980s, but there was no theoretical reflection on such practices. In the last twenty years, speech therapy with groups of patients has evolved; it is focused on health promotion and involves clinicians and therapists, subjects with different pathologies, and their families[1-6].

Particularly in the area of language, group speech therapy can be effective when it promotes emotional, social, cognitive and linguistic exchanges, enables shared knowledge and constructions by the group members, favors observation, perception, attention, memory, development of mental processes, and allows the development of altruism and solidarity[7].

Research on speech therapy groups, specifically in the area of language, has gained relevance in recent years,[8-10] but in the case of aphasia, they are still very scarce.

Internationally, group treatments for aphasic individuals have been the subject of discussion since the 1950s[11]. At first, they focused on psychosocial issues, and they currently emphasize pragmatic issues in order to increase communication and the effectiveness of group care. Research shows that group treatment offers advantages over individual treatment. For example, it facilitates the generalization of functional communication in a natural environment and promotes interaction between group members, thus providing pragmatic abilities. These skills are: increase of turn-taking and communication initiatives, increased variety of communicative functions and speech acts. Moreover, researchers claim that the group environment can also result in the generalization of these functions to other contexts, considering that the group provides conversational practices which are similar to those in other social environments. Thus, group actions can directly or indirectly promote increased psychosocial functions and participation in community life, and still have a lower cost compared with individual therapies[12-15].

In general, the above studies described in the literature are based on pragmatics and conversation analysis. Thus, they have primarily focused on the recovery of conversational skills that were assumed to be lost because of aphasia. In pragmatic theory, language is defined in terms of action. That is, words are tools of an agent while stating his intentions. The origin of meaning lies precisely in the way speakers use the language. Language is, thus, about performing individual and social actions. Previous studies have indicated that conversation is the most common social practice among humans; it plays a privileged role in the construction of social identities and interpersonal relations, and requires speakers to have great linguistic ability. These studies have made an in-depth analysis of how language is structured to encourage conversation: topic of discourse, change of topic, turn-taking, types

of shifts (concordance, discordance, clarification, etc.), use of conversational markers[16], etc. These analyses are, thus, more focused on the notion of use whereby speakers take hold of language and use it for specific purposes. This concept is different from an enunciative-discursive perspective, as discussed further in this paper.

While there are several studies on groups of aphasic individuals in the international literature, these studies can still be considered to be incipient in Brazil. This is evident in the few publications in Brazil on groups of aphasic individuals in the context of speech therapy[17,18].

There are previous studies of aphasia groups, but mostly conducted in reference research centers in the area of linguistics[19]; i.e., the discussions are not explicitly centered on speech therapy. Perhaps the reason lies in the fact that the coordinators of those research centers are linguists rather than speech therapists and, thus, they do not have a concern with clinical issues (therapist/patient relationship, rehabilitation, therapeutic setting). As pointed by Morato, one of the coordinators of the Social Center for Aphasic Individuals (CCA/Unicamp):

> If the evocation of different social and communicative practices has to do with the possibility of recovery of linguistic and cognitive processes disturbed in aphasia, they allow CCA to act "therapeutically" by strengthening social roles, sharing a symbolic space, strengthening interactions, restoring subjectivity. This characterizes CCA as a kind of social microcosm. Thus, CCA is nevertheless therapeutical in the sense that human relations can have a therapeutic effect; or in that the recognition of social rituals (empathy, friendship, group action, reflection) can be therapeutic[20].

As regards speech therapy practices based on a concept of enunciative-discursive language[21-,24], groups are considered as social spaces where aphasic individuals can express themselves discursively, despite the limitations caused by aphasia. The relationship between aphasic individuals enhances interpersonal situations that expand the possibilities of exchange and of significant language practices. Groups also promote social interaction with direct implications for the (re)construction of subjectivity of aphasic patients.

Group speech therapy favors situations and discursive practices similar to daily social practices, which provides aphasic individuals with interactive situations beyond the patient-therapist dyad, thus promoting different possibilities of practices with language in the constitution of the subject and in the processes of social inclusion.

When speech therapists use interaction as a therapeutic practice, they become privileged interlocutors who see the group as a locus of linguistic practices[25,26]. Departing from a therapeutic approach where interaction is the main founding element of language and of subjects, means considering not only the discourses produced orally and in writing, but also language practices, gestures, movements in space, orientation of glances which are foundational of referral and of the construction of meaning. Therapists, when promoting language practices and assigning meaning to different meaning-construction mechanisms, foster changes in the role of subjects as speakers.

Therefore, some issues have arisen: what factors can influence the practice of a speech therapy group in cases of aphasia? What are the specific characteristics of this group? The objective of this paper is to discuss the factors that affect the setup of a group in cases of aphasia.

Method

This is a qualitative research study. The methodology is based on aenunciative-discursive theory in which the analysis has focused on interaction and dialogic processes. The analysis, thus, comprises the process of enunciation and the factors that subjects take hold to express themselves as speakers. Therefore, both speech therapists and aphasic patients are part of the research "scenario". In this sense, during the intervention, the speech therapist presents the linguistic difficulties while highlighting the linguistic strategies used by speakers. This means that researchers/speech therapists are an object of research themselves, as they participate in dialogical events together with aphasic patients [20,22,24].

a) Research Subjects

This discussion will focus on the group of aphasic patients of Tuiuti University of Paraná (UTP). This research has been approved by the Ethics Committee of the Tuiuti University of Paraná, Project "Aphasia in Social Context" - (CEP 22/2004). The group is open and the aphasic patients who are treated at the UTP Clinic or

elsewhere come by referral and are invited to join the group. In this sense, the subjects themselves decide how long they wish to stay. Together, the participants decided that the maximum number of subject members should be twelve. In some periods, there are only three or four subjects, depending on the mobility opportunities for other members, because many of them have to be accompanied by their caregiver.

Nine aphasic subjects participated in this research: AM, AR, IR, JO, JU, MA, CO, LU, MC, and two speech therapists. All aphasic subjects have difficulty in speaking, and one of the subjects has difficulty in understanding and speaking. It is known that the different types of aphasia, and the degree of severity that characterizes each case, arise from impairment of any of the language levels[24]. In general, the subjects of the group have phonetic--phonological difficulties, difficulties with lexical access, with the syntactic structure and the semantic/pragmatic/discursive system. Because language, just like the brain, is a complex functional system, impairment might be more pronounced at one particular level, but it will certainly influence others.

b) Data Collection Procedures

The reports of the episodes below were based on the notes on the group's field research documents (described in report form) and also on transcripts of recordings of episodes of 32 two-hour sessions that took place over a period of three years (2008, 2009 and 2010).

During the sessions, the following therapeutic strategies were deployed: a) discussion of national news, international news and various topics brought by the subjects through magazines, oral comments and the Internet (shown to the group with a multimedia projector); b) group production of a book on the biography of the subjects; c) monthly tours in the region of Curitiba (sightseeing, movies, theater plays, visits to museums, etc.); d) games among participants (games with miming, dominoes, cards, drama exercises) and musical practices.

These strategies are designed to promote different enunciative situations where aphasic individuals need to express themselves discursively through various genres (comments, personal stories, explanations, information, music, etc.).

To analyze the results of this work, the episodes will be presented in the form of categories: degree of severity in aphasia, inclusion and exclusion mechanisms, the aphasic group within and outside the speech and language clinic, and the analysis of interactions. These categories were established from the longitudinal analysis of the sessions and the identification of factors that have direct implications for the setup of the group.

Results

DEGREE OF SEVERITY OF APHASIA

Episode 1

Most of the group's participants were absent, and only AR and IR were present with the therapist (TP). They discussed the World Cup. The therapist was saying that Zico was the coach of Japan's national team, and asked the aphasic subjects if they knew him.

TP: Do you know Zico? [addressing the group]
IR: I know [raising his index finger]
TP: Do you?
IR: [nods]
TP: What did Zico use to do before that? [addressing the group]
IR: (unintelligible)
TP: He was a...
IR: (unintelligible)
TP: He was a play... [prompting]
IR: (unintelligible)
TP: He plays...
IR: Occer
TP: Soccer, yeah! Right! You know! Do you know Zico, Mr. AR?
AR: Yippee! [holding up his thumb and forefinger] yippee! [raising his hand palm up]
TP: Let's say it then; I - know - him.
AR: [puts on a facil expression as if he did not know]
TP: Listen, repeat after me, Mr. AR: I - know- him.
AR: [sighs and looks at TP]
TP: Let's do it? I - know - him.
AR: I [makes a gesture of one]-know [makes a gesture of two]-know [makes a gesture of three]

Episode 2

The therapists (TP1 and TP2) and the aphasic subjects (AM and CO) were talking about the

personal narrative that CO had built in the previous session. It is worth mentioning that CO lived most of his life in the United States and uses some English words (here, because) when making his statements. In this context, AM, who has aphasia, helps CO in this construction. He wants to change the text that had been written in the previous session. The text was written as part of a book by the aphasic subjects about their life stories.

TTP1: Want to change something?
CO: [points back to the text] Here, here ... Ohh... Yeah [gesture
that signals a long time ago] ...
AM: Cat, armadillo ...
TP1: Armadillo?
CO: No.
AM: Armadillo.
CO: [repeats the gesture, pointing to the text].
AM: Ah, ARMA… armadillo ..
CO: Pa-pa-pa-pa [gesture of throwing] pisshiuuu... [movement of falling with his body] Pa-pa-pa-pa. Here... here [points to the text].
TP1: Here... Hunted ocelot with shotgun. Is that it?
CO: Yeah... Because is... Yeah [gesture, hands on the wall, climbing and then shootinh] Pitshu, pitshu!
TP1: Rifle? Shotgun? [TP1 erased what had been written].
CO: That's it, that's it.
TP1: Hunting ocelot with a shotgun?
CO: [He makes hand gesture showing three and then three sequenced movements, which seem to mean three people, and then he counts] ONE, TWO, THREE. Pshi... Pshi... [sound of shotgun].
TP1: That is it...
CO: Because is... [gesture with his hands to follow path, track].
AM: O... o... celot...
CO: [Continues making the gesture with his hands, to follow].

TP1: Cat?
CO: [Gesture showing a small animal].
AM: PECCARY
TP1: A dog?
AM: Peccary?
CO: THAT'S RIGHT
AM: Yeah, yeah...
TP1: What is it, Mr. AM?
CO: Yeah... yeah...

AM: PEC-CA-RY. PECCARY.
AP: Pec? I don't get it!
AM: Peccary.
TP2: Peccary.
TP1: Four?
CO: No... No! (...)
CO: Yeah... Yeah... Because... [points to the text and shows the line to be rewritten].
AM writes the word on paper and TP2 reads .. PEC...].
TP2: Peccary.

CO: [Repeated the gesture of pointing to the text].
TP2: What is a peccary?
CO: Yeah [small animal gesture].
AM: [Makes the same gesture as CO].
TP2: It is an animal?
CO: YEAH!
TP2: What animal does it look like?
AM: ... Like wild pig !!
CO:[Gesture showing a small animal].
TP2: A wild pig!

CO: THAT'S IT.... THAT'S IT.... [gesture that signals "plenty"] but is... [repeats the same gesture] Yeah, yeah!
TP2: So here... [changes the text that read ocelot] I will only put here that it looks like a wild pig. With a shotgun?
TP1: Got it! A peccary is an animal that looks like a wild pig.

After this dialog, the therapist wrote the following personal account by CO:

Once there was an ocelot surrounding me when I was two years old. I was very afraid. I lived on a small farm in the mountains. My father went hunting. He hunted peccaries with his shotgun. I climbed the trees and shot from above.

We know that the engagement of individuals in interactive practices is related to their language possibilities, with their possibilities of enunciative constructions. At this point, some questions arise: to what extent does the degree of severity of aphasia impair the subject's participation in the group? How can one structure a group of nonfluent aphasic

individuals? Are there changes in the group when fluent aphasic subjects are present? What are the implications for the therapeutic process?

In Episode 1, as in other group sessions with the presence of subjects with many language difficulties only, the interaction took place between AR/therapist and between IR/therapist, but not between AR/IR. AR, for example, shows stereotypy and his oral language is often restricted to uttering the word "YIPPEE". At this and other times, *the subjects responded only when requested, not addressing any other member of the group*. The therapist, thus, had to prompt the participation of the aphasic individuals. The interactions between the aphasic subjects were basically glances and facial expressions and greetings at the beginning and the at end of the group session. Without the intervention of the therapist, the aphasic subjects did not engage in conversation. Topical continuity occurs only by means of the speech of the therapist. It is the therapist who starts and who takes the turn, who prompts the aphasic subjects to speak *(let's talk, repeat after me)*. This process shows that the therapist requires the aphasic subjects to take their turn in the dialog, whether by speaking together, by complementing the statement of the therapist or even through repetition.

On the other hand, *Episode 2* shows that the degree of severity does not determine the participation of the subjects in the group. There are cases where, even with significant difficulties in speaking, the aphasic subjects express themselves, explain, narrate. This reveals that there are other important factors that should be considered: how the subjects refer to language and how they deal with aphasia in different interactions. This is perhaps more significant for interaction than the degree of severity. It is known that the degree of severity is not the same for the same person every time. The discussion of the degree of severity is far from translating the difficulties that individuals have with their language[25].

Take the case of CO, a Brazilian with American citizenship, who communicates primarily through gestures and drawings. He orally produces a stereotypy, *"because"*, and speaks very few words in Portuguese and English. His difficulties do not prevent him from acting in speech. He is a *speaker,* even in the absence of orality. This episode shows the linguistic work of CO in making a correction in the text written before, trying to replace the word "ocelot" with "peccary". It is this "arena of struggle for meaning" (according to Bakhtin, 1929/1981), in which the therapist does not know the word "peccary", that CO - along with the other aphasia subect, AM - can construct meaning for the therapist. This construction of meaning was also due to a effort of the aphasic subject in the production of several statements. That was not an easy task, as the therapist, using his linguistic repertoire and ignoring the word "peccary," mistakenly interpreted the production of the subject as a paraphasia, i.e. the production of an inappropriate word in place of a target word. There is also the effect of "imaginary positions" that occur in the context of interactions. In this case, it is necessary to recognize the image that the therapist makes of the aphasic individual as a "subject that produces paraphasias", in addition to a certain difficulty of the therapist in understanding the statement of the aphasic subject. AM's word becomes legitimized only when CO explains to his interlocutor what collared peccary means through the "small animal gesture".

There are differences in the interaction between what happens in *Episodes 1* and 2. Apparently, what makes the difference between the two episodes is the quality and diversity of interactions. The actions of CO on the language, on others, his various possibilities of enunciation and his role as speaker in engaging the therapist and AM into participating together in the construction of meanings that arise in the group, which did not occur in *Episode 1*. This was not because the subjects of this episode have more or less difficulty, but because of the way they express themselves in the group and outside, as *aphasic subjects*.

Additionally, studies that seek to understand the inclusion of subjects in groups, and how they relate to their own aphasia, should also be considered. Each subject has their own condition of belonging, sharing and relating to others, which causes them to remain or even leave the group.

It is also evident that the speech therapist is a privileged interlocutor, one that considers the different enunciative demands, who values the different forms of construction of meaning (gestures, facial expressions, writing), thus favoring the expression of aphasic subjects as *speakers*. It is because of this position that the group is an "arena of negotiations of meaning. In this group, aphasic subjects are not "patients with a disease who go to the clinic to heal"; rather, they are subjects who,

despite their aphasia, can and should express themselves as speakers.

INCLUSION OR EXCLUSION MECHANISMS IN THE APHASIC GROUP

Episode 3 (report described as a narrative)

MA participated in his first session in the group. That day, the group members were discussing the next trip that they were going to take in the region. They all decide to go to the beach house of one of the aphasic subjects. MA disagrees and says: "God save me from going to the beach! There are sharks there! No way I'm coming!" In view of this comment, the other aphasic subjects glanced at one another disapprovingly. MC, another aphasic subject, made a gesture to signal that "MA is crazy." The subjects laughed at her. The conflict was resolved when the therapist mande an Internet search for "Sharks in Matinhos". They found the news that a fisherman had been wounded by a Blue Marlin that "looked like a shark." Although the source of information was a news story on the Internet, the group did not accept MA's speech, although she speaks. She speaks a great deal, and she speaks *well*.

MA's speech shows occasional trouble finding words. For interlocutors who do not know her, she does not have "visible" deficits. However, she complains: "I do not speak as much as before." In this episode, it is clear that the formation of a group of people with alterations in language cannot be discussed without taking into account social issues, since the language has its 'bylaws'. Thus, participation and attendance of the subjects in the group have a direct relationship with both social inequality and the isolation that aphasic subjects suffer because of their difficulties in *speech*.

Language is a source of discrimination and prejudice. Speaking well, writing well, understanding and making oneself understood provides legitimacy and authority to those who have this "capacity". The discussion about what is normal or pathological in language goes beyond a purely biological or linguistic issue *strictosensu*. It also has to do with social issues[27]. That is, not only difficulties with language discriminate us, but also "what" we say and "how" we say it. The acceptance or rejection of MA's speech does not correspond to discrimination on fluency, but the way she puts on the events that are discussed by the group and relate to the world of knowledge that each subject brings to the group.

Another example is the suggestion made by MA. When the group proposed lunch in a typical Italian restaurant in the region, MA made another suggestion: "Let's have lunch at "Bandejão do BetoRicha". It costs one real and they say it's very good." At the time, BetoRicha was the mayor of Curitiba, and the "Bandejão" was a low-cost restaurant sponsored by the city council.

MA is a retired cleaner. The other members of the group have the following occupations: a doctor, a salesman, an engineer, an elementary school teacher, a university professor and a driver. It should be noted that the driver only produced the statement "No" and generally did not express arguments or opinions in the group, unless prompted to do so. That is, unlike MA, his speech was not unauthorized by the other members of the group, as there was no "opportunity" for this.

This episode shows that "fluent" speech alone does not ensure membership status to the group; on the contrary, it disallows it. Apparently, MA's views oppose to the opinions of the group; she shows other "likes and dislikes". Discrimination equates with exclusion that seems to be of a social nature. Although the therapist tried to negotiate other meanings, consider several opinions, playing the role of mediator, the sequence of statements that MA produces always put her in a situation of opposition to the group. No wonder MA participated only in three sessions and left soon after that. The support of the therapist alone does not guarantee the sense of belonging to the group. Moreover, as the most proficient aphasic member of the group, MA did not identify in this scenario, although she complained, "I do not speak as much as before."

This is an issue that deserves attention not only in research on treatments with aphasic individuals, but also in research on language treatment, in a comprehensive way. MA was not discriminated against because she did not speak, but rather because she *did speak*. Discrimination against her, however, was not on the use of language, but on what such uses denoted, i.e. social inequality: inequality of values, ideas, tastes. The therapeutic group is obviously not a homogeneous space.

APHASICS INSIDE AND OUTSIDE THE GROUP

Episode 4

JU and JO show, in their speeches, some paraphasias and difficulties in finding words. When writing their biographies, they commented their language practices within and outside the group.

JJU: I like to come here because it's people like us ... They speak the same way, everyone. I go elsewhere and there are people who need more, so there is no talk. In the Association of the Physically Disabled of the State of Paraná. There are people, but there are people who need more, then they talk, but it is not like that.
JO: When I am about to speak, I don't speak ... in the choir... in the church ...
TP: Do you keep quiet?
JO: Yes, I keep quiet... (weeps)
TP: Do you feel embarrassed?
JO: I can't speak... I can't speak... I keep quiet. I can't talk to other people that are not speech therapists.
TP: When you traveled, did you keep quiet?
JO: Other people... talk, talk... talk... and I listen.
TP: Do you wish you could speak in another space? But you don't have the courage?
JO: Yes, I want to talk to my sister, but she talks too fast, she has no patience ...
TP: Have you tried to talk to her?
JO: Yes, "calm", she rushes.
TP: Is there anyone else you talk to?
JO: With the maid, but it's not clear, with the CCR (Catholic Charismatic Renewal), but it's not perfect, in the computer class I can't speak because .... I don't know ...
TP: But can you participate in the class ... ?
JO: I can participate ... but I can't ... I can't understand ... I mean, speak. Before I used to speak perfectly but couldn't read ... no one could understand me, it was so fast ... (...) Discrimination ... That's what I feel. I go to the bank, but I can't say what I want ... I want to invest 25,000, for example, I can't ...

The literature previously mentioned points to a generalization of conversational practices of group aphasic members to other contexts. This statement assumes that speech is a communicative act that is independent of the interlocutors. However, it is known that speech production conditions, that is, what the subject can/should or should not say, considering the place he occupies and the representations he makes while articulating, are not established before the subject enunciates his speech. This game develops as speech itself is formed (Mussalim, 2000).

In this sense, it cannot be generalized that discursive practices are the same inside and outside the group. *In the case where the aphasic individual only speaks in the group, which are the gains of the therapy?* It would be a mistake to consider that all aphasic individuals speak the same way, within or outside the group, regardless of context and interlocutors; therefore, these analyses differ from Conversation Analysis.

Aphasia, the pathology, the deficit, for JO, is what relates him to the other subjects. It should be noted that the group members wrote their biographies and the name for the book suggested by JO is "Stroke: Our lives". JO is a doctor and lives on his own. When addressing the group, the disease, the deficit, represented the core of his speech, and he used it when describing all his problems in detail. For him, the group also appears to legitimize a place of exclusion, given here by the loss of "human virtue: language. Language bias can be found in JO's identification with the aphasic group, with the 'excluded'.

There are other episodes that signal this feeling of exclusion, disempowerment imposed by himself first. In one of the group rides, JO explained to the therapist the way that the driver should take. After his explanation, the therapist asked him to explain it to the driver and he replied: "I can't, I can't speak." The group seems to work as the only place where JO feels safe to speak. The place where he believes his speech is accepted, and it is only possible *to be a speaker* in this context. It is in this place that he feels confident to express himself, even with difficulties. It is in the group that his speech is authorized, legitimized. This legitimacy, however, is based not just on his "authority" or "competence" on the use of language, but precisely on his "impossibility".

The therapeutic work should focus, thus, on resignifying the relationship of this subject with his own speech and with aphasia, and also resignifying the place symptoms (difficulty in lexical access, paraphasiasetc.) occupy in their discursive practices so that, in fact, the group is not a place of

exclusion, and aphasic subjects can express themselves both within and outside the group. This is a therapeutic/speech therapy practice: working the subject's relationship with language, understanding how the symptoms affect their role as speakers, and resignifying these symptoms. Therapeutic work goes beyond linguistic work: it focuses on language, subjects and their symptoms; on aphasic subjects rather than on aphasia.

THE SPEECH AND LANGUAGE CLINIC AND THE CLINIC OF INTERACTIONS

Episode 5

In the episode below, the group discusses the murder of a four-year-old. The session was attended by two therapists, TP1 and TP2, and aphasic subjects AM, CO, JO, JU and MC. Police investigations pointed the girl's father and stepmother as the main suspects. They allegedly pushed the child out of the apartment window after strangling her. JO, one of aphasic subjects, believes in the innocence of her parents and had already spoken about this issue in the last session.

TP1: Are you now convinced that her father is guilty? Because Mr. JO had said that a father never kills his child.
JO: No ... I'm not convinced.
TP1: You're not convinced?
JO: I ... I am convinced that they ... is ... is ... there was something in the apartment.
TP1: Was there anyone there?
JO: Yes... there was something there.
TP1: Even with all the evidence...
JO: Yes.
TP1: Who else has the same opinion as Mr. JO? (...)
CO: [points to JO and makes gesture of denial and then a gesture meaning "down"]
TP1: The girl?
CO: THIS [gesture pointing down] HERE [gesture pointing up], IN HERE!
TP1: That she fell on the ground?
CO: No.
TP1: Down below?
CO: Yes.
TP1: Hit? Fell down? Her clothes?
CO: No [makes gesture showing his clothes and his neck]
TP1: Her body?
CO: No, HERE [points to the floor]
TP2: So she died when she fell down, do you think?
CO: No, no.
ES: Have they hit her in the car? Do you think so?
CO: THAT'S IT, THAT'S IT.
TP1: Do you think they had hit her before?
CO: THAT'S IT, THAT'S IT.
TP1: So when they went upstairs, they just threw her body out of the window?
CO: YEAH
TP2: Do you think her parents have done it?
CO: YEAH [gesture of approval]
TP1: And you, Ms. LO?
LO: What? [laughs]
TP1: Have you seen the story about a father and a stepmother? His daughter fell out the window and died.
LO: Yes, IIIIIII ... seeeeee.... oooon...
TP2: Where do you live... What do you think?
LO: I don't know ... I think [points to CO]
AM: OK... and Mr. AM?
AM: Also... FATHER...
TP1: Ok, also the father and stepmother, Mr. MA?
MC: Also ... the same thing.
TP1: Ms. JU?
JU: Also, her parents killed her.
JO: Their sentence... it will be two years. They'll get away with it.
TP2: They'll get away with it, because they'll find it?
JO: That's it.
TP2: Why do you think so? Few people think like that, just so we know it.
JO: FATHER does not kill his child [laughs].
TP2: And would a stepmother kill her stepdaughter? [Silence]
AM: [Gesture of disagreement].
JO: A father does not kill his child.
TP1: But she was not the mother.
AM: [facial expression showing disagreement on JO's opinion]

The episode of the group reported above can be seen as a discursive space, but also an arena of voices, of *speaking possibilities*. The therapist provides an enunciative scene where the aphasic subjects are prompted to be "critical" of the fact. The discussion activity is, thus, a text about which the subjects have to express their opinion. The staging of a point of view takes form in the articulation of the text and it involves a series of linguistic efforts

by the subjects for lexical selection: interpretive gestures, thematic continuity based on the speech of the therapist or the other aphasic subjects. The participation of everyone in the group is made possible by the acceptance of different modes of subject's resignification.

The episode also shows that one of the strategies used by the group for "speaking" is referencing. In this case, the gesture of pointing to the other aphasic subject that *speaks more* when his opinion is asked, as if to say 'I agree with what (s) he said' or 'I think like (s)he does'. This strategy demonstrates the engagement of the subjects in the discussion and even their identification with the group, considering that they find support in the speech of others to do their own talking.

In the group, the subject is a speaker: what he says is valuable and is legitimized by the other members. The offer of these discursive possibilities gradually turns aphasic members into subjects of language. While they effectively participate in discursive practices, they promote linguistic changes in their aphasia. Therefore, the therapist plays the role of enhancing linguistic practices, considering that a group is always seen as a *discursive arena*. A therapeutic treatment is effective, precisely, when it mediates situations that trigger chaos and order, which are typical of interactions.

Based on the discussions of the episodes reported in this paper, it seems possible to conclude that *group speech therapy* should consider:

1) language as a group construction of meaning, and interaction as the possibility for a variety of verbal and nonverbal dialogic practices. That is, what aphasic subjects cannot perform linguistically on their own, they can achieve in the group, as the conditions of best speaker are ensured by his interlocutors. Thus, the speech therapist should offer subjects the possibility of playing their role as interlocutors. Therefore, the group should have linguistic practices that can help aphasic subjects to regain their status as *speaking subjects*. The aim goes beyond promoting effective interaction. Therapists *look into* both *what the subject speaks* and *does not speak*, but wanted to, as well as *how he speaks.* Thus, the speech of others is constructed from his own speech, in order to form meaning--construction processes. In this case, the practices with the other modes of language, gestures and written words, are still encouraged, considering that both reading and writing as well as gestures are interrelated[28,29]. Thus, retextualization processes take place from oral to written form, and from gestures to oral and/or written form, in the most diverse discursive genres. This highlights the therapist's role in (re)constructing the aphasic subjects' language and mediating such practices among all interlocutors. Therapists, in this case, consider non-verbal language (gestures, physiognomic expressions, intonation, drawings) as constituent of significance as verbal language. The therapeutic work should encourage aphasic subjects to use these resources in their interactions. Even in cases where speech is restricted to crystallized expressions (stereotypies), speech therapists promote interactive situations where the aphasic can use several ways of expressing themselves as speaking subjects.

2) (re) construction or rescue of subjectivity as a result of interactive practices, of the discourses produced, which underpin such subjectivity[30]. This implies that there is a relationship between the subject and the language which is somehow impaired by aphasia. This relationship should be analyzed and undergo therapeutic intervention. Given the impact of aphasia for a subject who was *competent* in his speech and whose *competence* was changed, the therapist must intervene for redefining the symptoms in language, setting it apart from a normative view of the language that emphasizes *deficits*. In addition, the possibilities of language use, of understanding and being understood, of *saying* without *speaking*, modify the subject's relationship with his language, a subject that speaks, but in many cases, *does not speak*;

3) the interactions are related to the historically constructed places and social positions, and they have direct implications in the discursive processes that occur in the group. The therapist must be aware of the different *statements* that are the result of social places and positions, conflicts, values, tastes, and varying beliefs. Application of speech therapy is also evident when the therapist analyzes the speech of aphasic individuals and the conflicts that can occur in the group: interpretation, opinion, construction of meanings as a result of a social and historical construction. Another point to consider is the imaginary positions that take place in interactions. The image that aphasics have of therapists, of themselves and of other aphasic individuals makes them speak, or not speak in one way or another. It

is the therapist's role to mediate situations where everyone can express themselves and recognize themselves as interlocutors;

4) the group as a place where subjects can feel welcome and have the sense that they belong to it. It is often the only place where they can be considered "speakers". However, this varies from subject to subject, according to their social practices and the concept of speaker. In the group, unlike individual assistance, aphasic subjects feel that they are not alone; they feel supported. Thus, in a group of subjects who have difficulties with speech, the "lack of speaking" does not set them apart. On the contrary, it brings them together, makes them "equal", despite the heterogeneity of symptoms. It is this identity with the group that allows individuals to occupy a position of authorship, author of their own text, whether oral or written.

Based on these considerations, interaction can be considered the guiding principle of group treatment and discursive practices are a key element in speech and language clinics. However, this interaction cannot be established a *priori*. It "happens" in the dynamics within the group and is influenced by social, subjective and linguistic factors that are articulated around a common object, namely, how an aphasic individual deals with his *deficits* in the various interactions he participates of and how he recognizes himself as a *speaker* in these interactions[30].

Conclusion

If the group, on the one hand, gathers together the excluded, the speechless, on the other hand, it is a therapeutic space that may foster rehabilitation and consequently, *inclusion*. For this very reason, it is a space that is ambiguous, i.e., not always determined. *Speech therapy, from the perspective of enunciative-discursive neurolinguistics, conceives speech and language clinics as clinics of interactions.* The guiding principle and uniqueness of this work lies in the concept of language that it has adopted: language is dialogy, work, group construction of meaning which is expressed through various mechanisms of signification (orality, writing, gestures, drawings). It is only by considering these premises that one can understand the speech therapy process, which must take into account the multiple facets of language: biological (in this case, a socially-formed brain [21]), interactive, subjective and social.

What this study shows is that the interactive practice of an aphasic group can only be understood when linguistic, social, subjective and therapeutic aspects are taken into account. These aspects can merge in clinical practice and clearly show that any therapeutic work that fails to include them is limited to conducting conversational practices that often remain restricted to the context of that particular group.

Thus, in addition to an analysis of the conversation, a therapist is expected to see what is not visible and hearwhat is not being said. The analysis of imaginary positions in the discursive process is evidence of its importance for forming the group as a therapeutic space. These images cannot be determined a *priori* and reveal subjective aspects, conflicts of a subject who *speaks* "without speaking", or whose *speech* is not accepted, which is indicative that discursive practices do not take plave, despite the interlocutors and our social practices.

In short, the group, in the speech and language clinic, should consider the role of the speech therapist as a mediator of practices with language, social places, the relationship language/subject/symptom, the discursive practices within and outside the group, the images constructed by subjects of speech and the role of the group for each subject, a group that fosters both inclusion and exclusion, possibilities and impossibilities, gestures and speech, but, above all, is made of *speaking* subjects.

References

1. Ribeiro, VV, Panhoca, I, Dassie-Leite, AP, Bagarollo, MF. Grupo terapêutico em fonoaudiologia: revisão de literatura. Rev. CEFAC. 2012, mai/jun; 14(3):544-52.

2.Santana, A. P.; Berberian, A. P; Guarinello, S. C.; Massi, G. Abordagens Grupais na Fonoaudiologia. São Paulo, Editora Plexus, 2009.

3.Berberian, AP; Santana, AP. Fonoaudiologia em contextos grupais: referenciais teóricos e práticos. São Paulo; Plexus, 2012.

4.Ribeiro, VV, Dassie Leite, AP, Filho, LL, Cielo, CA, Bagarollo, MF. Percepção dos pais sobre a qualidade de vida em voz e evolução clínica de crianças disfônicas pré e pós-terapia fonoaudiológica em grupo. Disturb Comun. 2013, abril; 25(1): 81-90.

5.Ramos, AP, Wiethan, F.M, Klinger, EF. O grupo operativo de pais como espera assistida em casos de distúrbios de linguagem oral na infância. In Berberian, AP; Santana, AP. Fonoaudiologia em contextos grupais: referenciais teóricos e práticos. São Paulo; Plexus, 2012. p. 61-82.

6.Moleta, F, Guarinello, AC, Berberian, AP, Santana, AP. O cuidador familiar no contexto da afasia. Disturb Comun. 2011, dez; 23(3): 343-52.

7.Panhoca, I, Dassie. AP. A constituição de sujeitos no grupo terapêutico fonoaudiológico – identidade e subjetividade no universo da clínica fonoaudiológica. Disturb Comun. 2003, dez; 15(2): 289-308.

8.Machado, MLCA, Berberian, AP, Santana, AP. Linguagem escrita e subjetividade: implicações do trabalho grupal. Rev. CEFAC. 2009, out/dez; 11(4):713-9.

9.Souza APR, Crestani AH, Vieira CR, Machado FCM, Pereira LL. O grupo na fonoaudiologia: origens clínicas e na saúde coletiva. Rev. CEFAC. 2011, jan/fev; 13 (1): 140-51.

10.Guarinello, AC, Figueiredo, LC. Grupo de Familiares de Surdos. In: Marcolino, J, Zaboroski, AP, Oliveira, JP. Perspectivas atuais em Fonoaudiologia: Refletindo sobre ações na comunidade. São José dos Campos: Editora Pulso, 2010. p.183-94.

11.Elman, RJ, Bernstein-Ellis, E. The efficacy of group communication treatment in adults with chronic aphasia. J Speech Lang Hear Res. 1999, april; 42: 411-9.

12.Davidson, B, Worrall, L, Hickson, L. Identifying the communication activities of older people with aphasia: Evidence from naturalistic observation. Aphasiology. 2003, march; 17 (3): 243-64.

13.Boyle, MM, Busch, CR. Effects of aphasia group treatment on conversation and psychosocial well-being. Conference presented at the 2005 Annual American Speech-Language-Hearing Association Convention, November 18, 2005 San Diego, CA.

14.Antonucci, SM. Use of semantic feature analusis in group aphasia treatment. Aphasiology. 2009, july; 23 (7-8):854-66.

15.Goff, R, Hinckley, J, Douglas, N. Systematic evaluation of the evidence on aphasia group treatments. Clinical Aphasiology Conference. 2012, Lake Tahoe, CA, may; 20-25.

16.Dionísio, AP. Análise da Conversaçao. In: Mussalin, F, Bentes, AC, São Paulo, Editora Cortez. 2003, p. 69-100. Fernandes, DF. Processos Interativos em grupo: sujeitos afásicos no grupo terapêutico-fonoaudiológico [Dissertação]. Curitiba (PR): Universidade Tuiuti do Paraná, 2007.

17.Santana, AP, Guarinello, AC, Fernandes, D. O grupo terapêutico-fonoaudiológico nas afasias. In: Mancopes, R, Santana, AP, (Orgs.). Perspectivas na Clínica das Afasias: o sujeito e o discurso. São Paulo, Editora Santos, 2009. p. 240-61.

18.Morato, E. M. Aportes da perspectiva sociocognitiva às ações terapêuticas: a experiência do Centro de Convivência de Afásicos (CCA-Unicamp). In: Santana, AP, Berberian, AP, Guarinello, SC, Massi, G. Abordagens Grupais na Fonoaudiologia, São Paulo, Editora Plexus. 2007, p. 39-57.

19.Morato, EM; (org.) Sobre as afasias e os afásicos – Subsídios teóricos e práticos elaborados pelo centro de convivência de afásicos. Campinas, Unicamp, 2002.

20.Novaes-Pinto, RC. Cérebro, linguagem e funcionamento cognitivo na perspectiva sócio-histórico-cultural: inferências a partir do estudo das afasias. Letras de Hoje, 2012, jan/mar; 47 (1): 55-64.

21.Morato, E. Vigotski e a perspectiva enunciativa da relação entre linguagem, cognição e mundo social. Educ. Soc. 2000, julho; 71: 149-65.

22.Coudry, MI. Neurolinguística Discursiva: afasia como tradução. Est. da Ling. 2008, dezembro; 6 (2): 7-36.

23.Novaes-Pinto, R, Santana AP. Semiologia das Afasias: uma discussão crítica. Psicol.Reflex. Crit. 2009; 22(3): 413-42.

24.Novaes-Pinto, RC. Uma reinterpretação do conceito de grau de severidade a partir de uma concepção enunciativo-discursiva de linguagem e dos relatos dos sujeitos afásicos sobre suas dificuldades. 53o. Seminário do GEL - Grupo de Estudos Linguísticos do Estado de São Paulo, 2006,julho; XXXV: 1730-5.

25.Santana, AP. A linguagem na clinica fonoaudiológica. Disturb Comun. 2001, 13 (1):161-74.

26.Novaes-Pinto, RC. Preconceito Linguístico e Exclusão Social na Normalidade e nas chamadas Patologias de Linguagem. Avesso do Avesso. 2009, 6: 8-36.

27.Santana, AP, Guarinello, AC, Berberian, AP ,Massi, GA. O estatuto simbólico dos gestos no contexto da surdez. Psicol. Estud. 2008, abr./jun, 13: 297-306.

28.Santana, AP, Fedosse, E. Gesto e fala: continuidade ou ruptura? Disturb Comum. 2002, 13 (2): 243-55.

29.Pires, VL, Sobral, A. Implicações do estatuto ontológico do sujeito na teoria discursiva do Círculo Bakhtin. Bakhtiniana, 2013, jan/jun 8 (1): 205-19.

30.Santana, AP. A constituição de um grupo terapêutico-fonoaudiológico com afásicos [Monografia apresentada no Concurso Público para Professor Adjunto da Universidade Federal de Santa Catarina]. Florianópolis (SC): UFSC; 2009..